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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 94G4

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 **11/04/2015** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE NEII 11/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/10/2015 (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
06/24/2015 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5366

On October 22, 2015, November 2 and November 4, 2015 the Minnesota Department of Public Safety, Office of Health Facility Complaints and Licensing and Certificion coducted Post Certification Revisits to verify the facilty achieved and maintained compliance. Based on the visits we determined the facility has corrected the remaining deficiences, effective November 4, 2015. As a result of the visits, we discontinued the Category 1 remedy of State monitoring.

In addition we recommended the following action as it relates to previous letters sent by this Department and CMS Region V office:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015 be discontinued effective November 4, 2015. (42 CFR 488.417 (b))

• Federal civil money penalty of $7,000.00 per instance for the instance of non-compliance at F323 for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

• Federal civil money penalty of $3,000.00 instance of non-compliance at F314, remain in effect. (42 CFR 488.430 through 488.444)

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 an extended or partial extended survey as a result of a finding of substandard quality of care. 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 July 21, 2015.

Refer to the CMS 2567b forms for the results of this visit.

Effective November 4, 2015, the facility is certified for 170 skilled nursing facility beds.

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245366

December 9, 2015

Mr. Edward Brady, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

Dear Mr. Brady:

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 November 4, 2015 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

Electronically delivered
November 19, 2015

Mr. Edward Brady, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366025, H5366063, F5366024, F5366025, H5366064

Dear Mr. Brady:

On July 22, 2015, as authorized by CMS Region V office, this Department informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of July 22, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 20, 2015.

This was based on deficiencies cited this department for a standard survey and an abbreviated standard survey completed on May 20, 2015, and lack of verification of compliance of both standard and abbreviated standard surveys at the time of our July 22, 2015. The standard and abbreviated standard surveys found 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 July 29, 2015, CMS Region V office forwarded the results of the Federal Monitoring Survey (FMS) completed on July 14, 2015. As the surveyor informed you during the exit conference, The FMS revealed the facility continues to not be in substantial compliance. The FMS 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.

As a result the survey findings, and as authorized by CMS Region V office, this Department notified you on July 22, 2015, of the imposition of the following remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015. (42 CFR 488.417 (b))

Also, as we notified you in our letter of July 22, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 20, 2015.

On July 21, 2015, the Minnesota Department of Health, Office of Health Facility Complaints and Licensing and Certification completed a PCR and on July 9, 2015, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard and abbreviated standard surveys completed on May 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 20, 2015. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard and abbreviated standard surveys completed on May 20, 2015. Substandard Quality of Care (SQC), which resulted in an extended survey where we found conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety.

As a result of the revisit and extended survey findings, this Department imposed the Category 1 remedy of state monitoring, effective August 12, 2015.

In addition, this Department recommended to the CMS Region V office the following action related to the imposed remedies in our letters of July 22, 2015 an August 6, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015, remain in effect. (42 CFR 488.417 (b))

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 an extended or partial extended survey as a result of a finding of substandard quality of care. 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 July 21, 2015. 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.

Furthermore, this Department recommended the following additional remedies to the CMS Region V office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

On September 9 and 10, 2015, the Minnesota Department of Health's Licensing and Certification Program and Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 19, 2015. Based on our visit, we had determined that your facility had not corrected the deficiencies issued pursuant to our PCR, completed on September 9 and 10, 2015. As a result of the revisit findings, the Category 1 remedy of State monitoring remained in effect.

On September 28, 2015, CMS Region V office notified you of the continuation of previously imposed remedies and recommendations by this Department to impose additional remedies. CMS concurs that a CMP is warranted and imposed the following:

- Federal civil money penalty of $7,000.00 per instance for the instance of non-compliance at F323 for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Federal civil money penalty of $3,000.00 instance of non-compliance at F314. (42 CFR 488.430 through 488.444)

On October 27, 2015, CMS Region V office notified you of Continuation of previously imposed remedies and imposition of termination. If the facility fails to achieve substantial compliance by November 20, 2015, the following additional remedy would be imposed:

- Mandatory Termination of your Medicare and Medicaid provider agreements, effective November 20, 2015.

On October 22, 2015, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify the facility achieved and maintained compliance with deficiencies issued pursuant to the Federal Monitoring Survey (FMS) completed on July 14, 2015. Based on our visit, we have determined that your facility corrected the deficiencies issued pursuant to the FMS completed on July 14, 2015 as of August 20, 2015.

In addition, on November 2 and 4, 2015, the Minnesota Department of Health's Licensing and Certification Program and Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 9 and 10, 2015. Based on this visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 9 and 10 2015, effective November 4, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 4, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies outlined in this letter and detailed in previously letters sent to you from this Department and CMS Region V office:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015 be discontinued effective November 4, 2015. (42 CFR 488.417 (b))

• Federal civil money penalty of $7,000.00 per instance for the instance of non-compliance at F323 for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

• Federal civil money penalty of $3,000.00 instance of non-compliance at F314, remain in effect. (42 CFR 488.430 through 488.444)

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 an extended or partial extended survey as a result of a finding of substandard quality of care. 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 July 21, 2015. 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.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245366	A. Building B. Wing	11/4/2015

Name of Facility	Street Address, City, State, Zip Code
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **11/04/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/04/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/04/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/04/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/04/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/04/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **11/04/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	11/19/2015	18617	11/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/20/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245366	A. Building B. Wing	11/2/2015

Name of Facility	Street Address, City, State, Zip Code
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **11/02/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **11/02/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/02/2015**
ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **11/02/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **11/02/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MN/mm	11/19/2015	20784	11/02/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/9/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 94G4

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 **09/10/2015** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 10/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/23/2015 (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
06/24/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5366

On September 9, 2015, an abbreviated standard survey was conducted by the Department's Office of Health Facility Complaints, alongside the Post Certification Revisit (PCR) completed by the Department's, Licensing and Certification Program on September 10, 2015. Based on this visit, we have determined that complaint number H5366064 pursuant to the abbreviated standard survey completed on September 9, 2015, was found to be substantiated and on September 10, 2015 a PCR completed to verify that the facility achieved and maintained compliance with federal certification deficiencies issued pursuant to the PCR, completed on July 21, 2015. We presumed, based on your plan of correction, that the facility had corrected the deficiencies from the July 21, 2015 PCR. Based on our visit, we have determined that the facility has not achieved substantial compliance with the deficiencies issued pursuant to the PCR, completed on July 21, 2015. The deficiencies not corrected are as follows:

-F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
-F0314 -- S/S: E -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
-F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
-F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans

In addition, at the time of this visit, we identified the following deficiencies pursuant to the abbreviated standard survey completed on September 9, 2015 and the PCR completed September 10, 2015:

-F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified
-F0312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents
-F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder
-F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) Invest/Report Alleg Individuals
-F0226 -- S/S: D -- 483.13(c) Development/Implment Abuse/Neglect ETC Policies
-F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans
-F0333 -- S/S: D -- 483.25(m)(2) Residents Free of Significant Med Errors
-F0425 -- S/S: D -- 483.60(a),(b) Pharmaceutical Svc-Accurate Procedures, RPH

The most serious deficiencies in the facility were found 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 attached CMS-2567, whereby corrections are required.

As a result of this visit, the Category 1 remedy of state monitoring will remain in effect. In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letters of July 22, 2015 and August 6, 2015:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015, remain in effect. (42 CFR 488.417 (b))
• Civil money penalty for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

Furthermore, as we notified you in our letters of July 22, 2015 and August 6, 2015, 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), the facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 21, 2015 as a result of the extended survey that identified SQC. Post Certification Revisit (PCR) to follow.

Refer to the CMS 2567 along with the facilitys plan of correction and CMS 2567b for health only.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

REVISED

Electronically delivered
September 23, 2015

Ms. Lynn Hickey, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366025, H5366063, F5366024, H5366064

Dear Ms. Hickey:

Please note: Language was added to this letter related to the September 9, 2015 abbreviated standard survey (complaint number H5366064) that was conducted alongside the September 10, 2015 revisit.

On July 22, 2015, this Department, as authorized by the CMS Region V Office, informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015. (42 CFR 488.417 (b))

Also, you were notified in our letter of July 22, 2015, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 20, 2015.

This was based on lack of verification of substantial compliance health deficiencies issued pursuant to the May 20, 2015 standard and abbreviated standard surveys, at the time of our July 22, 2015 notice. The most serious were found 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 July 14, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were 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 July 21, 2015, a Post Certification Revisit was conducted by the Department of health to verify that the facility had achieved and maintained compliance with deficiencies issued pursuant to the standard and abbreviated standard survey completed on May 20, 2015. Substandard Qualty of Care (SQC) was identified, which resulted in an extended survey.

The extended survey was conducted July 16, 2015 through July 21, 2015. Conditions in the facility at the time of the extended survey constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety.

Based on the July 21, 2015 visit, this Department found that your facility had corrected the deficiencies issued pursuant to the abbreviated standard survey completed on May 20, 2015. However, the facility had not achieved substantial compliance with the deficiencies issued pursuant to the standard survey completed on May 20, 2015. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

As a result of finding that the facility continues to not be in substantial compliance, this Department imposed the Category 1 remedy of State monitoring, effective August 12, 2015.

On July 29, 2015, CMS forwarded the results of the July 14, 2015 FMS and informed you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and as authorized by CMS Region V Office, This department notified you in our letter of July 22, 2015, that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015. (42 CFR 488.417 (b))

In addition, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Chris Jensen Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 21, 2015 (As a result of the extended survey that identified SQC, this date changed from August 20, 2015 to July 21, 2015). This prohibition remains in effect for the specified period even though substantial compliance is attained.

Furthermore, this Department recommended the following additional remedies to the CMS Region V office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

On September 9, 2015, an abbreviated standard survey was conducted by the Department's, Office of Health Facility Complaints, alongside the Post Certification Revisit (PCR) completed by the Department's, Licensing and Certification Program on September 10, 2015. Based on this visit, we have determined that complaint number H5366064 pursuant to the abbreviated standard survey

completed on September 9, 2015, was found to be substantiated and on September 10, 2015 a PCR completed to verify that the facility achieved and maintained compliance with federal certification deficiencies issued pursuant to the PCR, completed on July 21, 2015. We presumed, based on your plan of correction, that your facility had corrected the deficiencies from the July 21, 2015 PCR.

Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to the PCR, completed on July 21, 2015. The deficiencies not corrected are as follows:

F0282 -- S/S: E -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0314 -- S/S: E -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans

In addition, at the time of this visit, we identified the following deficiencies pursuant to the abbreviated standard survey completed on September 9, 2015 and the PCR completed September 10, 2015:

F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified
F0312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents
F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder
F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) Invest/Report Alleg Individuals
F0226 -- S/S: D -- 483.13(c) Development/Implment Abuse/Neglect ETC Policies
F0279 -- S/S: D -- 483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans
F0333 -- S/S: D -- 483.25(m)(2) Residents Free of Significant Med Errors
F0425 -- S/S: D -- 483.60(a),(b) Pharmaceutical Svc-Accurate Procedures, RPH

The most serious deficiencies in your facility were found 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 attached CMS-2567, whereby corrections are required.

As a result of this visit, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letters of July 22, 2015 and August 6, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015, remain in effect. (42 CFR 488.417 (b))

- Civil money penalty for the deficiency cited at F314, remain in effect. (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

Furthermore, as we notified you in our letters of July 22, 2015 and August 6, 2015, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 21, 2015 as a result of the extended survey that identified SQC.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) and and State Form Revisit Report from this visit is posted to the ePOC system.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag **(from the PCR completed on September 10, 2015**), i.e., the electronic plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag **(from the abbreviated standard survey completed on September 9, 2015**), i.e., the electronic plan of correction should be directed to:

Michelle Ness, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
Email: michelle.ness@state.mn.us

Phone: (651) 201-4217
Fax: (651) 281-9796

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 Office of Health Facility Complaints staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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 November 20, 2015 (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 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	R 09/10/2015

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 An second onsite resurvey was conducted by surveyors of this department on September 8, 9, 10, 2015, to determine compliance with federal deficiencies issued during a revisit survey exited on July 21, 2015. During this visit the following regulations were determined to be not corrected. 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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		10/19/15

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

Electronically Signed | 10/02/2015

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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F 278	Continued From page 1 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's Minimum Data Set (MDS) accurately identified falls with injury for 1 of 3 residents (R83) reviewed for accidents. Findings include: R83 had multiple falls including one on 6/15/15, which resulted in a head laceration that required closure with staples at the emergency department. Another one on 7/3/15, in which the facility applied steri-strips to a laceration on his forehead. Although R83's quarterly MDS dated 8/2/15, indicated R83 had sustained two or more falls since the prior MDS dated 5/9/15, it had not identified the falls which resulted in injury. Review of R83's fall incident report and post fall assessments revealed the following: -On 6/15/15, at 1:00 p.m. R83 was found on the	F 278	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Resident # 83 has had an MDS modification completed. An audit was completed of residents with falls to assure proper coding of MDS. Education was provided to MDS coordinator to assure proper coding of MDS takes place for residents with falls. Ongoing audits of MDS¿s will take place	

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F 278	Continued From page 2 floor in his room, he had attempted to self-transfer to the toilet. R83 received a laceration on his head and required a visit to the emergency room for closure with staples. -On 7/3/15, at 6:50 p.m. R83 was in the dining room, stood up out of his wheelchair and fell, hitting his head on the table. R83 received a laceration to his forehead and was treated at the facility with steri-strips (used to hold the laceration together). On 9/10/15, at 8:19 a.m. registered nurse (RN)-L, who completed R83's 8/2/15, MDS verified the above falls with injury and stated she should have identified the injuries sustained from the falls on the MDS.	F 278	monthly x 3 by MDS consultant and then re-evaluate by the QAA committee. The DON/Designee will report results and trends of all audits to the QAA committee for review and follow up as needed.	
{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide toileting assistance and/or incontinence care as directed by the individual care plan for 6 of 7 residents (R229 , R172, R19, R155, R105, R202) reviewed for urinary incontinence. In addition, the facility also failed to provide repositioning services as directed by the individualized care plans for 5 of 8 residents (R19, R155, R105, R202, R86) reviewed who required staff assistance for	{F 282}	Residents¿ number 229, 172, 19, 155,105 and 202 have been assessed by the nurse manager of the respective unit and have had no ill effects from the deficient practice. Care plans were reviewed to assure that they accurately reflect resident care needs. Any resident who needs assistance with toileting or repositioning could be affected	10/19/15

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{F 282}	Continued From page 3 repositioning and were at risk for pressure ulcers. Findings include: R229 did not receive timely toileting assistance as directed by the care plan. R229's current care plan dated 8/18/15, indicated R229 required extensive assistance of one staff for toileting and directed staff to toilet R229 every 2 hours while awake and as tolerated and to check/change incontinent brief and offer toilet every 2 hours at night. The Nursing Assistant (NA) Care Sheet dated 9/9/15, indicated R229 was incontinent of bowel and bladder and directed staff to offer R229 the toilet every two hours while awake and check/change on night shift, if awake. On 09/08/2015, at 4:20 p.m. R229 was observed to ambulate independently in the hallway. -at 5:15 p.m. R229 was seated at a table in the dining area eating independently. -at 5:35 p.m. R229 ambulated independently in the hallway. -at 6:14 p.m. R229 continued to ambulate up and down the halls. Her pants were noted to be drooping in the seat. -at 6:18 p.m. R229 was bumped by another resident in a wheelchair. R229 grimaced and cursed. -at 6:19 p.m. R229 continued to ambulate in the hall. Her incontinent brief was observed sagging inside her pant leg to the middle of her left thigh. -at 6:21 p.m. registered nurse (RN)-B assisted R229 to ambulate to her room. R229 held her pants up as she ambulated. RN-B checked her	{F 282}	by this practice. Nursing staff have been educated on following resident specific care guides to direct them with their plan of care to assure deficient practice does not re-occur. DON/Designees will complete toileting and repositioning audits five times per week, with review of prior 24 hours of documentation. This audit will be completed five times per week on random shifts by the DON/Designee to assure all shifts are following POC as written x 3 month and then reevaluated by the QAA committee. The DON/Designee will report results and trends of all audits to the QAA committee for review and follow up as needed. Any system noted not to be sustained by review of audits will be revised per QAA recommendations The DON/Designee will report results and trends of all audits to the QAA committee for review and follow up as needed.	

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{F 282}	Continued From page 4 feet for injury and then left the room. -at 6:26 p.m. R229 ambulated independently in the hallway. Her brief sagged to her left knee inside her pants leg. -at 6:28 p.m. nursing assistant (NA)-D offered R229 the bathroom and assisted her to ambulate to her bathroom. NA-D assisted R229 to lower her pants and sit on the toilet. R229 had been incontinent of large amount of bowel movement and also incontinent of urine. R229 voided additional urine in the toilet. NA-D provided R229 with peri cares. She stated R229 had last been offered the toilet at 3:30 p.m., (3 hours) however, should be offered the toilet and checked/changed every two hours. On 09/09/2015, at 2:57 p.m. RN-B verified R229's care plan directed staff to offer R229 the toilet every 2 hours while awake and check/change every 2 hours at night. RN-B confirmed R229's care plan was not followed and should have been offered the toilet as directed by the care plan. R172 did not receive toileting assistance as directed by the care plan. R172's current care plan dated 8/20/15, indicated R172 required extensive assist of one person for toileting or two persons if increased behavioral expression. The care plan directed staff to check/change incontinent brief and offer R172 the toilet every two hours. The NA Care Sheet dated 9/9/15, indicated R172 was incontinent of bowel and bladder and directed staff to check/change incontinent brief every two hours.	{F 282}		

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{F 282}	Continued From page 5 On 9/8/15, at 4:15 p.m. R172 was seated in a wheelchair wheeling herself within her room and occasionally leaning forward at the waist. -at 4:33 p.m. R172's family member (FM)-D entered the room to visit. -at 4:34 p.m. NA-D entered the room, applied a gait belt to R172's waist and ambulated her to the dining room. NA-AF followed behind with a wheelchair. R172 was continuously observed seated at a table in the dining room being assisted with supper by FM-D until 5:29 p.m. -at 5:29 p.m. R172 stood up at the table while FM-D assisted her with her meal and encourage her to sit down. -at 5:33 p.m. R172 again stood up at the table while eating her meal and was assisted to sit down -At 5:34 p.m. R172 again stood up at the table. FM-D stated to NA-D she thought R172 was wet and was why she continued to stand up during the meal. R172 was assisted to sit down. -at 5:39 p.m. NA-D wheeled R172 to her room and assisted her to the toilet. R172's brief was saturated with urine. R172 smelled strongly of urine and was observed to have a reddened groin. NA-D stated R172 was last toileted at 2:20 p.m. (3 hours 20 minutes) and NA-D confirmed R172 was to be offered the toilet/checked/changed every two hours and stated she should have brought her to the bathroom before ambulating her to supper. On 09/09/2015, at 2:14 p.m. RN-B verified R172 should have been toileted/checked/changed every 2 hours as directed by her care plan. R19 was not provided incontinence care or repositioning assistance as directed by the care	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHRIS JENSEN HEALTH & REHABILITATION CENTER	**2501 RICE LAKE ROAD DULUTH, MN 55811**

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{F 282}	Continued From page 6 plan. R19's care plan dated 6/25/15, indicated R19 was at risk for skin breakdown due to impaired mobility, limitations in range of motion and history of skin ulcers to her feet and legs. The care plan directed staff to turn and reposition R19 every two hours and as needed. The NA Care Sheet directed staff to assist R19 out of her wheelchair and assist her into bed for at least one hour after each meal. The care plan also indicated R19 was incontinent of bladder at all times, and directed R19 to be checked upon rising, before and after meals, at bedtime and as needed. During continuous observations on 9/8/15, from 4:23 p.m. until 6:35 p.m. R19 was observed sitting in her wheelchair in the dining room and near the nurse's station. -at 6:35 p.m. R19 was brought out to the nurse's station where she remained in her wheelchair until 6:54 p.m. when registered nurse (RN)-H brought R19 back into the dining room where a movie was playing. -at 7:10 p.m. (after 2 hours and 47 minutes) the surveyor informed RN-H that R19 had not been checked for incontinence or repositioned for nearly three hours. -at 7:12 p.m. NA-O brought R19 to her room, and stated R19 should be check/change and repositioned every two hours. NA-O placed a hoyer lift sling under R19. - at 7:17 p.m. (two hours and fifty-five minutes after the first observation) NA-S came into the room to assist with laying R19 in the bed. R19's incontinent brief was saturated with urine. NA-S stated she had gotten R19 up at 3:00 p.m., gave	{F 282}		

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{F 282}	Continued From page 7 her a bath, then had transferred her to the wheelchair and taken her into the dining room at about 4:00 p.m. (4 hours and 17 minutes without check/change or repositioning). NA-S stated she was aware R19 was to be check/change and repositioned every two hours. On 9/8/15, at 7:18 p.m. RN-H verified R19 should have had her incontinent brief changed after supper and repositioned every two hours as directed by the care plan. R155 was not provided incontinent care or repositioned as directed by the care plan. R155's Comprehensive Skin Risk Data Collection dated 7/31/15, directed staff to reposition R155 every two hours. The NA group sheet directed staff to reposition R155 every two hours. R155's care plan dated 6/22/15, directed staff to check R155's incontinent brief upon rising, before and after meals, at bedtime and as needed and during rounds at night. During continuous observations on 9/8/15, from 4:23 p.m. to 6:34 p.m. R155 was observed to remain seated in his wheelchair, in the dining room. -at 6:35 p.m. R155 was wheeled out to the nurse's station. -at 6:58 p.m. RN-H was notified by the surveyor that R155 had not been checked for incontinence	{F 282}		

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{F 282}	Continued From page 8	{F 282}		

care for two and a half hours. At that time, NA-S and NA-Y assisted R155 to his room and transferred R155 via a mechanical stand up lift onto the toilet. R155's incontinence brief was saturated with urine. NA-Y stated R155 had been up in his wheelchair since 2:30 or 3:00 p.m. (4 hours earlier). NA-Y stated she was aware R155 was supposed to be repositioned and changed every two hours.

On 9/8/15, at 7:18 p.m. RN-H verified R155 should have been repositioned and had his incontinent brief changed after supper as directed by the care plan.

R105 was not provided repositioning assistance or incontinence care as directed by the care plan.

R105's Admission Record indicated admission diagnoses including Advanced Parkinson's disease, dementia, prostate cancer and anxiety.

R105's Bowel/Bladder Care Plan, revised 8/17/15, indicated R105 was incontinent and directed staff to check and changed R105's incontinent brief every two hours. The Skin Integrity Care Plan, directed staff to follow facility protocol for repositioning every two hours.

The Birch Group Nursing Assistant Worksheet for 9/9/15, directed staff to position R105 side to side every two hours.

On 9/8/15, at 4:14 p.m. NA-U was observed to wheel R105 from his room to in front of the TV

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{F 282}	Continued From page 9 near the nurse's station. R105 was observed to remain seated in the wheelchair until assisted into the dining room for supper at 5:00 p.m. Once in the dining room, R105 remained seated in the wheelchair. -at 6:01 p.m. R105 was assisted back the the TV area. -at 6:15 p.m. R105 remained seated in the wheelchair, was shaking his arms with hands clasped together. -at 6:23 p.m. R105's entire body was shaking in a manner that suggested agitation. R105 had pushed his wheelchair back until it had been stopped by a table. No staff assisted R105. -at 6:47 p.m. NA-U stated R105 was last repositioned around 4:15 p.m. -at 6:53, R105 remained in the wheelchair in front of the TV. -at 7:17 p.m. NA-U and NA-W were observed to transfer R105 to bed via a mechanical lift. While NA-U and NA-W provided R105's incontinence care, R105's brief was saturated with urine and had a strong urine smell. NA-U stated she usually did not work on R105's unit. R105 was observed to remain seated without repositioning assistance or incontinence care for 3 hours. R202 was not repositioned or provided incontinence care as directed by the care plan. R202's Skin Integrity care plan updated 8/24/15, directed staff to change R202' position every 30 minutes, attempt to minimize sheering of butt, provide a pressure reduction cushion in wheelchair, pressure reduction mattress on bed, incontinence care with every incontinent brief change.	{F 282}		

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{F 282}	Continued From page 10	{F 282}		

R202's bowel and bladder care plan dated 8/24/15, directed staff to provide toileting assistance upon rising, between meals, at bedtime and to check and change incontinent brief every two hours at night as needed (PRN).

The nursing assistant Elm Group #2 sheet dated 9/8/15, indicated in bold print, the direction to for staff to reposition R202 every 30 minutes.

On 9/8/15, at 4:15 p.m. R202 was observed in bed, lying on back.
-at 4:38 p.m. family member (FM)-C entered and remained in the room until 5:20 p.m.
-at 4:45 p.m. FM-C stated R202 was placed into bed after 3:00 p.m. and had remained in bed, on back without repositioning.
-at 5:30 p.m. NA-AB entered the room with R202's a dinner tray. NA-AB elevated R202's head of the bed, placed the bedside table over the bed, set up R202's meal tray and left the room.
-at 5:40 p.m. until to 6:21 p.m. R202 was intermittently observed to remain in bed with the meal in front of her. R202 was either sleeping or eating during the observations.
-at 6:19 p.m. NA-AB stated R202 was last repositioned around "four-ish." When asked how often R202 was to be repositioned, NA-AB stated probably every two hours as that was the standard. NA-AB reviewed the Elm Group #2 sheet and verified it directed staff to reposition R202 every 30 minutes. NA-AB stated, "I will go do that now."
-at 6:21 p.m. NA-AB entered R202's room to

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{F 282}	Continued From page 11	{F 282}		

reposition R202 and stated R202 was incontinent of urine. The brief was observed wet with urine. NA-AB proceeded to provide R202 incontinence cares. R202's skin was intact and not reddened. NA-AB could not state the last time R202 was assisted to the bathroom or checked for incontinence.

On 9/8/15, at 6:40 p.m. R202 stated most of the time she could not tell when she needed to go to the bathroom and could not tell when her incontinent brief was soiled and required changing.

On 9/8/15, at 6:40 p.m. RN-A stated R202 was to be repositioned every 30 minutes "for life" as it was a physician order.

On 9/10/15, at 9:44 a.m. the director of nursing (DON) verified R202 had a physician order and was also care planned to be repositioned every 30 minutes and stated staff should have repositioned R202 as directed.

On 9/10/15, at 1:14 p.m. RN-A stated R202 should have been brought to the bathroom or checked for incontinence as directed by the care plan.

On 9/10/15, at 2:41 p.m. the DON verified R202 should have been taken to the bathroom or had her incontinent brief checked / changed prior to dinner on 9/8/15, as directed by the care plan.

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{F 282}	Continued From page 12 R86 was not repositioned as directed by the plan of care. R86's undated Admission Record indicated R86 was diagnosed with dementia, cerebral artery occlusion (stroke) and generalized pain. R86's Comprehensive Skin Risk Data Collection Form dated 4/24/15, directed staff to turn and reposition R86 every two hours and utilize a pillow for support. -A follow up RN narrative assessment dated 8/15/15, and written on the above collection form indicated R86 remained at risk for pressure ulcers and required side to side repositioning assistance every 1 to 2 hours. R86's Skin Integrity Care Plan dated 6/25/15, indicated R86 was at risk for pressure ulcers and directed staff to turn R86 side to side when in bed every one to two hours and to provide a pressure redistribution mattress on R86's bed. The Birch Group #3 Nursing Assistant Sheet (Group Sheet) indicated R86 was to be repositioned every one to two hours. On 9/8/15, at 4:28 p.m. R86 was observed in bed lying on her back with one pillow under her knees and the bed at approximately a 45 degree angle. -at 4:32 p.m. NA-V entered the room, put the head of the bed down to about 20 degrees, talked to R86 and then left the room. -at 4:49 p.m. R86 remained in bed, on her back. -at 5:00 p.m. licensed practical nurse (LPN)-G	{F 282}		

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{F 282}	Continued From page 13 entered the room and administered medications to R86 and left the room. -at 5:20 p.m. NA-U entered the room with R86's supper tray. NA-U left to get straws, then returned to assist R86 with her meal. R86 remained on her back, in bed during the meal. -at 5:48 p.m. NA-U removed R86's supper tray out of the room. R86 remained in the same position. -at 7:04 p.m. R86 remained in bed, on her back. (2 hours 36 minutes) On 9/8/15, at 7:02 p.m. NA-U stated she usually did not work on R86's unit and she did not have the NA group sheet that included R86 so she was not aware of how often or when R86 was last repositioned. On 9/8/15, at 7:04 p.m. NA-V stated R86 was not on her NA group list, therefore she did not know when R86 was last repositioned, however, the two aides that worked between 2:00-6:00 p.m. talked about what resident cares needed to be done. The facility policy and procedure on Care Plans - Comprehensive dated 4/1/08, indicated the care plans included measurable objectives and timetables designed to meet the resident's medical, nursing, mental and psychosocial needs, as identified in the comprehensive assessments.	{F 282}		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		10/19/15

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F 312	Continued From page 14 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care for 3 of 3 residents (R19, R155, R105) who were incontinent of bowel/bladder. Findings include: R19 was not provided incontinence care for 4 hours and 17 minutes minutes on 9/8/15. R19's Admission Record identified diagnoses that included dementia, urinary incontinence and rheumatoid arthritis. The quarterly Minimum Data Set (MDS) dated 6/20/15, identified R19 was cognitively intact, and required extensive assistance of two staff for bed mobility, transfers and toileting. The MDS further identified R19 was always incontinent of bladder, and was not on a bladder retraining program. The Bowel and Bladder Functional Evaluation Tool dated 6/25/15, indicated R19 was incontinent of urine, and wore an incontinence brief at all times. The care plan dated 6/25/15, indicated R19 was incontinent of bladder at all times, and was to be checked upon rising, before and after meals, at bedtime and as needed. During continuous observations on 9/8/15, from	F 312	Resident # 19, 155, and 105 202 have been assessed by the nurse manager of the respective unit and have had no ill effects from the deficient practice. Care plans were reviewed to assure that they accurately reflect resident care needs. All residents requiring assistance with toileting or repositioning could be affected by this practice. Nursing staff have been educated on following resident specific care guides to direct them with their plan of care to assure deficient practice does not re-occur. Care plans were reviewed to assure that they accurately reflect resident care needs. DON/Designees will complete toileting audits five times per week on random shifts with review of the prior 24 hours of documentation. This audit will be completed five times per week by the DON/Designee x 3 months and then re-evaluated by the QAA committee. The DON/Designee will report results and trends of all audits to the QAA committee for review and follow up as needed. Any	

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F 312	Continued From page 15 4:23 p.m. until 6:35 p.m. R19 was observed sitting in her wheelchair in the dining room and near the nurse's station. -at 6:35 p.m. R19 was brought out to the nurse's station where she remained in her wheelchair until 6:54 p.m. when registered nurse (RN)-H brought R19 back into the dining room where a movie was playing. -at 7:10 p.m. after 2 hours and 47 minutes the surveyor informed RN-H that R19 had not been checked for incontinence for nearly three hours. -at 7:12 p.m. nursing assistant (NA)-O brought R19 to her room, and stated R19 should be check/change every two hours. NA-O placed a hoyer lift sling under R19. - at 7:17 p.m. (two hours and fifty-five minutes after the first observation) NA-S came into the room to assist with laying R19 in the bed. R19's incontinent brief was saturated with urine. NA-S stated she had gotten R19 up at 3:00 p.m., gave her a bath, then had transferred her to the wheelchair and taken her into the dining room at about 4:00 p.m. (4 hours and 20 minutes without check/change). NA-S stated she was aware R19 was to be check/change every two hours. On 9/8/15, at 7:18 p.m. RN-H verified R19 should have had her incontinent brief changed after supper according to the care plan. R155 was not provided incontinence care for at least 4 hours 9/8/15. R155's Admission Record identified diagnoses that included dementia and hypertension. The quarterly MDS dated 7/29/15, indicated R155 had severe cognitive impairment, required extensive assistance of two staff for bed mobility and transfers, and extensive assistance of one staff for toileting. The MDS further indicated R155 was	F 312	system noted not to be sustained by review of audits will be revised per QAA recommendations.	

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F 312	Continued From page 16	F 312		

frequently incontinent of urine, and was not on a toileting program.

The Bowel and Bladder Functional Evaluation Tool dated 7/31/15, indicated R155 was to be checked and changed every two hours and as needed, and that staff were to provide pericare after each incontinent episode. The care plan dated 6/22/15, directed staff to check incontinent brief upon rising, before and after meals, at bedtime and as needed, and during rounds at night.

During continuous observations on 9/8/15, from 4:23 p.m. to 6:34 p.m. R155 was in his wheelchair in the dining room.
-at 6:35 p.m. R155 was wheeled out to the nurse's station.
-at 6:58 p.m. RN-H was notified by the surveyor that R155 had not been checked for incontinence care for over two and a half hours. At that time, NA-S and NA-Y brought R155 to his room, and used the stand assist lift to put R155 on the toilet. R155's incontinence brief was saturated with urine. NA-Y stated R155 had been up in his wheelchair since 2:30 or 3:00 p.m. NA-Y stated she was aware R155 was supposed to be changed every two hours.

On 9/8/15, at 7:18 p.m. RN-H verified R155 should have had his incontinent brief changed after supper according to the care plan.

R105 was not provided incontinence care for 3 hours on 9/8/15.

R105's Admission Record indicated admission diagnoses including advanced Parkinson's

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F 312	Continued From page 17 disease, dementia, prostate cancer and anxiety. R105's quarterly MDS dated 8/2/15, indicated R105 had severely impaired cognition, was always incontinent of bladder and was frequently incontinent of bowel. R105's Bowel and Bladder Functional Evaluation Tool, dated 12/8/14, and reviewed most recently on 8/17/15, identified R105 as incontinent of bladder, frequently incontinent of bowel and required a total assist of 2 for transfers and toileting. The narrative summary indicated R105 uses a bedside commode and is to be checked and changed every 2 hours. R105's Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA identified R105 as incontinent of bladder, and frequently incontinent of bowel. R105 was to be toileted every 2 hours due to retention. R105's Urinary Incontinence CAA dated 12/4/15, identified incontinence of bladder, prostate cancer with occasional retention, and frequent bowel incontinence. R105's Bowel/Bladder Care Plan, revised most recently on 8/17/15, listed a goal for the resident to be clean, dry with incontinence cares done every two hours through next review date. Interventions listed included check and change every two hours. On 9/8/15, at 4:14 p.m. R105 was observed sitting in his wheelchair watching TV near the nurse's station. - at 5:00 p.m. R105 remained in his wheelchair watching TV when a staff member wheeled R105 to the dining room for supper. - at 6:01 p.m. R105 was wheeled back to the TV area. -at 6:15 p.m. R105 started to shake his arms while sitting in his wheelchair.	F 312		

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	245366	A. BUILDING _____ B. WING _____	R 09/10/2015

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F 312	Continued From page 18 -at 6:23 p.m. R105's entire body was shaking, in a manner that suggested agitation. R105 had pushed his wheelchair back until it had been stopped by a table. -at 6:53 p.m. R105 was still in his wheelchair in front of the TV. -at 6:59 p.m. NA-U came to assist R105 with cares. On 9/8/15, at 7:02 p.m. NA-U stated she does not usually work this unit. On 9/8/15, at 7:17 p.m. NA-U and NA-W transferred R105 to bed using a total lift device. NA-U and NA-W then changed R105's incontinence product. There was a strong urine smell and the incontinence product was soaked with urine. The facility policy and procedure on Bowel and Bladder Management dated 3/1/14, directed residents who are unable to participate in a toilet schedule program or do not respond to toileting trial will receive individualized supportive management (i.e. check and change schedule). The facility policy and Procedure on Activities of Daily Living dated 4/1/08, directed a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to toilet. A resident who is unable to carry out activities of daily living receives the necessary care and services to maintain good nutrition, grooming, and personal hygiene.	F 312		
{F 314} SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	{F 314}		10/19/15

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{F 314}	Continued From page 19 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 5 of 8 residents (R19, R155, R86, R105, R202) identified with history of pressure ulcers and/or at risk for pressure ulcers and required staff assistance for repositioning. Findings include: R19 was at risk for pressure related ulcers and was not repositioned on 9/8/15, for 4 hours and 17 minutes. R19's undated Admission Record identified diagnoses that included dementia, urinary incontinence and rheumatoid arthritis. R19's quarterly Minimum Data Set (MDS) dated 6/20/15, indicated R19 was cognitively intact and required extensive assistance of two staff for bed mobility, transfers and toileting. The MDS further	{F 314}	Residents number 19, 155, 86, 105, and 202 have been assessed by the nurse manager of the respective units and have had no ill effects from the deficient practice. Care plans were reviewed to assure that they accurately reflect resident care needs. Any resident who needs assistance with repositioning could be affected by this practice. Nursing staff have been educated on following resident specific care guides to direct them with their plan of care to assure deficient practice does not re-occur. Care plans were reviewed to assure that they accurately reflect residents¿ care needs. DON/Designees will complete repositioning audits five times per week with review of the prior 24 hours of documentation. This audit will be completed five times per week on random	

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{F 314}	Continued From page 20 indicated R19 was always incontinent of bladder and was at high risk for the development of a pressure ulcer. R19's care plan dated 6/25/15, indicated R19 was at risk for skin breakdown due to impaired mobility, limitations in range of motion and history of skin ulcers to her feet and legs. The care plan directed staff to turn and reposition R19 every two hours and as needed. The Nursing Assistant (NA) care group sheet directed staff to assist R19 out of her wheelchair and into bed for at least one hour after each meal. During continuous observations on 9/8/15, from 4:23 p.m. until 6:35 p.m. the following was observed: -at 4:23 p.m. R19 was observed seated in her wheelchair in the dining room and also near the nurse's station. -at 6:35 p.m. R19 was assisted out of the dining and placed near the nurse's station where she remained in her wheelchair. -at 6:54 p.m. registered nurse (RN)-H assisted R19 back into the dining room where a movie was playing. -at 7:10 p.m. the surveyor informed RN-H that R19 had not been checked for incontinence for nearly three hours (2 hours and 47 minutes). -at 7:12 p.m. NA-O assisted R19 to her room. NA-O positioned a mechanical lift sling under R19 and waited for another staff to assist. -at 7:17 p.m. (two hours and fifty-five minutes later) NA-S entered R19's room and assisted to	{F 314}	shifts by the DON/Designee x 3 months and then reevaluated by the QAA committee. The DON/Designee will report results and trends of all audits to the QAA committee for review and follow up as needed. Any system noted not to be sustained by review of audits will be revised per QAA recommendations	

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{F 314}	Continued From page 21 transfer R19 into bed. R19's incontinent brief was saturated with urine. NA-S stated she had last provided cares to R19 at about 3:00 p.m. when she assisted R19 into the wheelchair following her bath. NA-S stated she was aware R19 was to be repositioned every two hours and staff did the best they could to provide timely care. At the same time, NA-O also verified R19 was to be turned and repositioned every two hours. On 9/8/15, at 7:18 p.m. RN-H stated R19 should have been repositioned every two hours as directed by the care plan. R155 was at risk for pressure related ulcers and was not repositioned for 4 hours on 9/8/15. R155's undated Admission record indicated R155 was diagnosed with dementia. R155's quarterly MDS dated 7/29/15, indicated R155 had severe cognitive impairment, was at risk for the development of pressure ulcers and required extensive assistance of two staff for bed mobility and transfers. R155's Pressure Ulcer Care Area Assessment (CAA) dated 2/16/15, indicated R155 was at risk for the development of a pressure ulcer. R155's The Comprehensive Skin Risk Data Collection dated 7/31/15, directed staff to	{F 314}		

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{F 314}	Continued From page 22 reposition R155 every two hours. The NA group sheets directed staff to reposition R155 every two hours. During continuous observations on 9/8/15, from 4:23 p.m. to 6:34 p.m. R155 was observed to remain seated in his wheelchair, in the dining room. -at 6:35 p.m. R155 was wheeled out to the nurse's station. -at 6:58 p.m. RN-H was notified by the surveyor that R155 had not been provided cares for two and a half hours. At that time, NA-S and NA-Y assisted R155 to his room and transferred R155 via a mechanical stand up lift onto the toilet. NA-Y stated R155 had been up in his wheelchair without repositioning since 2:30 or 3:00 p.m. (4 hours earlier). NA-Y stated she was aware R155 was supposed to be repositioned every two hours. On 9/8/15, at 7:18 p.m. RN-H stated R155 should have been repositioned as directed by the care plan. R86 was at risk for pressure related ulcers and was not repositioned for 2 hours and 36 minutes on 9/8/15. R86's undated Admission Record indicated R86 was diagnosed with dementia, cerebral artery occlusion (stroke) and generalized pain. R86's quarterly MDS dated 7/16/15, indicated R86 had moderate cognitive impairment, required	{F 314}		

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{F 314}	Continued From page 23 extensive assistance with bed mobility and transfers and had not ambulated during the MDS assessment period. The MDS also indicated R86 was at risk of pressure ulcers, skin was currently intact and utilized pressure redistribution devices in the bed and chair. R86's Pressure Ulcer CAA dated 4/23/15, indicated R86 required extensive assistance with bed mobility, had an undesirable weight loss and was at risk of developing pressure ulcers. The CAA indicated R86's risk factors consisted of immobility, incontinence, altered mental status, poor nutrition and the use of an antidepressant medication. R86's Activities of Daily Living (ADL) CAA dated 4/23/15, indicated R86 required extensive assist of two staff with bed mobility. R86's Comprehensive Skin Risk Data Collection Form, dated 4/24/15, directed staff to turn and reposition R86 every two hours and utilize a pillow for support. -A follow up RN narrative assessment dated 8/15/15, and written on the above collection form indicated R86 remained at risk for pressure ulcers and R86 had a stage 1 (intact skin with non-blanchable redness) pressure ulcer area on her coccyx. The note further indicated R86's tissue tolerance completed 7/9/15, revealed R86 required side to side repositioning assistance every 1 to 2 hours. R86's Skin Integrity Care Plan, dated 6/25/15, indicated R86 was at risk for pressure ulcers and	{F 314}		

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{F 314}	Continued From page 24 directed staff to turn R86 side to side when in bed every one to two hours and to provide a pressure redistribution mattress on R86's bed. R86's Braden assessment (a tool used to determine risk for the development of pressure related ulcers) score dated 8/15/15, indicated R86 was at risk for the development of pressure ulcers. The Birch Group #3 Nursing Assistant Sheet (Group Sheet) indicated R86 was to be repositioned every one to two hours. On 9/8/15, at 4:28 p.m., R86 was observed in bed lying on her back with one pillow under her knees and the bed at approximately a 45 degree angle. -at 4:32 p.m. NA-V entered the room, put the head of the bed down to about 20 degrees, talked to R86 and then left the room. -at 4:49 p.m. R86 remained in bed, on her back. -at 5:00 p.m. licensed practical nurse (LPN)-G entered the room and administered medications to R86 and left the room. -at 5:20 p.m. NA-U entered the room with R86's supper tray. NA-U left to get straws, then returned to assist R86 with her meal. R86 remained on her back, in bed during the meal. -at 5:48 p.m. NA-U removed R86's supper tray out of the room. R86 remained in the same position. -at 7:04 p.m. R86 remained in bed, on her back. (2 hours 36 minutes)	{F 314}		

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{F 314}	Continued From page 25 On 9/8/15, at 7:02 p.m. NA-U stated she usually did not work on R86's unit and she did not have the NA group sheet that included R86 so she was not aware of how often or when R86 was last repositioned. On 9/8/15, at 7:04 p.m. NA-V stated R86 was not on her NA group list, therefore she did not know when R86 was last repositioned, however, the two aides that worked between 2:00-6:00 p.m. talked about what resident cares needed to be done. R105 was at risk for pressure related ulcers and was not repositioned for 3 hours on 9/8/15. R105's undated Admission Record indicated R105 was diagnosed with advanced Parkinson's disease, dementia and prostate cancer. R105's quarterly MDS dated 8/2/15, indicated R105 had severely impaired cognition, was at risk for pressure ulcers and skin was intact. R105's Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA indicated R105 was at risk for press ulcer ulcers. R105's Comprehensive Skin Risk Data Collection form, updated on 8/17/15, indicated R105's Braden score indicated R105 was at risk for the development of pressure ulcers. The Birch Group Nursing Assistant Worksheet for 9/9/15, directed staff to reposition R105 side to side every two hours.	{F 314}		

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{F 314}	Continued From page 26	{F 314}		

On 9/8/15, at 4:14 p.m. NA-U was observed to wheel R105 from his room to in front of the TV which was near the nurse's station. R105 was observed to remain seated in the wheelchair until assisted into the dining room for supper at 5:00 p.m.
-at 6:01 p.m. R105 was assisted back the the TV area. R105 remained seated in the wheelchair without repositioning.
-at 6:15 p.m. R105 started to shake his arms while sitting in his wheelchair. R105's hands were clasped together, and raised nearly horizontal to his shoulders.
-at 6:23 p.m. R105's entire body was shaking in a manner that suggested agitation. R105 had pushed his wheelchair back until it had been stopped by a table. No staff assisted R105.
-at 6:47 p.m. NA-U stated R105 was last repositioned around 4:15 p.m.
-at 6:53 p.m. R105 remained in the wheelchair in front of the TV.
-at 7:02 p.m. NA-U stated she usually did not work R105's unit therefore was unfamiliar with the residents' care needs.
-at 7:17 p.m. NA-U and NA-W were observed to transfer R105 to bed via a mechanical lift. R105 was observed to remain seated without repositioning assistance for 3 hours and 1 minute.

R202 was at risk for the development of pressure ulcers and was not repositioned for 3 hours and 20 minutes on 9/8/15.

R202's quarterly MDS dated 6/12/15, indicated R202 was diagnosed with dementia, was at risk

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{F 314}	Continued From page 27 for pressure ulcers, had moderate cognitive impairment and required extensive assistance with bed mobility and transferring. R202's physician orders dated 1/9/14, indicated R202 required position changes every 30 minutes, for life. R202's Braden assessment dated 6/15/15, indicated R202 was at low risk for developing pressure ulcers. R202's Comprehensive Skin Risk Data Collection quarterly assessment dated 6/15/15, indicated R202 was at risk to develop pressure ulcers due to a history of a pressure ulcer with a flap procedure in October 2013, age, diagnoses, incontinence, assistance needed with toileting and decreased mobility. The assessment directed staff to complete weekly skin checks, daily visualization with care, pressure redistribution mattress on bed, cushion on chair and assist with repositioning. R202's skin integrity care plan updated 8/24/15, directed staff to reposition R202 every 30 minutes, attempt to minimize sheering of butt, pressure redistribution cushion in wheelchair and bed, incontinence care with every incontinent brief change and to observe R202's skin with a.m. and p.m. cares as well as perform a skin check weekly with bath. The nursing assistant Elm Group #2 sheet dated	{F 314}		

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{F 314}	Continued From page 28 9/8/15, indicated in bold print, the directive to reposition R202 every 30 minutes. On 9/8/15, at 4:15 p.m. R202 was observed in bed, lying on back. -at 4:38 p.m. family member (FM)-C entered and remained in the room until 5:20 p.m. -at 4:45 p.m. FM-C stated R202 was placed into bed after 3:00 p.m. and had remained in bed, on back without repositioning. -at 5:30 p.m. NA-AB entered the room with R202's a dinner tray. NA-AB elevated R202's head of the bed, placed the bedside table over the bed, set up R202's meal tray and left the room. -at 5:40 p.m. until to 6:21 p.m. R202 was intermittently observed to remain in bed with the meal in front of her. R202 was either sleeping or eating during the observations. -at 6:19 p.m. NA-AB stated R202 was last repositioned around "four-ish." When asked how often R202 was to be repositioned, NA-AB stated probably every two hours as that was the standard. NA-AB reviewed the Elm Group #2 sheet and verified it directed staff to reposition R202 every 30 minutes. NA-AB stated, "I will go do that now." -at 6:21 p.m. NA-AB entered R202's room and assisted R202 to reposition. During incontinence cares, R202's skin was observed intact and not reddened. On 9/8/15, at 6:40 p.m. RN-A stated R202 was to be repositioned every 30 minutes "for life" which was ordered following R202's surgical flap repair of a previous pressure ulcer. RN-A again stated R202 required staff assistance to reposition when	{F 314}		

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{F 314}	Continued From page 29 in bed. On 9/10/15, at 9:44 a.m. the director of nursing (DON) verified R202 had a physician order and a care plan directive for every 30 minute repositioning assistance. The DON stated she believed the physician order was outdated and should have been discontinued when the surgical wound had healed. The DON also stated it was doubtful staff were able to implement R202's care plan related to repositioning every 30 minutes and would be contacting R202's plastic surgeon to discontinue the order. The facility was unable to provide a policy on repositioning.	{F 314}		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely	F 315	Resident # 229, 172, and 202 will have new bowel and bladder assessments	10/19/15

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F 315	Continued From page 30 assistance with toileting/incontinence care for 3 of 4 residents (R229, F172, R202) assessed to be incontinent of bladder with ability to toilet. Findings include: R229 did not receive toileting assistance for 3 hours on 9/8/15. R229's quarterly Minimum Data Set (MDS) dated 7/31/15, indicated R229 had severe cognitive impairment and diagnoses that included Alzheimer's disease. The MDS also indicated R229 required extensive assistance of 2+ persons for toilet use and 1 person for personal hygiene and supervision with ambulation. The MDS further identified R229 was always incontinent of urine, frequently incontinent of bowel and no toileting program was currently being used to manage R229's bowel or bladder incontinence. R229's Communication Care Area Assessment (CAA) dated 2/18/15, indicated R229 was incontinent of bladder and frequently incontinent of bowel. R229's Urinary Incontinence and Indwelling CAA dated 2/18/15, indicated with a decline in continence, cognitive loss and decline in activities of daily living status. R229's Bowel and Bladder Functional Evaluation Tool Quarterly Review dated 8/5/15, indicated R229 remained incontinent of bowel and bladder, was independent with ambulation but needed assist of one person with toileting and incontinence cares. The review identified R229 was to be assisted to the toilet every two hours while awake and checked/changed at night if awake.	F 315	completed and care plans updated. Residents have been assessed by the nurse manager of the respective unit and have had no ill effects from the deficient practice. Any resident who needs assistance with toileting could be affected by this practice. Nursing staff have been educated on following resident specific care guides and care plans for their toileting plan to assure deficient practice does not re-occur. Care plans were reviewed to assure that they accurately reflect residents¿ care needs. DON/Designees will complete toileting audits five times per week on random shifts, with review of the prior 24 hours of documentation. This audit will be completed five times per week by the DON/Designee x 3 month and then reevaluated by the QAA committee. The DON/Designee will report results and trends of all audits to the QAA committee for review and follow up as needed. Any system noted not to be sustained by review of audits will be revised per QAA recommendations	

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R229's current care plan dated 8/18/15, indicated R229 required extensive assistance of one staff for bathing and toileting and directed staff to toilet R229 every 2 hours while awake and as tolerated and to check/change and offer toilet every 2 hours at night.
The nursing assistant (NA) care sheet dated 9/9/15, indicated R229 was incontinent of bowel and bladder and directed staff to offer R229 the toilet every 2 hours while awake and check/change on night shift if awake.

On 09/08/2015, at 4:20 p.m. R229 was observed to ambulate independently in the hallway.
-at 5:15 p.m. R229 was seated at a table in the dining area eating independently.
-at 5:35 p.m. R229 ambulated independently in the hallway.
-at 6:14 p.m. R229 continued to ambulate up and down the halls. Her pants were noted to be drooping in the seat.
-at 6:18 p.m. R229 was bumped by another resident in a wheelchair. R229 grimaced and cursed.
-at 6:19 p.m. R229 continued to ambulate in the hall. Her incontinent brief was observed sagging inside her pant leg to the middle of her left thigh.
-at 6:21 p.m. registered nurse (RN)-B assisted R229 to ambulate to her room. R229 held her pants up as she ambulated. RN-B checked her feet for injury and then left the room.
-at 6:26 p.m. R229 ambulated independently in the hallway. Her brief sagged to her left knee inside her pants leg.
-at 6:28 p.m. nursing assistant (NA)-D offered R229 the bathroom and assisted her to ambulate to her bathroom. NA-D assisted R229 to lower her pants and sit on the toilet. R229 had been incontinent of large amount of bowel movement

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and also incontinent of urine. R229 voided additional urine in the toilet. NA-D provided R229 with peri cares. She stated R229 had last been offered the toilet at 3:30 p.m., however, should be offered the toilet and checked/changed every two hours.

On 09/09/2015, at 2:57 p.m. RN-B verified R229's care plan indicated staff were to offer the toilet every 2 hours while awake and check/change every 2 hours at night. RN-B confirmed R229 should have been offered the toilet as directed by the care plan.

R172 did not receive toileting assistance for 3 hours 20 minutes on 9/8/15.

R172's annual MDS dated 7/3/15, indicated R172 had severe cognitive impairment and diagnoses that included Alzheimer's disease and urinary incontinence. The MDS also indicated R172 required extensive assist of 2+ persons for toilet use and ambulation and extensive assist of one person for transfers and personal hygiene. The MDS further indicated R172 was always incontinent of urine and bowel and no toileting program was currently being used to manage R172's bowel or bladder incontinence.

R172's Urinary Incontinence and Indwelling Catheter CAA dated 7/15/15, indicated R172 was always incontinent of bowel and bladder and her needs would have to be anticipated. The CAA indicated R172 was to be checked/changed every 2 hours and/or as needed.

R172's Bowel and Bladder Functional Evaluation Tool dated 6/3/15, indicated R172 was mostly incontinent of bowel and bladder secondary to

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severe advanced dementia. The evaluation indicated R172 was checked and toileted every 2 hours while awake and incontinence care was provided as needed.

R172's current care plan dated 8/20/15, indicated R172 required extensive assist of one person for toileting or two persons if increased behavioral expression. The care plan directed staff to check/change and offer R172 the toilet every two hours.

The NA care sheet dated 9/9/15, indicated R172 was incontinent of bowel and bladder and directed staff to check/change every two hours.

On 9/8/15, at 4:15 p.m. R172 was seated in a wheelchair wheeling herself within her room and occasionally leaning forward at the waist.
-at 4:33 p.m. R172's family member (FM)-D entered the room to visit.
-at 4:34 p.m. NA-D entered the room, applied a gait belt to R172's waist and ambulated her to the dining room. NA-AF followed behind with a wheelchair. R172 was continuously observed seated at a table in the dining room being assisted with supper by FM-D until 5:29 p.m.
-at 5:29 p.m. R172 stood up at the table while FM-D assisted her with her meal and encourage her to sit down.
-at 5:33 p.m. R172 again stood up at the table while eating her meal and was assisted to sit down
-At 5:34 p.m. R172 again stood up at the table. FM-D stated to NA-D she thought R172 was wet and was why she continued to stand up during the meal. R172 was assisted to sit down.
-at 5:39 p.m. NA-D wheeled R172 to her room and assisted her to the toilet. R172's brief was

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saturated with urine. R172 smelled strongly of urine and was observed to have a reddened groin. NA-D stated R172 was last toileted at 2:20 p.m. and NA-D confirmed R172 was to be offered the toilet/checked/changed every two hours and stated she should have brought her to the bathroom before ambulating her to supper.

On 09/09/2015, at 2:14 p.m. RN-B verified R172 should have been toileted/checked/changed every 2 hours. RN-B confirmed R172 should have been toileted every two hours as directed by her care plan.

R202 did not receive toileting assistance for 3 hours and 20 minutes on 9/8/15.

R202's quarterly MDS dated 6/12/15, identified R202 had a moderate cognitive impairment and diagnosis of dementia. The MDS identified R202 required extensive assistance with bed mobility, transferring and toileting assistance. The MDS also identified R202 to be frequently incontinent of bladder and bowel and was not appropriate for a toileting program.

R202's annual 3 Day B&B (bowel & bladder) Assessment dated 11/7/14, had incomplete data and could not accurately identify the resident's bowel and bladder patterns over the three day period.

R202's Bowel and Bladder Functional Evaluation Tool quarterly assessment dated 6/15/15, indicated R202 was frequently incontinent of bowel and bladder and needed extensive assist with toileting needs. The assessment indicated R202 could make their needs known and could

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use the call light appropriately. The section "current elimination symptoms" was left blank and did not identify the reason for R202's incontinence.

R202's bowel and bladder care plan dated 8/24/15, included the following interventions: toilet upon rising, between meals, at bedtime and as needed (PRN).

The nursing assistant Elm Group #2 sheet listed R202 as incontinent and directed staff to toilet upon rising, between meals, at bedtime PRN

During continuous observations on 9/8/15, at 4:15 p.m. to 4:38 p.m. R202 was observed to be lying in a supine position in bed. At no time did a staff member assist R202 to the bathroom or check resident for incontinence.

On 9/8/15, at 4:38 p.m. family member (FM)-C entered the room to visit and was present at R202's bedside until 5:20 p.m. At 4:45 p.m. FM-C reported that R202 was placed into bed after 3:00 p.m. R202 was not assisted to the bathroom or checked for incontinence during this time and was in the same position as when continuous observations began at 4:15 p.m..

On 9/8/15, at 5:30 p.m. NA-AB entered the room to bring R202 a dinner tray. NA-AB elevated the HOB to approximately 45 degrees and placed the dinner tray on the bed side table. The bed side table was placed over R202's bed and NA-AB set up R202's dinner tray. NA-AB left the room. R202 was not assisted to the bathroom or checked for incontinence at this time.

On 9/8/15, during intermittent observations from

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5:40 p.m. to 6:21 p.m. R202 was observed in bed with the dinner tray in position over the bed. R202's HOB was elevated to approximately 45 degrees lying in bed. R202 was either sleeping or eating dinner during that time frame. R202 remained in the same position and was not observed to be assisted to the bathroom or checked for incontinence.

On 9/8/15, at 6:21 p.m. NA-AB entered R202's room to reposition R202 and reported that R202 was incontinent of urine. The brief was observed to be wet with the whole indicator strip on the brief dark blue. NA-AB assisted R202 with incontinence cares. R202's skin was intact and not reddened. NA-AB could not report the last time R202 was assisted to the bathroom or checked for incontinence.

On 9/8/15, at 6:40 p.m. R202 explained she does not know when she needs to go to the bathroom most of the time and cannot tell when she needs her brief changed.

On 9/10/15, 1:14 p.m. RN-A explained the process for developing resident's toileting schedules. An annual Bowel and Bladder Functional Evaluation Tool are filled out to determine the resident's needs. The facility uses the 3 Day B&B Assessment, review of nursing assistant charting and nursing home interviews to determine toileting/incontinence needs. RN-A acknowledge the 3 Day B&B Assessment dated 11/7/15, and the Bowel and Bladder Functional Evaluation Tool dated 6/15/15, were not fully completed. RN-A stated that R202 should have been brought to the bathroom or checked for incontinence per the care plan. RN-A could not explain how an individualized toileting/check and

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change schedule is developed in the facility. RN-A reported that a new annual assessment is in the process of being completed and the data gathered at this time is showing a decrease in the resident's urinary status.

On 9/10/15, at 2:41 p.m. director of nursing (DON) stated she has expectations that all areas of the Bowel and Bladder Functional Evaluation Tool and 3 Day B&B Assessment are to be completed. DON verified that R202 should have been taken to the bathroom or checked and changed if needed prior to dinner, per R202's care plan. DON further explained the facility goal is to eventually get everyone on a personalized toileting program as the toilet upon rising, between meals and bedtime and check and change every two hours at night is a standard program unless someone's need is greater.

The facility policy and procedure on Bowel and Bladder Management dated 3/1/14, directed residents who are unable to participate in a toilet schedule program or do not respond to toileting trial will receive individualized supportive management (i.e. check and change schedule). The facility policy and Procedure on Activities of Daily Living dated 4/1/08, directed a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to toilet. A resident who is unable to carry out activities of daily living receives the necessary care and services to maintain good nutrition, grooming, and personal hygiene.

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{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 comprehensively assess efficacy of interventions to minimize the risk of falls for 2 of 4 residents (R75, R222) reviewed for accidents. Findings include: R75 has a history of multiple falls without a comprehensive assessment regarding risk for falls to determine possible root causes for falls and continued attempts for self transferring. R75 sustained a 2nd fall on 8/24/15, when he was left unattended and sustained an injury. R75's Admission Record identified diagnoses that included dementia with behaviors, hallucinations and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 7/5/15, indicated R75 was cognitively impaired, had mood indicators of feeling down, depressed or hopeless. The MDS also identified physical behaviors directed at others 1-3 days. The MDS further indicated R23 required extensive assistance of 2 staff with bed mobility, transfers and ambulation, and limited	{F 323}	Resident R75 is currently in acute care and will be reassessed upon return to the facility. R222 has had his current fall care plan interventions assessed by the nurse manager of respective unit and has had no ill effects from the deficient practice. Any resident who falls may be at risk for this deficient practice. Education has been provided to licensed nurses and nurse managers related to fall policy, proper fall interventions, and reviewing post fall investigation process. A process has been implemented to cue an additional review of new interventions status post one week from fall to assure interventions have been effective or to drive a new review of interventions. Education has been provided to direct care staff with regard to importance of following the plan of care related to fall prevention and safety interventions. DON/Designees will complete fall review	10/19/15

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{F 323}	Continued From page 39 assistance of 1 staff for locomotion on and off the unit. R75's Falls Care Area Assessment (CAA) dated 1/29/15, indicated R75 was at risk for fractures, soft tissue injuries, and fear of falling limiting activities. However, the CAA failed to comprehensively assess R75's risk for falls. R75's care plan dated 6/18/15, directed staff to use the following measures to reduce injuries with falls: fall mat to left side of bed, call light positioned for easy access, ensure environment is free of clutter, have commonly used articles within easy reach,offer activities after dinner to keep resident awake later in the evening, and keep in observable areas. On 7/14/15, the following interventions were added: keep bed at knee height so feet can touch floor, and ambulate on p.m. shift. The care plan also indicated R75 was always incontinent of bladder and frequently incontinent of urine. It directed R75 required extensive assistance of one staff to toilet upon rising, between meals, at bedtime and as needed, and check and change every two hours at night. Review of R75's fall incident reports and post-fall assessments since 6/15, revealed the following: - 6/10/15, at 6:30 p.m. R75 was in the dining room in his wheelchair, he stood to walk and fell to his knees. R75 sustained an abrasion to his right knee. Registered Nurse (RN) summary indicated resident has poor safety awareness/impaired gait. He attempted to walk independently to room and fell to the floor. The post-fall assessment indicated fall interventions currently being used: wheelchair alarm. Interventions to be implemented as a result of the assessment: medication review.	{F 323}	audits five times per week. This audit will be completed five times per week by the DON/Designee x 3 month and then reevaluated by the QAA committee. The IDT will meet twice per day four times per week to review plan of care for any resident with falls/incidents as part of morning IDT stand up and to review any additional follow ups at afternoon cool down meeting. New interventions will be reviewed by the IDT one week post fall to evaluate effectiveness of the new intervention. The DON/Designee will report results and trends of all audits to the QAA committee for review and follow up as needed.	

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{F 323}	Continued From page 40 - 6/23/15, at 4:50 a.m. R75 was found sitting on the floor of his bathroom. R75 sustained a shallow 2.5 centimeter (cm) laceration on his right forearm. The RN summary indicated resident has dementia with impaired safety awareness, impaired gait/balance related to Parkinson's disease. He walked to his bathroom and fell. The post-fall assessment indicated fall interventions currently being used: pressure alarms. Interventions to be implemented as a result of the assessment: request urinalysis, resident has a history of urinary tract infections. - 6/29/15, at 2:30 p.m. R75 was found kneeling next to his bed. R75 did not have an injury. The RN summary indicated resident was found kneeling next to his bed, no injury noted. Resident has dementia with poor safety awareness and judgement. Fall mat placed next to bed. The post-fall assessment indicated fall interventions currently being used: pressure alarms on bed and wheelchair. Interventions to be implemented as a result of the assessment: fall mat placed on left side of resident's bed. - 7/11/15, at 6:45 a.m. R75 was found on the floor in the doorway to his room. R75 sustained a 3 cm x 2 cm abrasion on his right knee. The RN summary indicated resident has impaired gait related to Parkinson's disease with no safety awareness. Very impulsive and will get up to walk without assistance. Alarm pressure mat had linen piled on it. The post-fall assessment indicated fall interventions currently being used: there was no documentation. Interventions to be implemented as a result of the assessment: started with physical therapy to help with gait/stability/safety. On 7/17/15, the care plan indicated the pressure	{F 323}		

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{F 323}	Continued From page 41 alarm on the bed and wheelchair was discontinued. - 8/16/15, at 6:40 p.m. R75 had gotten up out of his wheelchair and attempted to ambulate in the hallway, tripped over a stand assist lift and fell. R75 sustained a bruise to his right hand. The RN summary indicated R75 had impaired gait related to Parkinson's disease, impaired judgement and safety awareness related to dementia. The post-fall assessment was not provided by facility. - 8/19/15, at 1:30 p.m. R75 was found on the floor, did not sustain an injury. The RN summary indicated resident has cognitive impairment and is impulsive, and is currently on antibiotics for a urinary tract infection (UTI). The post-fall assessment indicated fall interventions currently being used: there was no documentation. Interventions to be implemented as a result of the assessment: resident's chart reviewed, resident had a history of UTIs, has a diagnosis of benign prostatic hyperplasia (BPH, commonly known as an enlarged prostate) with no medication ordered. Nursing to check for post void residual (PVR; checking the amount of urine left in the bladder after voiding) for 3 days, and physician was called in the p.m. for a change in antibiotics. - 8/24/15, at 9:00 a.m. R75 was in the dining room in his wheelchair when he stood up. Staff went to assist him to sit down, he swung out at staff, and fell. R75 sustained a red spot on his right outer hip. The RN summary indicated R75 attempted to get up, when staff assisted him he became combative, tried to strike staff which caused him to lose his balance and fall. The post-fall assessment indicated fall interventions currently being used: keep resident in common	{F 323}		

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area to be observed frequently. Summary of post-fall findings: continue to keep resident in common area to be observed. Interventions to be implemented as a result of the assessment: was not completed.

- 8/24/15, at 10:00 a.m. R75 was found on the floor in his room. R75 sustained a laceration to the right side of his head above the ear. The RN summary indicated R75 was placed on a 1:1, and an investigation was initiated. The post-fall assessment indicated fall interventions currently being used: observation, keep resident in common area. Summary of post-fall findings: resident has had increased confusion, treatment for UTI. Due to increased confusion resident has attempted to get up, lost his balance and fell. Interventions to be implemented as a result of the assessment: was not completed. Review of the nurse's record and progress notes 8/24/15, indicated R75 sustained a laceration on the right side of his head, and on his forehead, and R75 complained of head pain. R75 was sent to the emergency room, and was admitted to the hospital with diagnoses of UTI and subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover the brain). R75 returned to the facility on 8/26/15.

On 8/27/15, a Falls Risk Assessment indicated R75 was at risk for falls due to dementia, no safety awareness and compulsiveness. The assessment was updated on 9/2/15, and identified R75 remained at high risk for falls related to diagnoses of dementia, Parkinson's disease, use of antihypertensive medications, and psychotropic medications. Continue with current interventions. However, the assessment failed to comprehensively assess risk factors

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which would include analysis of falls to determine trends, reason for attempts to transfer, and efficacy of interventions.

On 9/10/15, from 7:26 a.m. to 9:41 a.m. R75 was continuously observed sitting in his wheelchair in the dining room. At 9:41 a.m. R75 attempted to push himself away from the table, and was brought to his room by nursing assistant (NA)-L. NA-L assisted R75 to bed with a stand assist lift. NA-L stated R75 was going to take a nap, and she was aware he was not to be left alone in his room when not sleeping. NA-L left the room, and R75 had the call light across his chest, and a mat was placed next to the bed.

On 9/10/15, at 1:10 p.m. RN-H was interviewed and stated R75 can move around in his wheelchair independently at times. RN-H verified R75's fall with significant injury on 8/24/15, occurred while he was in his room, and she "suspected" he had pushed himself to his room. RN-H verified she had not added any new fall interventions since R75 returned from the hospital 8/26/15.

On 9/10/15, the director of nursing (DON) was interviewed and stated the facility did complete a PVR for R75, and it indicated he had little to no residual urine in his bladder after voiding. The DON also stated R75 was currently receiving physical therapy (PT) since his hospital return.

PT Initial Evaluation notes dated 8/27/15, indicated R75 was referred to skilled PT following acute hospitalization due to fall in facility and subarachnoid hemorrhage with scalp laceration. R75 was well known to this therapy department,

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and had previously been seen to address balance and falls. R75 presented with decreased activity tolerance, impaired gait and balance, increased assist for transfers, high fall risk, shorter gait distance, decreased range of bilateral lower extremities, and functional decline. R75 was referred to skilled PT five times a week for 30 days.

R222 had a history of falls, and the facility did not assess the interventions in place to prevent falls.

R222's Admission Record identified diagnoses that included dementia with behavioral disturbances and osteoarthritis. The quarterly MDS dated 6/4/15, indicated R222 had severe cognitive impairment, had mood indicators of trouble concentrating on things such as reading the newspaper or watching television half or more of the days. The MDS also identified R222 had physical behavior symptoms directed towards others 1-3 days, and other behaviors symptoms not directed at others 1-3 days. The MDS indicated R222 required extensive assistance of 2 staff for transfers, extensive assistance of 1 staff for locomotion on and off the unit, and was totally incontinent of bowel and bladder. R222's CAA dated 9/25/14, indicated R222 was at risk for fractures, soft tissue injuries, and fear of falling limiting activities. However, the CAA failed to comprehensively assess R22's risk for falls.

R222's care plan dated 9/25/14, identified R222 was at risk for falls, and the goal was that he would not be injured due to a fall. Interventions included cookies at bedside at night, ensure environment is free of clutter, have commonly used articles within easy reach, if restless/awake at night ask if he would like to get up for a snack,

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{F 323}	Continued From page 45 anti-roll backs on wheelchair, fall mats, low bed, keep in common area for closer observation during waking areas, and one way glide to personal recliner. Review of R222's fall incident reports and post-fall assessments since 6/15, revealed the following: -6/7/15, at 3:15 a.m. R222 was found sitting on the floor next to his bed. There was no injury. The RN summary indicated R222 often attempts to get up independently, diagnoses of Lewy body dementia. No safety awareness. Poor judgement. -6/23/15, at 7:05 p.m. R222 stood up from the wheelchair and fell while in the common area, hitting against the cupboard. No injury noted. RN summary indicated R222 had impaired cognition and mobility, and not aware of own limitations. Diagnoses of Lewy body dementia. -7/8/15, 8:30 a.m. R222 stood up from the wheelchair and fell. R222 sustained a skin tear to his left elbow. The RN summary indicated R222 had impaired balance/mobility and safety awareness. He is compulsive, gets up to walk frequently. -7/10/15, at 3:25 a.m. R222 was found on the mat next to his bed. R222 sustained skin tears to both elbows. The RN summary indicated R222 frequently attempted to get out of bed independently. Has impaired cognition/impulsive/impaired gait. Current interventions prevented injury. -7/15/15, at 4:20 p.m. R222 slid out of the recliner and onto the floor. No injury. The RN summary	{F 323}		

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indicated frequent falls due to impaired cognition/mobility/balance. R222 slipped out of recliner on to floor, recliner is leather.

-7/24/15, at 2:10 p.m. R222 was in his wheelchair, stood up and tripped on the wheelchair pedals. No injury. RN summary indicated the foot pedals were then removed and will not be used unless being transported.

-7/28/15, at 3:15 a.m. R222 slid out of the recliner. No injury. The RN summary indicated R222 was sleeping in the recliner and attempted to get up, causing the chair to tilt forward. A one way glide was applied to the chair.

-8/3/15, at 11:30 p.m. R222 was at the nurse's station and tilted his wheelchair back and fell. No injury. RN summary indicated R222 was agitated, restless and often combative through out of the night shift, and was kept at the nurse's station for closer observation.

-8/9/15, at 12:30 a.m. R222 was found on the floor next to his bed. A pre-existing skin tear reopened. The RN summary indicated R222 had a UTI, and antibiotics were not sensitive; a new antibiotic was ordered on 8/10/15. The UTI likely contributed to fall.

-8/17/15, at 3:30 a.m. R222 was found sitting on the floor next to his bed. No injury. The RN summary indicated R222 does not use call light. He has poor safety awareness but was calling out when he decided he needed help. Was then brought out to the nurse's station.

-8/19/15, at 6:15 a.m. R222 was found on the floor next to his bed. No injury. The RN summary

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indicated R222 stated he was getting up and he had removed his clothing. He had been checked and changed 1 hour prior to fall.

-8/20/15, at 5:00 a.m. R22 was found sitting on the floor next to the bed, eating a cookie he had gotten from his nightstand. No injury. The RN summary indicated R222 is unsteady and has poor safety awareness, and does not recollect his physical limitations.

-8/24/14, at 9:45 a.m. R22 was in the dining room, got up and slipped on the recently mopped floor. No injury. The RN summary indicated R222 has impaired gait/balance. Res has no safety awareness, unable to realize chance for fall.

-8/30/15, at 12:30 a.m. R222 was found on the floor next to his bed, trying to crawl back into bed. No injury. The RN summary indicated R222 has poor safety awareness and forgets he needs assistance to transfer/ambulate safely/effectively. R222 was then brought out to the nurse's station and given a snack.

-8/31/15, at 11:30 p.m. R222 was found sitting on the bathroom floor. No injury. The RN summary indicated R222 had been toileted 45 minutes prior to the fall.

On 9/7/15, a Fall Risk Assessment was completed and identified R222 was at a greater risk for falls due to a history of falls, Lewy body dementia, very impulsive, doesn't recognize limitations and will attempt to get up and walk. Diagnosis of Parkinson's disease with weak/impaired gait. However, the assessment failed to comprehensively assess risk factors which would include analysis of falls to determine

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{F 323}	Continued From page 48 trends, reason for attempts to transfer, and efficacy of interventions. On 9/9/15, at 9:01 a.m. R222 was continuously observed sitting in his wheelchair, seated outside of the dining room. At 9:45 a.m. the Admissions Director (AD)-H approached R222 and stated she was going to being him to his room to clean the oatmeal off him. AD-H propelled R222 to his room, cleaned off his clothing, and brought him back to sit outside the nurse's station. At 10:52 a.m. NA-J brought R222 to his room, used a stand assist to transfer him to the toilet, and changed his incontinent brief. On 9/10/15, at 1:10 p.m. RN-H was interviewed and stated R222 had been placed on a restorative ambulation program on 8/27/15. RN-H stated the facility was going to continue with the current interventions to reduce falls to see if they were effective before adding any further interventions. The facility policy and procedure on Accident-Falls dated 2/14, directed the resident's individualized care plan is to be updated with any changes or new interventions post fall/incident/accident, communicated to appropriate staff, and implemented.	{F 323}		
{F 353} SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and	{F 353}		10/19/15

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{F 353}	Continued From page 49 individual plans of care. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) 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 provide sufficient staffing to ensure residents received care and services in accordance with their assessed individual needs. This had the potential to affect all 161 residents residing in the facility. Findings include: Refer to F312 and F315 related to residents not receiving timely assistance with toileting and/or incontinence care. R19 was not provided incontinence care for 4 hours and 17 minutes minutes on 9/8/15. R155 was not provided incontinence care for at	{F 353}	Resident # 19, 155, and 105 202, 172, 86 and 229 have been assessed by the nurse manager of the respective units and have had no ill effects from the deficient practice. Care plans were reviewed to assure that they accurately reflect resident care needs. All residents may be affected by this deficient practice of insufficient staffing. Nursing staff have been educated re following resident specific care guidelines to assure that the deficient practice does not occur. The facility has contracted with per diem and traveler agencies to obtain additional staff in the event that staffing is	

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{F 353}	Continued From page 50 least 4 hours 9/8/15. R105 was not provided incontinence care for 3 hours on 9/8/15. R229 was not provided toileting assistance for 3 hours on 9/8/15. R172 was not provided toileting assistance for 3 hours 20 minutes on 9/8/15. R202 was not provided toileting assistance for 3 hours and 20 minutes on 9/8/15. Refer to F314 related to residents with a history of pressure ulcers, or identified at risk for pressure ulcer development, not receiving timely assistance with repositioning . R19 was not provided repositioning for 4 hours and 17 minutes on 9/8/15. R155 was not provided repositioning for at least 4 hours 9/8/15. R105 was not provided repositioning for 3 hours on 9/8/15. R202 was not provided repositioning for 3 hours and 20 minutes on 9/8/15. R86 was not provided repositioning for 2 hours and 36 minutes on 9/8/15. STAFFING SCHEDULES: On 9/10/15, at 3:04 p.m. the administrator was interviewed and stated the minimum amount of	{F 353}	insufficient to meet resident needs. Sister facilities have been contacted with regard to availability of additional staff as well. The facility leadership team has an ongoing meetings with the Union Field Representative and Union Steward to explore options to improve staffing recruitment and retention. The facility Pilot Program of using universal workers has expanded into a full program. These staff provide nursing support such as resident transport, room orderliness, bed making, passing water, and meal support with tray delivery. Their job duties include answering call lights and supplying residents with assistance within their scope of practice and obtaining other staff members to assist with duties they are not able to supply, thus freeing up direct staff. The facility manager on duty program, begun 7/11/15, helps to support nursing staff with guidance and oversight, assistance with meal delivery, answering call lights, and meeting with families, thus freeing up direct care staff to provide cares. The weekend Nurse Manager Program, implemented 7/25/15, helps to support the House Supervisor and nursing staff during high volume care times. Changes in resident activity times on the Cedar Unit have been implemented to support direct care staff during heavy care	

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{F 353}	Continued From page 51 nursing assistants (NAs) the facility would have on each unit would be 3 on each unit for day shift, 3 on each unit for evening shift and 2 on each unit for the night shift. Review of the facility staffing schedule revealed less than 3 staff working on each unit for the following dates: 8/21/15: Spruce unit: Resident census 24. 2 NAs on day shift, 2.5 NAs on evening shift Birch unit: Resident census 34. 2 NAs on day shift. 8/22/15: Birch unit: Resident census 34. 2 NAs on day shift. Elm unit: Resident census 33. 2 NAs on day shift, .5 NA on night shift. Spruce unit: Resident census: 24. 2 NAs on day shift, 2 NAs on evening shift. 8/23/15: Elm unit: Resident census 33. 2.5 NAs on evening shift. Spruce unit: Resident census 23. 2.5 NAs on evening shift. 8/24/15: Birch unit: Resident census 33. 2.5 NAs on evening shift, 1.5 NAs on nights. 8/25/15: Spruce unit: Resident census 23. 2.5 NAs on day shift. 8/27/15:	{F 353}	times. This allows NARs to focus on resident care as they are engaged in activity programs. Dining assistance is being provided by assignment of departmental managers to assist with passing of trays at various meals, so that NARs can focus on assistance with resident dining. Staff received education to reach out directly to nurse managers when they need assistance due to changes in resident care loads. DON/Nurse Managers review and make changes to group assignments as needed based upon feedback from staff and evaluation of care needs. Nurse Managers were educated on providing support to direct care staff when requested as well as to assist in organizing staff work flow. The DON has contact with the staffing coordinator five times per week to review and rearrange staffing levels per unit and per shift. The ED/Assistant ED will continue to attend family council meetings to give updates on programs implemented to support staff. The DON/Designee will perform audits of turning and positioning, toileting, and other direct resident care five times per week with review of the prior 24 hours of documentation to assure that care is delivered as per the plan of care.	

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{F 353}	Continued From page 52 Elm unit: Resident census 32. 2 NAs on day shift. Spruce unit: Resident census 23. 2 NAs on day shift, 2 NAs on evening shift, 1.5 NAs on night shift. 8/28/15: Birch unit: Resident census 33. 2 NAs on day shift, 2 NAs on evening shift. Elm unit: Resident census 32. 2 NAs on day shift, 2.5 NAs on evening shift. Spruce unit: Resident census 26. 2 NAs on day shift, 2 NAs on evening shift. Willows unit: Resident census 29. 2.5 NAs on evening shift. 8/29/15: Elm unit: Resident census 33. 2 NAs on evening shift..5 Spruce unit: Resident census 27. 2.5 NAs on evening shift, 1.5 NAs on night shift. 8/30/15: Birch unit: Resident census 33. 2.5 NAs on day shift, 2.5 NAs on evening shift. Elm unit: Resident census 33. 2.5 NAs on evening shift. Spruce unit: Resident census 27 2.5 NAs on day shift, 2.5 NAs on evening shift. 8/31/15: Birch unit: Resident census 33. 2 NAs on day shift. Elm unit: Resident census 33. 2.5 NAs on evening shift. Spruce unit: Resident census 28. 2 NAs on day shift, 2.25 NAs on evening shift. 9/1/15: Birch unit: Resident census 33. 2 NAs on day	{F 353}	Resident interviews will be completed weekly by the Social Services Director/Designee to evaluate effectiveness of programs and staffing changes as it relates to staff being able to get tasks and duties completed. Results and trends of audits will be reported by the DON/Designee and the Social Services Director/Designee to the QAA meeting for review and follow up as needed.	

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{F 353}	Continued From page 53 shift, 2.5 NAs on evening shift. Spruce unit: Resident census 29. 2 NAs on evening shift. Willows unit: Resident census 28. 2.5 NAs on evening shift. 9/2/15: Spruce unit: Resident census 28. 2 NAs on day shift. 9/3/15: Spruce unit: Resident census 28. 2 NAs on evening shift. 9/4/15: Birch unit: Resident census 34. 2 NAs on day shift. Elm unit: Resident census 32. 2 NAs on day shift. Spruce unit: Resident census 27. 2 NAs on day shift, 2 NAs on evening shift. Willows unit: Resident census 28. 2.5 NAs on day shift, 2.5 NAs on evening shift. 9/5/15: Spruce unit: Resident census 27. 2 NAs on day shift. STAFF INTERVIEWS: On 9/8/15, at 6:21 p.m. nursing assistant (NA)-D reported that at times the NAs were not able to get things completed per the residents' care plans including repositioning and toileting. NA-AD added, "This is very difficult to get done especially with the resident's requiring two people to assist when there are only three aids on the unit." On 9/8/15, at 6:47 p.m. NA-U stated she does not have time to get her work done. NA-U stated the	{F 353}		

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{F 353}	Continued From page 54 last time the Birch Unit had 3 NAs working between 2:00 p.m. to 6:00 p.m. was "about a month ago." On 9/8/15, at 7:32 p.m. NA-AC stated that the "staffing was horrific" and that there was no management. NA-AC further stated that units were lucky to have two NAs on per 44 residents on the unit. There is no way possible to get all the toileting and repositioning done. On 9/9/15, at 10:29 a.m. NA-R stated they always ended up with someone not coming in and added, "We make the best of it." NA-R stated the first thing she hears when they are short was "we're not going to get to showers today." NA-R stated she was yelled at last Friday for giveing a resident a shower. On that day, there was one light-duty NA in addition to one NA-R. A NA from another unit helped from 6:00 a.m. until 8:00 a.m., but he didn't know the unit. NA-R stated they didn't get showers done, but they were able to get everyone up for breakfast and another staff person came in at 10:00 a.m.. NA-R stated that on the Birch unit, they usually had 3 NAs working during the day. On 9/9/15, at 3:37 p.m. NA-B stated they usually had three NAs working on the unit and it was a challenge with three staff to get all of their work done. NA-B stated sometimes they just could not get everyone toileted or repositioned on time. On 09/10/2015, at 7:40 a.m. NA-J stated staffing was still difficult and they do work short. NA-J	{F 353}		

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 _____	R 09/10/2015

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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{F 353}	Continued From page 55	{F 353}		

stated they do the best they can and try to prioritize residents based on need, however, it was not possible to get all of the repositioning, toileting, baths and ambulation done as required.

On 09/10/2015, at 7:57 a.m. NA-X stated staff would get pulled to different floors often and every unit was short staffed. NA-X stated the Cedar unit was supposed to have 5 staff but often worked with only three staff and sometimes only 2 staff. NA-X stated work such as turning, repositioning, toileting, baths, oral cares and ambulation was not getting done and indicated some residents had gone 2 weeks without a bath because there was no time. NA-X also stated meals ran into each other and they sometimes could not lay people down in the morning who required it because by the time they got time to do so, it was time for the next meal. NA-X stated staff was often required to stay over into the next shift due to shortages. NA-X further stated they were supposed to get a manager for 4 hours each shift to assist, but often the manager was reassigned to work the medication cart because nursing staff were short too. NA-X reported a recent incident with a resident fall where there was no supervisor available to assist with the post fall assessment because she was working a medication cart and could not leave it. NA-X stated there were residents with urinary tract infections she felt were due to toileting not being provided as it should be.

On 9/10/15, at 8:19 a.m. NA-J and NA-X reported that they had received comments from other family members that one resident was receiving so much care that staff were not able to meet the

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

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{F 353}	Continued From page 56	{F 353}		

needs of the other residents. They stated they felt bad but were told the other resident was the priority. Both stated they had eight residents on their assigned hallway that were total lifts and required two people to assis and that some people only recieved cares in the morning because they were not able to get to them again during the day / shift and that included repositioning and toileting needs. They stated they have to prioritize between those requesting help to go to the bathroom and those who they know were wet.

On 9/10/15, at 8:30 a.m. registered nurse (RN)-G stated staffing had been a problem and that they often worked short on all of the units. RN-G stated the Willow unit should have 4 NAs working the day shift, however, verified they often worked with three staff as the facility would not pay overtime for a fourth person. RN-G stated at times, they had worked with only 2 staff. RN-G acknowledged cares such as oral cares, turning, repositioning, baths, and incontinence cares were not getting done and this was a problem on other units as well. RN-G stated nurses were getting mandated to stay an additional shift as they just did not have enough nursing staff. She stated supervisors were needing to "work the cart" as they did not have enough staff. RN-G stated the lack of NAs impacted her ability to get her work done because she needed to assist on the floor at times if an NA could not find another NA to assist them. RN-G stated she was aware there was a daily manager. She stated the daily manager would stop by and leave a phone number to be reached, but that she really hadn't seen them assisting on the floor at all.

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

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{F 353}	Continued From page 57	{F 353}		

On 9/10/15, at 8:51 a.m. licensed practical nurse (LPN)-B stated she felt like staffing was in a crisis mode for both nursing and NAs at the facility. LPN-B stated she had spoken with the administrator this morning about her concerns and the administrator had suggested she call the corporate hotline to report her concerns. LPN-B stated she felt residents were being neglected on a daily basis, not because staff didn't know what to do or want to care for the residents, but because there were simply not enough staff to go around. LPN-B stated NAs are often short staffed and she felt there was no physical way 2 NAs could care for all of the residents on the unit. LPN-B stated she was aware oral cares, turning, repositioning, toileting and other cares were not always getting done. LPN-B stated she was mandated to stay extra shifts or approached to stay late every shift she worked. LPN-B also stated the NAs would ask her for assistance every shift/daily. LPN-B stated she needed to prioritize her work to focus on medications and resident treatments however, was often unable to complete her charting as there was not enough time. LPN-B further stated she had refused extra shifts at times as she felt she was simply not safe to work as she was so tired.

On 9/10/15, at 9:11 a.m. physical therapist (PT) stated she had concerns regarding staffing at the facility. PT stated they had short term residents for rehab that returned to the community and she would like to have a good reputation for return business however, residents were unhappy. PT stated residents complained to her of waiting a long time for call lights to be answered. PT

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{F 353}	Continued From page 58	{F 353}		

stated she'd trained R89's family member to assist with transfers so they wouldn't have to wait for staff. PT stated she had concerns regarding those borderline residents who sometimes needed assistance because she felt those residents were overlooked for such things as toileting due to staff working short handed. PT also stated there had been incidents where residents came to therapy with saturated incontinent briefs. PT stated she also overseen the restorative nursing program and she had concerns restorative nursing work was not being done.

On 9/10/15, at 9:30 a.m. LPN-F stated she had given her two weeks notice as she "couldn't take it anymore." LPN-F stated staffing was a problem and they were mandated to stay extra shifts often. LPN-F stated she assisted on the floor with direct resident care daily to the point that non-emergent items she needed to do got put off. LPN-F indicated she was an experienced nurse so was able to prioritize and get her medications and resident treatments done however, did not have time to complete all of her charting. LPN-F also stated she could see new staff becoming overwhelmed. LPN-F further stated NAs were short staffed and not able to get their work done. LPN-F stated mealtimes had become drawn out and there were not enough staff to help. She indicated that at the time of the interview, all NA staff were currently in the dining room so she was covering the hall for residents still in their rooms who might call for assistance.

On 9/10/15, at 10:32 a.m. NA-J stated residents were to be repositioned and checked and

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{F 353}	Continued From page 59	{F 353}		

changed at least every two hours. NA-J stated, "Obviously that isn't happening." NA-J stated that if someone is the first person up on the unit, at perhaps 6:00 a.m., the first time they can get back to them would be around 9:30 a.m. after breakfast. NA-J stated the NAs just can't do it--there's not enough staff.

On 9/10/15, at 11:50 a.m. RN-J stated staffing was "horrible" for both nurses and NAs and that staff were required to stay mandatory shifts all of the time. RN-J stated staff were getting sick of it and were quitting. RN-J also stated staff were pulled to work different units frequently. RN-J stated they do not have enough staff to cover open shifts and confirmed staff were not able to get all of the resident cares completed including oral cares, repositioning, toileting, and range of motion services. RN-J further stated nurses were not able to get their charting done and supervisors were pulled to work the medication cart frequently.

On 9/10/15, at 1:30 p.m. LPN-C stated NAs on the Cedar unit don't take breaks. LPN-C added she doesn't take breaks, and when she does, she uses the time for charting.

RESIDENT/FAMILY INTERVIEW

On 9/8/15, at 5:53 p.m. family member (FM)-D stated staffing was still quite short on the weekends. FM-D reported doing most of the family members repositioning in order to keep their skin in good condition. FM-D stated they had

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{F 353}	Continued From page 60 noticed a lot of staff had quit lately. On 09/10/2015, at 10:22 a.m. R89 stated she has had FM-D help her to the bathroom and get into bed. R89 stated it took a long time, sometimes as long as an hour to answer her call light so FM-D helped her when he was there. R89 stated there were not enough staff to assist all of the residents and reported an incident where her ambulation was interrupted as the staff member who was ambulating with her had to stop to answer call lights. FM-D confirmed he assisted R89 to the bathroom and back to bed when he was there. FM-D stated they did not have the staff available to get to R89 in a timely fashion. On 9/9/15, at 2:16 p.m. R396 stated NAs don't have time to answer call lights. R396 stated, "It's not just once, it's often." R396 said one time she waited over 35 minutes from 10:30 p.m. until after 11:00 p.m. to get help to the bathroom. R396 was on a water pill, and said, "I can't wait! " R396 also stated she has been uncomfortable having to "hold it" when waiting for staff. R396 stated she has a bad bladder and kidney problems and at times her stomach has really hurt from having to "hold it." R396 stated, "last night was the worst." R396 turned on her call light at 2:35 a.m. but "Nobody came. I had to go so bad!" R396 said she waited an hour. After an hour, although her wheelchair was out of reach, she knew if she could get up to the edge of the bed, she figured she could reach the wheelchair. She pulled herself up. R396 stated she wasn't supposed to transfer herself, but it was either that or "I was going to have an accident." R396 stated that a staff person finally came at 4:15 a.m., when	{F 353}		

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{F 353}	Continued From page 61 she was exiting the bathroom, on her way back to bed. During observations on 9/10/15, at 9:23 a.m., the breakfast cart just arrived at the solarium on Cedar. Breakfast on the Cedar unit is scheduled for 8:20 a.m.	{F 353}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245366	A. Building B. Wing	9/10/2015

Name of Facility	Street Address, City, State, Zip Code
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **08/20/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/20/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/20/2015**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/20/2015**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **08/20/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/mm	09/18/2015	29433	09/10/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/20/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 94G4

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 **07/21/2015** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/25/2015 (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
06/24/2015 (L33)

DETERMINATION APPROVAL

CCN: 24 5366

On July 21, 2015, a Post Certification Revisit (PCR) was conducted by the Department of Health. Substandard Quality of Care (SQC) was identified which resulted in an extended survey. The extended survey was conducted July 16, 2015 through July 21, 2015. Conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety. We presume based on their plan of correction, that the facility had corrected these deficiencies as of June 29, 2015. Based on our visit, we had determined that the facility had achieved compliance with the deficiency issued pursuant to the abbreviated standard survey (complaint number H5366063) completed on May 20, 2015.

However, the facility has not achieved substantial compliance with the deficiencies issued pursuant to the standard survey completed on May 20, 2015. The deficiencies not corrected are as follows:

F0221 -- S/S: D -- 483.13(a) -- Right To Be Free From Physical Restraints
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans

In addition, at the time of this revisit, we identified the following deficiencies:

F0241 -- S/S: E -- 483.15(a) -- Dignity And Respect Of Individuality
F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion
F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being
F0497 -- S/S: E -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

This revisit found the most serious deficiencies in the facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

As a result of the revisit, this Department imposed the Category 1 remedy of State monitoring went into effect August 12, 2015.

In addition, this Department reommended the following action related to the remedy in our letter of July 22, 2015, as authorized by CMS Region V Office, for imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015 remain in effect. (42 CFR 488.417 (b))

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Chris Jensen Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 21, 2015.

Furthermore, this Department recommended the following additional remedies to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Refer to the CMS 2567b, CMS 2567 along with the facilitys plan of correction. Post Certification Revisit (PCR) to follow.

Electronically delivered
August 6, 2015

Ms Lynn Hickey, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366025, H5366063, F5366024

Dear Ms. Hickey:

On July 22, 2015, as authorized by the CMS Region V Office, this Department notified you of imposition of the following remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015 (42 CFR 488.417 (b))

Also, this Department notified you in our letter of July 22, 2015, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 20, 2015.

This was based on the deficiencies cited by this Department for a standard survey and an abbreviated standard survey completed on May 20, 2015 and lack of verification of compliance of the deficiencies issued pursuant to both the standard and abbreviated standard surveys, at the time of our July 22, 2015 notice. The most serious deficiencies were found 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 July 14, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were 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 July 29, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that this Department previously advised you, as authorized by CMS Region V Office of the following enforcement remedy for imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015 (42 CFR 488.417 (b))

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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 20, 2015

On July 21, 2015, a Post Certification Revisit (PCR) was conducted by the Department of Health. Substandard Quality of Care (SQC) was identified which resulted in an extended survey. The extended survey was conducted July 16, 2015 through July 21, 2015. Conditions in the facility constituted **both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ)** to resident health or safety. We presume based on your plan of correction, that your facility had corrected these deficiencies as of June 29, 2015. Based on our visit, we have determined that your facility has achieved compliance with the deficiency issued pursuant to the abbreviated standard survey (complaint number H5366063) completed on May 20, 2015. However, the facility has not achieved substantial compliance with the deficiencies issued pursuant to the standard survey completed on May 20, 2015. The deficiencies not corrected are as follows:

F0221 -- S/S: D -- 483.13(a) -- Right To Be Free From Physical Restraints
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0323 -- S/S: J -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans

In addition, at the time of this revisit, we identified the following deficiencies:

F0241 -- S/S: E -- 483.15(a) -- Dignity And Respect Of Individuality
F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion
F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being
F0497 -- S/S: E -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

This revisit found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective August 12, 2015. (42 CFR 488.422)

In addition, the Department recommended the following action related to the remedy in our letter of July 22, 2015 as authorized by the CMS Region V Office for imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 20, 2015 remain in effect. (42 CFR 488.417 (b))

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Chris Jensen Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective July 21, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

Furthermore, this Department is recommending the following additional remedies to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 21, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Chris Jensen Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 21, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 20, 2015 (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 November 20, 2015 (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 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File
Office of Health Facility Complaints File

Electronically delivered
July 22, 2015

Ms Lynn Hickey, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366025, H5366063, F5366024

Dear Ms. Hickey:

On June 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey and an abbreviated standard survey, completed on May 20, 2015. This surveys 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 July 9, 2015, the Minnesota Department of Public Safety 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 May 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 29, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on May 20, 2015.

However, compliance with the health deficiencies issued pursuant to the May 20, 2015 standard survey and abbreviated standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey and abbreviated standard survey were found 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.

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 August 20, 2015. (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 August 20, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 20, 2015.

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 August 20, 2015. 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:

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@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 November 20, 2015 (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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245366	A. Building B. Wing	7/21/2015

Name of Facility	Street Address, City, State, Zip Code
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0154** Reg. # **483.10(b)(3), 483.10(d)(2)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/30/2015**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/30/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **06/30/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	CC/mm	08/06/2015	29433	07/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/20/2015			

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 _____	R 07/21/2015

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 An onsite resurvey was conducted by surveyors of this department from July 13, 2015 to July 21, 2015 to determine compliance with Federal deficiencies issued during a recertification survey exited on May 20, 2015. In addition, at the time of this visit survey staff verified compliance of the deficiency issued pursuant to the abbreviated standard survey (complaint number H5366063). The resurvey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to address accident and supervision needs which resulted in the high potential for harm or death. The IJ began June 15, 2015 at 12:32 p.m. and was removed on July 21, 2015 at 1:43 p.m.. An extended survey was conducted by the Minnesota Department of Health from July 16, 2015 through July 21, 2015. During this visit the following regulations were determined to be not corrected. 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 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any	{F 221}		8/20/15

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

Electronically Signed | 08/25/2015

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.

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 _____	R 07/21/2015

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 221}	Continued From page 1 physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and provide evaluation for ongoing use of restraint devices to ensure the least restrictive device / intervention for 3 of 3 residents (R172, R54, R125) reviewed for physical restraints. Findings include: R172's quarterly Minimum Data Set (MDS) dated 4/9/15, indicated R172 had severely impaired cognitive skills for daily decision making (never/rarely made decisions), had diagnoses including Alzheimer's disease, required extensive assistance for all activities of daily living (ADLs), had not fallen in the past quarter, and had a trunk restraint which was used daily. R172's care plan revised 6/10/15, directed use of an alarmed seat belt when in the wheelchair which was to be removed every two hours and at meals. R172's physical restraint assessment dated 6/4/15, indicated R172 had risk behaviors including being constantly in motion in the wheelchair, leaning forward while sitting in the wheelchair and touching the floor, and is severely demented. The assessment lacked any indications for gradual removal of the restraint.	{F 221}	Resident #172, 54, and 125 were reassessed for necessity of physical restraints and reduction plan. Care plans reviewed/updated to reflect current restraint device in use and reduction plan. Orders clarified with the appropriate diagnosis/medical symptom for use of restraint device. All other residents with a restraint were reviewed for necessity of the restraint, care plan, and proper diagnosis. Nursing staff educated on facility policy for residents using restraints and releasing restraints. Weekly audits by DON/Designee to assure that facility restraint policy is being followed. Audits will be reviewed at QAA.	

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{F 221}	Continued From page 2 On 6/4/15, the nurse practitioner (NP) ordered a self-releasing seat belt with an alarm to be used while R172 is up in the wheelchair for the safety of the resident due to the effects of advanced dementia. The NP order lacked the presence of a medical symptom for use of the seatbelt. During observation on 7/13/15, at 3:28 p.m. R172 was in the dining room sitting in her wheelchair and had a seatbelt secured around her waist. During interview on 7/20/15, at 10:01 p.m. registered nurse (RN)-B stated R172 had no medical symptoms for the use of the restraint, the facility had not attempted a gradual reduction of the restraint, nor was there a current plan in place to remove or reduce the use of the restraint. R54's quarterly MDS dated 6/9/15, indicated R54 had severely impaired cognitive skills for daily decision making (never/rarely made decisions), had diagnoses including dementia, required extensive assistance for all ADLs, had not fallen in the past quarter, and had a trunk restraint which was used daily. R54's care plan updated 7/9/15, directed the resident was to use a seatbelt with an alarm, which was to be released every two hours for 10 minutes, at meals, and with 1:1 activities. On 6/22/15, the NP ordered an attempted trial reduction of R54's seat belt restraint, which was to be reviewed after three days or sooner if there were increased safety concerns. On 6/26/15, progress notes indicated R54 had	{F 221}		

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{F 221}	Continued From page 3	{F 221}		

attempts to get out of the wheelchair and ambulate, and due to safety concerns they were unable to discontinue the seat belt. However, there were no new orders for the seat belt restraint to be reinstated, nor was there an assessment to determine if a less restrictive intervention could be implemented.

During observation on 7/14/15, at 10:55 a.m. R54 was sleeping in the wheelchair with a seat belt on.

During interview on 7/20/15, at 10:10 a.m. RN-B stated R54 did not have a medical symptom for use of the restraint. RN-B also stated that R54 would try to get up and walk without the restraint and cannot understand she can't do that. Use of the restraint therefore restricts her free movement.

R125's quarterly MDS dated 3/8/15, indicated R125 had severely impaired cognition, had diagnoses including dementia, required extensive assistance for all ADLs, had one fall in the last quarter, and had a truck restraint which was used daily. The MDS question asking if the chair prevents rising was answered "not used."

R125's care plan revised on 6/16/15, indicated the resident used an alarming, non-Velcro seat belt. There was a corresponding restraint assessment for the alarming, non-Velcro seat belt.

During observation of R125 on 7/15/15, at 10:45 a.m., 7/15/15 at 11:49 a.m., and again on 7/16/15, at 8:21 a.m., R125 was observed in the nurse manager's office reclining in her wheelchair and was secured in the wheelchair with a seat

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{F 221}	Continued From page 4 belt which was buckled around her waist. During interview on 7/16/15, at 8:21 a.m. RN-A stated R125 did not have a medical symptom for use of the restraint (seatbelt), and the facility had tried a seat belt with Velcro in the past, however, it did not work as R125 was able to release the belt. RN-A stated R125's family wanted something to prevent R125 from falling out of the wheelchair, and R125 had been using the buckled belt since December 2014, which RN-A stated R125 could not release the current buckle seatbelt. RN-A also stated if R125 was not in the reclining wheelchair she would lean forward and fall out of the chair, however, the facility had not considered the reclining wheelchair as a restraint, and there was not an assessment for the wheelchair as a restraint. RN-A stated R125 had been using the wheelchair since around March 2014. The facility policy and procedure titled Restraint Free Care dated 4/09, directed physical restraints are used only when they are used appropriately to treat the resident's medical symptoms and to promote an optimal level of function for the resident. If a resident is restrained, an assessment will be completed by a licensed nurse or therapist upon admission and thereafter, quarterly, and/or prior to an application of any restraint, to determine the appropriateness. The least restrictive device should be used with documentation of all other alternatives tried prior to the implementation of a restraint. There must be a physician's order for the use of the restraint which includes medical symptoms for use, frequency of use, type of restraint, release protocols, and plan for reduction.	{F 221}		

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F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignified care was maintained for 4 of 4 residents (R316, R279, R145, R165) reviewed for dignity. Findings include: R316 was being assessed and interviewed by a physician in the public area near the Elm Unit nursing station, and the personal interview could be heard by anyone in the area. R316's face sheet identified diagnoses including intracerebral hemorrhage, hemiplegia due to a cerebral vascular accident (stroke) on 5/7/15, diabetes, and atrial fibrillation. R316's quarterly Minimum Data Set (MDS) dated 6/26/15, indicated the resident had severe cognitive impairment. During observation on 7/15/15, at 11:50 a.m. physician (P)-G sat down with R316 near the television in the public area by the Elm Unit nursing station, and two other residents were nearby in the TV area. P-G began to ask R316 questions including questions about his stroke, his rectal area, and if his bowels were, "Working okay." Registered nurse (RN)-A was with P-G	F 241	Facility medical director re-educated providers on dignity/privacy when seeing residents at the facility. Facility staff educated on resident¿s right to dignity, which specifically included: physicians to see residents/discuss medical care in private areas, having resident¿s appropriately dressed/covered in the hallway, staff to be sitting down next to residents when assisting in feeding them (not standing), and staff providing catheter bag covers to residents using a catheter. Nurse Managers/Designee will complete weekly audits on their units to assure residents are being treated with dignity. Audits will be reviewed at QAA.	8/20/15

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F 241	Continued From page 6 when the public conversation was taking place. During interview at 7/15/15, at 11:53 a.m. RN-A stated she knew the conversation P-G was having with R316 was a private matter and could be a dignity issue, and then stated, "You tell him [P-G]." RN-A then returned to P-G, whispered something to him, and moved R316 to his room to continue the physician assessment. During follow-up interview on 7/16/15, at 8:34 a.m. RN-A stated she knew it was not right for physicians to interview residents in public areas, and she had seen P-G do that in the past, however, RN-A stated it can be difficult for the nurses to correct the physicians. During interview on 7/16/15, at 11:22 a.m. director of nursing (DON) stated physicians should be interviewing and assessing residents in their room. During interview on 7/16/15, at 3:07 p.m. RN-E stated most of the time physicians ask the nurses to have patients ready to be seen in their rooms, and she had heard of a concern of a physician interviewing a resident in a public area once. During an interview on 7/17/15, at 10:32 a.m. RN-F stated physicians usually meet with residents in their room on the Spruce Unit. R279 was being pushed in the wheelchair by nursing assistant (NA)-N on 7/15/15, at 9:03 a.m. down the Birch hallway from the shower room to his room with his full left leg and side of his left hip visible from under the bath blanket to anyone in the hallway.	F 241		

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R279's quarterly MDS dated 5/22/15, indicated R279 had severe cognitive impairment and was rarely or never understood, and had diagnoses including aphasic (unable to speak) and a traumatic brain injury.

R145 was observed in the main dining room on 7/17/15, from 8:50 a.m. until 9:01 a.m., receiving assistance with eating from NA-H, who was standing while feeding R145.

R145's quarterly MDS dated 4/10/15, indicated R145 was rarely or never understood and had severe cognitive impairment.

R145's care plan indicated the resident needed extensive assist of one staff for eating.

During interview on 7/20/15, at 3:52 p.m. DON stated staff should be sitting next to the resident when assisting them at meals, and if she saw staff standing while feeding a resident she would instruct them to sit down to maintain a residents dignity.

R165 had an indwelling Foley catheter (includes a bag that captured her urine) which was visible to anyone passing R165's room in the hallway on 7/15/15 and 7/16/15.

R165's significant change MDS dated 3/30/15, indicated the resident had severe cognitive impairment.

On 7/15/15, at 7:10 a.m. R165 was lying in bed, and the urine filled catheter bag was hanging from the side of the bed and visible from the hallway. Continuous observation on 7/15/15, from 8:39 a.m. until 8:57 a.m., the catheter bag

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F 241	Continued From page 8 remained uncovered until licensed practical nurse (LPN)-D noticed the uncovered catheter bag, left the unit to get a catheter bag cover, and applied the cover to the catheter bag. During interview on 7/15/15, at 8:57 a.m. LPN-D stated nursing assistants should be putting the catheter bag in a cover when R165 goes to bed at night so it is not visible from the hallway. During observation on 7/16/15, at 7:53 a.m. R165's urine filled catheter bag was again hanging from her bed and was uncovered and visible from the hallway. During interview on 7/16/15, at 7:53 a.m. RN-E stated all Foley catheter bags should be covered to ensure the residents dignity.	F 241		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan regarding fall interventions for 1 of 4 residents (R278), reviewed for accidents. In addition, the facility failed to follow the care plan for range of motion (ROM) and splinting for 1 of 1 residents (R127) reviewed with contracture's.	{F 282}	Resident #278 care plan is followed related to fall interventions. Resident #127 care plan is followed related to range of motion (ROM) and splinting. Residents at high risk for falls have had careplans reviewed and updated as necessary for appropriate interventions.	8/20/15

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{F 282}	Continued From page 9 R278 fall interventions were not consistently implemented. R278's admission MDS dated 5/9/15, indicated R278 had severe cognitive impairment, required extensive assistance of staff for transfers and did not ambulate. The MDS also identified R278 had a history of falls with a fracture within 6 months of admission. R278's Admission Record includes diagnoses of dementia, history of closed fracture to femur and restless legs syndrome. R278's care plan dated 6/22/15, listed safety as a focus area with the following interventions: -call light reminders to use assistance -non-skid footwear -low bed -do not leave unattended in the bathroom. -safety review per facility protocol -pressure alarm in wheelchair and bed -hip protectors -transfers extensive assistance of 1 -keep bed at transferable height On 7/14/15, at 2:05 p.m. R278 was observed resting with eyes closed in a stationary rocker sitting on a pressure alarm cushion in R278's room. R278's call light was across the room on the bed. R278 reach the call light for help if R278 needed assistance. On 7/15/15, at 12:50 p.m. R278 reported that she used her call light when she needed to. On 7/15/15, at 8:23 a.m. nursing assistant (NA)-I reported that R278 was to have her call light by her and to have hip protectors on. NA-I reported that R278's hip protectors were not on this a.m. because NA-I could not find them and she needed to report it to the nurse.	{F 282}	ROM/splinting programs reviewed for appropriateness and specific instruction so staff can understand how/what to do with residents on ROM and/or splinting program. Nursing staff educated on following fall interventions, ROM, and splinting programs. Nurse Managers/Designees will audit weekly to assure care plan interventions are taking place. Focus areas will be on fall interventions, ROM, and splints. Audits will be reviewed at QAA.	

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{F 282}	Continued From page 10 On 7/16/15, at 8:40 a.m. registered nurse (RN)-A verified that R278 was to have the call light within reach at all times and that R278's hip protectors were supposed to be on to reduce the risk of falls. On 7/16/15, at 4:22 p.m. the director of nursing (DON) reported that call lights were to be within reach of all residents that utilize them. The DON also stated the NA's were to follow the residents care plans. R127 care plan was not followed for range of motion and splinting. R127's annual Minimum Data Set (MDS) dated 5/21/15, identified R127 had severe cognitive impairment and was totally dependent with activities of daily living (ADL's). The Care Area Assessment (CAA) indicated R127 was at risk for a functional decline related to contracture's with a goal to slow or minimize decline and minimize risks. R127's Admission Record identified diagnoses of multiple sclerosis (MS) and contracture (a shortening or hardening of muscle, often leading to deformity) of hand joint. R127's care plan dated 5/26/15, identified R127 had an altercation in self-care ability related to MS and contracture's. The plan included: -Gentle active assistive ROM to left elbow, wrist, hand, shoulder 5 times weekly -Gentle passive ROM to right elbow, wrist, hand and shoulder 5 times weekly -Gentle stretch of head, neck to midline 10-15 times holding each time for 10 seconds -Pillow for neck support to be used in the wheelchair -Rolled washcloth in left hand	{F 282}		

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{F 282}	Continued From page 11 R127's nursing assistant Cedar Group sheet indicated: -Restorative nursing was to be done in the a.m. -Washcloth roll in left hand -Pillow support for neck when in wheelchair On 7/15/15, at 7:21 a.m. R127 was observed in the supine position with a pillow around R127's neck and a positioning pillow to the right hand. No washcloth was observed to be in the left hand. On 7/15/15, at 7:35 a.m. certified nursing assistant (NA)-R and NA-S assisted R127 with morning cares. R127 could not participate in cares; all morning cares were totally completed by NA-R and NA-S. No range of motion was performed at that time. When cares were finished NA-R positioned R127's neck with a pillow and placed R127's right hand on a positioning pillow, no washcloth was placed into R127's left hand. On 7/15/15, at 1:36 p.m. R127 was observed being totally assisted to eat lunch, positioning pillows to the neck and right hand were in place, and no washcloth was in the residents' left hand per care plan. On 7/15/15, at 2:56 p.m. NA-K stated that physical therapy did R127's range of motion and was not aware of a restorative nursing program for the NA's to complete. NA-K confirmed range of motion was not performed on R127 this shift and that a washcloth was not in R127's left hand. On 7/16/15, at 9:25 a.m. R127 was observed being totally assisted to eat breakfast, positioning pillows to the neck and right hand were in place	{F 282}		

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{F 282}	Continued From page 12 and a washcloth was in the residents' left hand. On 7/16/15, at 11:19 a.m. licensed practical nurse (LPN)-C stated the aids should be doing the restorative nursing and the documentation is in the restorative nursing book. The Restorative Nursing Documentation sheet for July was reviewed and noted to have 11 areas out of a 42 opportunities that were documented as completed. On the bottom of the form it instructed staff to leave the area blank if the program was not addressed that day. The Restorative Nursing Documentation sheet identified bilateral upper extremity range of motion daily, wash terry cloth cover at night and use washcloth in hand overnight. It was unclear what shift was responsible to document tasks. The ROM and splinting instructions on the Restorative Nursing Documentation sheet were incomplete for R127. On 7/16/15, at 11:29 a.m.. NA-R reported there were no instructions in the restorative nursing book on the exercise that should be done. NA-R just moved R127's arms more during cares. NA-R reported there hadn't been any education on how to do R127's exercises. On 7/16/15, at 3:07 p.m. registered nurse (RN)-H verified that there were no instructions for the NA's to follow in the restorative nursing book. RN-H acknowledged the missing documentation on the Restorative Nursing Documentation sheet. RN-H reported it was really hard to monitor the documentation and the NA's to ensure the restorative nursing programs were being done. RN-H reported she utilized the communication book to remind the NA's to do the restorative nursing programs and to document when	{F 282}		

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{F 282}	Continued From page 13 completed. RN-H verified that she has not shown the NA's what exercises were to be done with R127. On 7/16/15, at 4:22 p.m. the director of nursing (DON) acknowledged there were a lot of blanks on the Restorative Nursing Documentation sheet. The DON reported that the expectation was the NA'S were to do the restorative nursing programs and that devices need to be in place. The DON's expectation was that staff ask questions if it was unclear for each resident.	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that consistent communication with the dialysis program and ongoing supervision of fluid intake occurred for 1 of 1 residents (R50) reviewed receiving dialysis. Findings include: R50's Admission Record indicated diagnoses including diabetes, congestive heart failure, chronic kidney disease (stage IV-severe), mild cognitive impairment, and adjustment disorder	{F 309}	Resident #50 educated on current orders related to dialysis and fluid restrictions. Due to his noncompliance he has had risk benefits explained and documented related to effects of fluid overload. Nursing staff educated on following plan of care related to dialysis communication and fluid restrictions, and of documenting such. Nurses also educated on completing risks v. benefits with residents who are noncompliant with their orders.	8/20/15

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{F 309}	Continued From page 14 with depressed mood. The quarterly Minimum Data Set (MDS) dated 3/8/15, indicated R50 had a moderate cognitive impairment. R50's MDS also identified that he exhibited several behaviors, including rejection of cares, on 4-6 days and wandering 1-3 days within a 7 day period. R50's MDS also indicated he received dialysis. R50's care plan specified a 1500 ML fluid restriction with 480 mL provided by nursing and 1020 mL provided by dietary, per MD order. R50's care plan updated on 3/19/15, indicated R50 was on a 1500 milliliters (ml) fluid restriction and a renal low carbohydrate count diet. He was to have weights daily on non-dialysis days per dialysis protocol. R50's care plan indicated that he may not be compliant with fluid restrictions, but that he was aware of his diet restrictions. R50 stated on 7/16/15, at 8:38 a.m., that he got picked up at 5:00 a.m. to go to dialysis at Spirit Valley and stated, "They treat me pretty good there." R50 stated he went to dialysis on Mondays, Wednesdays and Fridays. He said the facility sent a lunch along with him when he went to dialysis and he usually started eating lunch as soon as he got there. R50 stated that he used to be on a fluid restriction, but wasn't anymore. R50 stated it's been a couple of weeks since they took him off the fluid restriction, as he drank a lot of water and could go three days without having to urinate. In an interview on 7/16/15, at 9:08 a.m. nursing assistant (NA)-H stated that R50 was on a fluid restriction, but he had a mind of his own. NA-H	{F 309}	DON/designee will complete audits weekly to assure that dialysis communication is happening per policy, staff are following residents plan of care for fluid restrictions, risks/benefits are being reviewed with resident refusals, and that same noted areas are being documented. Audits will be reviewed at QAA.	

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{F 309}	Continued From page 15	{F 309}		

stated that she recorded all the fluids that R50 drinks during a shift (meals and between meals). NA-H stated that R50 would go to Spruce and drink 2-3 cups of coffee.

During interview on 7/16/15, at 9:47 a.m. registered dietician (RD)-D stated that R50 was on a fluid restriction and this was communicated on a resident's tray ticket. She stated that she looked at fluid intake documentation by looking at the nursing assistant tasks in the facility's computerized records.

Notes on the nursing assistant group sheet directed staff that R50 is to have 1500 ml of fluid and stated, "No extra fluids from NAR's". Review of R50's fluid intake demonstrated incomplete documentation with 17 missed entries since 6/26/15. Entries could be documented as amounts, resident not available or resident refused.

During an interview on 7/17/15, at 9:31 a.m. Fresenius Medical Care - Spirit Valley Dialysis (SVD) registered nurse (RN)-K stated that the facility and his nephrologist were aware that R50 is not always compliant with his fluid restrictions. SVD RN-K stated that R50 had been explained the risks of not following his fluid restrictions many, many times at the dialysis unit.

During an interview on 7/17/15, at 9:31 a.m. SVD RN-K stated that they usually received regular communications forms from nursing homes. SVD RN-K stated that they don't typically get these forms for R50. When she did get the form, she completed it and sent it back. For R50, SVD RN-K stated she only got the form once every couple of weeks, or even once a month. It there

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were concerns, she would call the facility social worker or one of the nurses.

During an interview on 7/17/15, at 10:47 a.m. RN-A stated that the facility faxes a form to dialysis every time a resident goes out for dialysis. Then the dialysis center faxed the form back at the end of the resident's dialysis run. RN-A stated that they do this every time. Sometimes they do it by sending a hard copy of the form in an envelope with a resident. RN-A said they had the SVD fax number wrong, and the health unit coordinator figured that out last week. RN-A stated again that the process is to fax the form back and forth between the facility and the dialysis center and that they did not know that they had the wrong fax number.

During an interview on 7/16/15, at 10:47 a.m. RN-A stated that R50 is non-compliant with his fluid intake. RN-A stated that R50 would go to the Spruce unit to drink coffee. She stated that R50 had extra dialysis runs due to his excessive fluid intake, but it had been months since that happened. RN-A stated she did not know if there was a risk-benefit discussion with R50 but stated that likely there wasn't, as "that's why he has a guardian." When asked if there was a discussion of risks and benefits with the guardian RN-A stated she would look and provide it if they had one. None was provided.

During an interview on 7/16/15, at 10:47 a.m. a copy of all dialysis report forms since 6/29/15, was requested of RN-A. Later that day, a "Dialysis Report Form" was received with fax date stamp of 6/29/15. Other information received was pages 3 through 9 of a "Hemodialysis Treatment" for R50, which was faxed to the

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{F 309}	Continued From page 17 facility on 7/16/15. During an interview on 7/16/15, at 11:19 a.m. R50 stated he did not know the risks of taking in too much fluid. A review of R50's Nurse's Record and Progress Notes revealed that he was hospitalized on 6/17/15, for pneumonia, again on 7/6/15 through 7/10/15, and again from 7/17/15 through 7/20/15.	{F 309}		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement services to promote healing of a Stage III pressure ulcer and prevent further development of pressure ulcers for 1 of 3 residents (R165) reviewed for pressure ulcers. This resulted in actual harm for R165. Findings include: R165's face sheet identified diagnoses including severe sepsis, diabetes, dementia, hypertension, chronic heart failure, urinary tract infections,	{F 314}	Resident # 165 has received a new skin assessment and her plan of care has been reviewed and revised. All residents are assessed upon admission, quarterly and with a change of condition for potential for skin impairments have assessment and plan of care in place. Nursing staff educated on wound care policy and on reviewing care plans for	8/20/15

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{F 314}	Continued From page 18 anemia, respiratory failure, end stage renal disease and pressure ulcers on her buttocks. She was also wheelchair dependent and had an in-dwelling Foley catheter related to incontinence of bladder and pressure ulcers on her coccyx and buttock areas. R165's 3/30/15, significant change Minimum Data Set (MDS) indicated that she had severely impaired cognition. The MDS also indicated she was at risk for pressure ulcers and had an unhealed Stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). R165's 6/10/15, significant change MDS indicated four unstageable pressure ulcers and three stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.) that were not present or were a lesser stage at her last assessment. R165's skin integrity care plan was created on 1/9/15. A BRADEN Score of 9, which indicated she was at high risk for developing pressure ulcers. The care plan focus specified that R165 had multiple Stage III pressure ulcers on her coccyx that required treatment daily and as needed (PRN). The goal of the 1/9/15, skin integrity care plan was to have the coccyx area heal without further tissue breakdown. The care plan was revised on 6/23/15, with a target date of 9/10/15. The care plan interventions directed staff to: follow facility skin protocols; provide incontinence care with incontinent brief changes; follow physician orders;	{F 314}	individual interventions related to residents offloading and other interventions. Nurse Managers have received education on wound care policy and on reporting lack of wound healing progression to DON and MD when treatments are not effective for residents. DON will rotate wound rounds with Nurse Manager/Nurse completing measurements weekly to audit ensure proper measurement, staging of wounds, documentation, and physician notification as necessary. Audits will be reviewed and directed through QAA.	

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observe skin with AM/PM (morning and evening) cares and with toileting for redness, rashes, open areas, pain, swelling and report to team leader; weekly skin check on bath day and document findings; lotion to dry skin; review skin problems with physician; treatments as ordered, pressure reduction cushion in wheelchair, pressure reduction mattress on bed. R165's skin integrity care plan directed staff to "turn q [every] 2 hours side to side, limit time up on coccyx area." Although the care plan identified the repositioning schedule, there was no evidence in the assessment indicating this was the appropriate schedule for R165 with the current significant open areas.

According to her progress notes, R165 returned to the facility from a hospitalization on 6/3/15, with a 10 x 10 cm (centimeter) macerated (softened skin related to moisture) area on her coccyx, with multiple wound beds within the area, which were identified as Stage III pressure areas. The location was the same area of R165's pressure ulcers from 1/15. Treatment of the area was changed to calcium alginate silver to wound beds and cover with foam dressings daily and PRN with cleaning area. Pat dry. The note further indicated that R165 had chronic incontinence of stool and required multiple dressing changes to the coccyx area related to being soiled. According to this note, R165 was unable to let her needs be known or to use her call light.

R165's Bowel and Bladder Care plan stated that she had an indwelling Foley catheter placed related to a Stage II coccyx wound.

On 7/15/15, from 7:10 a.m. until 8:39 a.m. R165 was intermittently observed laying on her back in

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bed. Two pillows were observed under her left side, however, the pillows did not off-load pressure from the resident's coccyx area as her coccyx remained on the bed.

During an interview on 7/15/15, at 7:30 a.m. licensed practical nurse (LPN)-D stated that R165 has the pressure ulcer dressing changed on the night shift. LPN-D stated the day shift only changed it when the nursing assistants saw the dressing had gotten soiled.

During continuous observations on 7/15/15, from 8:39 a.m. until 9:35 a.m., one pillow was removed from under R165's left side at 9:11 a.m., otherwise R165 remained on her back. Specifically, on 7/15/15, at 9:11 a.m. nursing assistant (NA)-M entered the room with R165's breakfast tray. NA-M removed one pillow from under R165's left side and raised up the head of the bed. NA-M assisted R165 with breakfast until 9:25 a.m. when NA-P came in and took over the task of assisting R165 to eat breakfast.

At 9:41 a.m., licensed practical nurse (LPN)-D entered R165's room with morning medications. LPN-D raised the head of R165's bed in order to give medications, but R165 remained in the same position: on her back with one pillow under her left shoulder and pressure remaining on her coccyx.

Continuous observations on 7/15/15, revealed that R165 remained in the same position from 9:57 a.m., until 10:31 a.m. which was on her back in bed with one pillow under shoulder. However, pressure was not removed from the coccyx/buttocks in this position.

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{F 314}	Continued From page 21 On 7/15/15, at 10:24 NA-M stated that R165 was not on her group list, as she just moved to a new room on 7/14/15. The new room was across the hall and on the group 4 list. On 7/15/15, at 10:31 a.m. NA-P entered R165's room, asking, "When was she repositioned last?" NA-P stated that R165 is to be repositioned every two hours. On 7/15/15, at 10:33 a.m. NA-P re-entered R165's room with NA-M, shut the door, and removed the pillow from under R165's left shoulder. Using the overhead lift in the room, NA-P and NA-M repositioned R165 with one pillow under her right side. No pressure relief/off loading was provided to the coccyx. On 7/15/15 at 12:53 p.m. R165 was observed laying on her back in bed, just finishing lunch. There were no pillows under her on either side. On 7/15/15, at 12:59 p.m. NA-M was going to reposition R165 to her right side. Upon questioning, NA-M placed the pillow under R165's left side. During an interview on 7/15/15, at 1:38 p.m. RN-E stated that she measured R165's wounds weekly. She stated that the wound on R165's coccyx cleft was "down" last week from a 10 x 10 cm area with multiple wounds to just one as of last week. RN-E described the daily cares to include: cleansing with normal saline and applying calcium alginate silver to the wound. RN-E stated this was usually done on the first round of the night shift, between 12:00 a.m. and 1:00 a.m.. Staff was directed to turn R165 from side to side. RN-E also stated she didn't like R165 to be "on her bottom" and stated the aides were supposed to be following their group sheets to ensure R165 was turned every two hours.	{F 314}		

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{F 314}	Continued From page 22 According to RN-E, the aides get R165 out of bed at around 3:00 p.m. because a family member came to visit and assist her with supper. Record review identified there was no documented assessment for the pressure areas including location, stage, dimensions, any tunneling/undermining, wound base description, drainage, wound edges, odor, pain and progress. Progress notes revealed: · 6/29/15: measured and assessed coccyx wounds. The previous area of maceration no longer shows maceration and there are now IV defined wound beds. "the wounds healing " · 7/5/15: wound bed has red granulated tissue with scant amount of serous drainage. · 7/8/15: pressure ulcers on coccyx and right buttock healing. scant amount of drainage. · 7/12/15: Dark purple, approximately quarter sized on right buttock with skin no longer intact. · 7/14/15: resident dressing still intact-wound nearest coccyx looks wider. · 7/15/15: resident ' s sores on buttocks have scant amount of blood and granulated tissue is present. · 7/15/15: Proximal coccyx has now reopened. On 7/15/15, at 1:50 p.m. NA-H was interviewed and her group sheet was observed. NA-H stated she started her shift at 10:00 a.m. The group sheet for R165's room/bed was blank. When asked how she knew about R165's positioning needs, NA-H stated she would ask other staff. NA-H also stated that NA-M repositioned R165 after lunch. However, when repositioning was observed, no off loading was provided to the coccyx.	{F 314}		

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{F 314}	Continued From page 23 On 7/15/15, at 2:44 p.m. R165 was observed laying on her back in bed. R165 was not observed to have pressure relieved/off loading to her coccyx from 7:10 a.m. until 2:51 p.m.. On 7/15/15, at 2:51 p.m. RN-E entered to perform a wound check and dressing change for R165. During the observation, R165 called out numerous times, "ouch", "Let me go", and verbally complained about being held on her side and stating, "Quit playing with my butt!". During the observation and interview on 7/15/15, at 2:51 p.m. RN-E stated that when R165 had returned from the hospital on 6/3/15, the wound was macerated. RN-E stated that last week the coccyx wound was closed, healing, and in a dried state, but stated it was not crusty and closed anymore. RN-E stated that R165's dressing is changed once a day, on the midnight shift, and more often if the dressings were soiled when R165 is incontinent of bowel. RN-E stated that the wound on R165's coccyx was originally a stage III (1/15 admission) pressure ulcer, but last week was 100% slough and the whole area was dry. During the observation on 7/15/15, at 2:51 p.m. RN-E measured the wound to be 1.7 x 0.7 cm with 90% slough, maceration around the edges and a little bit granulation. RN-E continued that the area on R165's buttocks that was dry last week was now "like a butterfly" that started on the left buttock and bridged over to the right. RN-E described the area on the right buttock as 3.6 cm x 4.0 cm, with 50% slough, 50% granulation and as Stage III pressure ulcers. RN-E stated that interventions included "lots of turning" because she was incontinent, R165 was turned more	{F 314}		

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{F 314}	Continued From page 24 frequently. RN-E continued with the wound care and described the wound on R165's left buttocks as 5 cm x 0.8 cm with no slough, all granulation and also at a Stage III. RN-E stated that R165 was on a rescue mattress, but she will now need to order an air mattress for her. R165's nursing assistant group sheet dated 7/16/15, directed staff to ensure the resident was "side laying Q2H [every two hours]". The group sheet stated R165 had a Foley catheter to check every two hours as she was incontinent of bowel and check and change every two hours. The group sheet did not provide specific direction about coccyx pressure ulcer care, off-loading, observations of skin or reporting observations to licensed nurses. On 7/16/15, at 7:55 a.m. RN-E was interviewed in R165's room. RN-E agreed that the pillow placement provided by staff did not off load pressure from R165's coccyx. RN-E stated that since yesterday's observation, she has updated the physician and ordered an air mattress for R165. RN-E stated that R165 is hard to keep on her side, as noted by her complaints during the 7/15/15 observations. When asked if there were any directions to aides about off-loading pressure from the coccyx area, RN-E stated that they are informed to position R165 from side to side.	{F 314}		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F 318		8/20/15

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(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 318	Continued From page 25 decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services and a hand splint as ordered for 1 of 1 resident (R127) reviewed for range of motion services. Findings include: R127's undated Admission Record identified diagnoses of multiple sclerosis (MS) and contracture (a shortening or hardening of muscle, often leading to deformity) of hand joint. R127's annual Minimum Data Set (MDS) dated 5/21/15, identified R127 had severe cognitive impairment and was totally dependent on staff for activities of daily living (ADLs). R127's Care Area Assessment (CAA) dated 5/21/15, indicated R127 was at risk for a functional decline related to contracture's with a goal to slow or minimize decline and minimize risks. R127's restorative nursing program dated 1/7/15, and ordered by occupational therapy (OT) directed staff to provide range of motion (ROM) exercises to bilateral upper extremities (BUE), ROM to left hand and place a cone in the hand to prevent skin breakdown. R127's care plan dated 5/26/15, indicated R127 had an alteration in self-care ability related to MS and contracture's. The plan directed staff to provide the following:	F 318	Resident # 127 is provided range of motion and a hand splint per plan of care. Careplan and restorative nursing program for resident # 127 was reviewed/revised. Current residents on restorative programs were reviewed and revised as necessary. Nursing staff educated on following rom and splinting programs and to ask the nurse or nurse manager if there are questions about how to complete a resident¿s program. New ROM or splints being implemented will have therapy training completed to nursing staff along with detailed program in NAR documentation book. Nurse Manager/Designee will complete audits weekly of staff conducting ROM, and auditing that splints are in place per plan of care to ensure that staff know how to and are carrying out range of motion and splinting programs and is documented. Audits will be reviewed and directed through QAA.	

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F 318	Continued From page 26 -Gentle active assistive ROM to left elbow, wrist, hand, shoulder five times weekly -Gentle passive ROM to right elbow, wrist, hand and shoulder five times weekly -Gentle stretch of head, neck to midline 10-15 times holding each time for 10 seconds -Pillow for neck support to be used when in the wheelchair -Rolled washcloth in left hand R127's nursing assistant Cedar Group sheet which contained further nursing assistant (NA) directives indicated the following: -Restorative nursing was to be done in the a.m. -Washcloth roll in left hand -Pillow support for neck when in wheelchair On 7/15/15, at 7:21 a.m. R127 was observed with a pillow to the neck and a positioning pillow to the right hand. No washcloth was observed in the left hand. On 7/15/15, at 7:35 a.m. NA-R and NA-S were observed to assist R127 with morning cares. R127 was unable to participate in cares and all his morning cares were totally completed by NA-R and NA-S. No range of motion was performed at that time. When cares were finished NA-R positioned R127's neck with a pillow and placed R127's right hand on a positioning pillow, no washcloth was placed into R127's left hand. On 7/15/15, at 1:36 p.m. R127 was observed seated in a wheelchair, totally assisted by staff to eat lunch. Positioning pillows to the neck and right hand were in place and no washcloth was in R127's left hand.	F 318		

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On 7/15/15, at 2:56 p.m. NA-K stated physical therapy provided R127's range of motion and she was not aware of a restorative nursing program the NAs were responsible to complete. NA-K confirmed range of motion was not performed on R127 this shift and that a washcloth was not placed R127's left hand.

On 7/16/15, at 9:25 a.m. R127 was seated in the wheelchair being totally assisted to eat breakfast. Positioning pillows to the neck and right hand were in place and a washcloth was in the resident's left hand.

On 7/16/15, at 11:19 a.m. licensed practical nurse (LPN)-C stated the NAs should have been doing R127's restorative nursing and the documentation was in the restorative nursing book.

The Restorative Nursing Documentation sheet for July 2015, was reviewed and noted to have 11 areas documented out of 42 opportunities that were to be documented as completed. On the bottom of the form it instructed staff to leave the area blank if the program was not provided that day. The Restorative Nursing Documentation sheet directs staff to do bilateral upper extremity range of motion daily, wash terry cloth cover at night and use washcloth in hand overnight. It was unclear of what shift was responsible to document what tasks. There were no instructions on the Restorative Nursing Documentation sheet or book on what exercises were to be done with R127 or how many repetitions were to be completed.

On 7/16/15, at 11:29 a.m. NA-R stated there were no instructions in the restorative nursing book on

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what exercises that should have been provided. NA-R stated she just moved R127's arms more during cares but no formal ROM exercises. NA-R further stated the facility had not provided any education on how to do R127's exercises.

On 7/16/15, at 3:07 p.m. registered nurse (RN)-H verified there were no instructions for the NAs to follow in the restorative nursing book. RN-H acknowledged the multiple missing documentation on the Restorative Nursing Documentation sheet and stated it was really hard to monitor the documentation and the NAs to ensure restorative nursing programs were being done. RN-H stated she utilized the communication book to remind the NAs to perform the restorative nursing programs and to document when completed. RN-H verified that she has not shown the NAs the exercises that were to be done with R127.

On 7/16/15, at 3:40 p.m. occupational therapist (OT)-A stated R127's left hand contracture was measured on 7/15/15, for a decline, however, verified there were no previous measurements to compare the new measurements to. OT-A also stated therapy had not routinely measured resident contracture's in order to determine status of them. OT-A stated she firmly believed R127 had not had a decline or worsening contracture as the carrot cone previously used in the left hand still fit without adjustments. OT-A stated the carrot cone was changed to a wash cloth to the left hand for R127's improved comfort. OT-A stated the therapists trained the nurse managers on the exercises that were to be done for all the residents and the nurse managers were responsible for training the NA's.

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F 318	Continued From page 29 On 7/16/15, at 4:22 p.m. the director of nursing (DON) verified there were a lot of blanks in R127's restorative documentation and that it was an expectation the NAs provided the restorative nursing programs and devices as directed. The DON also verified the blanks indicated the service was not provided. The DON also stated it was an expectation that staff asked questions if it was not clear on what was to be done for each resident. A policy on range of motion was requested and not received.	F 318		
{F 323} SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 ensure comprehensive assessments were completed and interventions were implemented in an attempt to prevent falls for 4 of 4 residents (R83, R232, R200, R278) reviewed for falls. The facility failed to investigate and comprehensively assess resident falls to determine if new interventions could be implemented, and the facility did not ensure the interventions were consistently implemented to prevent falls, which resulted in a significant injury	{F 323}	Resident # 83, 232, 200, and 278 have had a new fall assessment completed and careplan reviewed/revised. Facility completed a fall analysis from the past 3 months of fall data. The analysis was reviewed with IDT. Resident activity times on the Cedar Unit were changed to target times when residents were identified as having the most falls occurring.	8/20/15

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{F 323}	Continued From page 30 for R83. The facility's failure resulted in an immediate jeopardy, with serious harm and injury for R83. The immediate jeopardy began on 6/15/15, when R83 fell, received a laceration to his head, was sent to the emergency room (ER), and required staples to close the head wound. The facility failed to comprehensively assess and implement interventions to prevent ongoing falls. The administrator, assistant administrator (AA), and the director of nursing (DON) were notified of the immediate jeopardy (IJ) for R83 on 7/16/15, at 12:32 p.m. The immediate jeopardy was removed on 7/21/15, at 1:43 p.m. but noncompliance remained at the lower scope and severity of a G, which indicated actual harm that was not immediate jeopardy. Findings include: R83 had multiple falls with patterns to the falls. He received a series of 3 head injuries during 3 separate falls identifying him to be high risk for significant injury. R83's Admission Record identified diagnoses that included chronic ischemic heart disease and bilateral hearing loss. R83's quarterly Minimum Data Set (MDS) dated 5/9/15, indicated R83 was severely cognitively impaired, had no behavior problems, and felt down, dependent or hopeless one day in the past seven days. The MDS further identified R83 required assistance of one staff for activities of daily living (ADLs), had not ambulated the past seven days, and was independent propelling himself in the wheelchair. The MDS also indicated R83 was totally incontinent of bowel and bladder, had not had a trial toileting program, and was not on a toileting program. The MDS further	{F 323}	Nursing staff has received education on following facility accident/incident procedure, to include: completing root cause analysis with each resident fall, proper documentation, implementing immediate/appropriate interventions for falls, care planning of and following interventions. Education also included NAR¿s informing the nurse if unable to complete interventions. Nurse Managers/Designee shall review residents at high risk for falls to assure plan of care in place with resident specific interventions. Nurse Managers/Designee to complete audit post each fall incident to ensure root cause analysis is being completed. DON/Designee to audit weekly to assure fall risk assessments are completed thoroughly, post fall assessments are complete with root cause analysis, fall care plans up to date and have resident specific fall interventions; with follow up to include re-education, corrective action, or system review through the QAA process as needed. Audits will be reviewed and directed through QAA.	

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identified R83's balance during transfers (moving from seated to standing) not steady, but able to stabilize without human assistance, moving on and off the toilet not steady, but able to stabilize without human assistance, surface-to-surface (transfers between bed and chair or wheelchair) not steady, but able to stabilize without human assistance. The MDS identified R83 had pain, and received pain medication daily, and was at risk of falls, and had a history of two or more falls without injury, and two or more falls with injury.

R83's Care Area Assessment (CAA) dated 11/24/14, indicated R83 was at high risk for falls, and had a history of falls in the past. Interventions in place included: low bed, mat on side of bed, pummel cushion in wheelchair, and anti-rollback on wheelchair. R83's fall risk assessment dated 11/21/14, indicated R83 was at high risk for falls, had no safety awareness, self-transfers and had fallen several times.

On 2/16/15, the fall assessment was updated and indicated R83 had multiple falls this quarter, was impulsive but also very active, and moving helps with back discomfort, does well if walked when trying to stand, and staff was to keep in common area where he could be observed. On 5/19/15, the fall assessment was updated and indicated R83 had multiple falls and was very impulsive and fall prevention measures were in place which had prevented injury for most falls. Staff was to keep R83 in common area for observation while awake.

R83's care plan dated 6/24/15, identified a goal: resident will not be injured in falls through the next review date, and listed interventions of call light positioned for easy access, ensure

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environment is free of clutter, fall review per facility policy, have commonly used articles within easy reach, keep in common area, provide with activity or newspaper, motion sensor next to bed while sleeping, next to bathroom door when up, pressure alarm to wheelchair, hip protectors on as resident allows, bed in low position, fall mats on both sides of the bed, anti-rollback to wheelchair, and theraband to assist with need for activity.

Interview with R83's power of attorney (POA)-A on 7/15/15, at 11:45 a.m. revealed concerns with his falls. R83 had multiple falls with head injury and they usually occurred when R83 "has to go to the bathroom." POA-A stated R83 "has all the bells and whistles" (alarms) yet keeps falling. POA-A had informed the nurse manager R83 needed to be toileted more often to assist with decreasing the need for self transfers and resulting falls, however, that had not happened. In addition, POA-A had requested staff use a white board for communication with R83 due to his hearing difficulty, however, that had not happened yet either.

Review of R83's fall incident reports and post fall assessments since 4/15 indicated the following:

4/3/15, at 6:15 a.m. R83 was found on the floor in his room. R83 stated he was trying to use the bathroom, and complained of pain in his left shoulder. Fall interventions in place at time of fall: low bed, fall mat. Registered Nurse (RN) summary: resident woke early, attempted to get out of bed and fell. Poor safety awareness due to dementia. New interventions implemented: continue with low bed, mat. Remove items from side of bed, care plan as roll out of bed.

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{F 323}	Continued From page 33 4/8/15, at 7:45 p.m. R83 was found sitting on the floor in his room. R83 stated he was trying to do something to his TV. There were no injuries. Fall interventions in place at time of fall: low bed, fall mat. RN summary: resident was found on his floor, sitting, Poor safety awareness related to dementia. New interventions implemented: keep in common area as much as possible, keep entertainment items easily assessable. 4/12/15, at 3:30 a.m. R83 was found on the left side of his bed on the floor. R83 received two abrasions on the center of his forehead, 1 measuring 1 centimeter (cm) x 1 cm, and the other 0.5 cm x 1 cm. Fall interventions in place at time of fall: low bed, fall mat. RN summary: resident is care planned to roll out of bed, attempted to get out of bed, resident fell. Abrasion to forehead, fall mat under bed. New interventions implemented: bed to be at level to allow legs to dangle. 4/22/15, at 2:30 p.m. R83 was found sitting on the floor in his bathroom. There were no injuries. Fall interventions in place at time of fall: hip protectors, motion alarm while in bed. RN summary: resident attempted to self-transfer to toilet and fell, poor safety awareness related dementia. New interventions implemented: check for hip protectors in room nightly, motion alarm near bathroom to alert staff when resident in room. 4/23/15, at 4:00 p.m. According to the Post-Fall Assessment Form R83 was in the solarium, stood up and fell. He sustained a 1 1/2 inch by 1 1/2 inch bump to the back of his head. Fall interventions in place at time of fall: low scoop	{F 323}		

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mattress and motion sensor in room. RN summary: Attempted to get up and fell, hit his head. New interventions implemented: eat in main dining room instead of solarium. After multiple requests, the facility was unable to provide an incident report for this fall.

4/28/15, at 6:30 a.m. R83 was found on the mat next to his bed. The bed was not in the low position, and the motion sensor was not turned on. Fall interventions in place at time of fall: low bed, fall mat, motion sensor, hip protectors. RN summary: resident found on floor mat - crawling, education provided to staff to use motion sensor and bed in low position when he is in bed. New interventions implemented: continue plan of care.

4/29/15, at 3:15 p.m. According to the Post-Fall Assessment Form staff was unable to determine circumstances of fall. R83 did not sustain an injury. Fall interventions in place at time of fall: low bed, fall mat, motion alarm, hip protectors. RN summary: resident unaware of weakness and safety. New interventions implemented: lab (PSA level, which was within normal limits) and urinalysis/urine culture (culture indicated no growth) ordered to rule out clinical problem. After multiple requests, the facility was unable to provide an incident report for this fall.

5/2/15, at 6:10 p.m. R83 leaned forward to grab a table in the dining room to stand and fell to the floor. There were no injuries. Fall interventions in place at time of fall: hip pads, scoop mattress, low bed, motion sensor alarm in bedroom. RN summary: resident has poor safety awareness/poor balance. He attempted to transfer independently and fell. New interventions implemented: continue with current plan of care.

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{F 323}	Continued From page 35 5/10/15, at 4:30 a.m. R83 attempted to take himself to the bathroom and fell. There were no injuries. Fall interventions in place at time of fall: none noted on document. RN summary: resident was attempting to get out of bed to go to the bathroom, resulting in a fall. He was incontinent of bowel. New interventions implemented: all staff educated to follow care plan. 5/28/15, at 8:10 p.m. R83 was found on the floor in his bathroom. There were no injuries. Fall interventions in place at time of fall: motion sensor, low bed, anti-lock brakes, scoop mattress, hip protectors. RN summary: resident has dementia with no safety awareness, impaired mobility and balance, both contributed to fall. New interventions implemented: update care plan to toilet before and after meals. 6/2/15, at 3:35 p.m. R83 stood up from his wheelchair at the nurse's desk, grabbed a wooden bar and fell. There were no injuries. Fall interventions in place at time of fall: low bed, fall mats. RN summary: resident will frequently hold rail at nurse's desk to stand, he has poor safety awareness. New interventions implemented: not documented. 6/15/15, at 1:00 p.m. R83 was found on the floor in his room, he had attempted to self transfer to the toilet. R83 received a laceration on his head, requiring a visit to the ER for staples. Fall interventions in place at time of fall: not documented. RN summary: resident stated he needed to go to the bathroom. no safety awareness/poor balance and mobility contributed to fall. New interventions implemented: 3 day bowel and bladder assessment to determine	{F 323}		

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{F 323}	Continued From page 36 toileting pattern. On 7/16/15, at 8:10 a.m. RN-H was interviewed and verified the bowel and bladder tracking form was not completed, and she did not do an assessment to determine R83's toileting pattern. 6/16/15, at 1:30 a.m. R83 was found in his room on the mat next to his bed. There were no injuries. Interventions in place at time of fall: motion sensor. RN summary: resident has dementia and frequently crawls out of bed, likely thinking it is time to get up. New interventions implemented: continue with current plan of care. 6/21/15, at 8:19 a.m. R83 stood up at the nurse's station and fell. There were no injuries. Interventions in place at time of fall: alarm on wheelchair. RN summary: resident is very impulsive, no safety awareness. He will grab bar at nurse's station. Impaired balance/gait, hypotension (low blood pressure). New interventions implemented: will have activities provided for him throughout the day, tool kit, etc. to keep him busy. 6/26/15, at 3:00 a.m. R83 was found on the floor next to his bed. There were no injuries. Interventions in place at time of fall: none noted. RN summary: resident has impaired cognition, no safety awareness. Plan of care followed, continue with current interventions. New interventions implemented: continue with alarm, floor mat, and pillow placement. 6/29/15, at 5:10 a.m. R83 was found on the floor next to his bed. No injury. Interventions in place at time of fall: motion sensor. RN summary: frequently attempts to get out of bed, no safety awareness/judgement. New interventions	{F 323}		

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{F 323}	Continued From page 37 implemented: fall mat placed on other side of bed. 7/3/15, at 6:50 p.m. R83 was in the dining room, stood up out of his wheelchair and fell, hitting his head on the table. R83 received a laceration to his forehead and was treated at the facility with steri-strips (used to hold the laceration together). Interventions in place at time of fall: left blank. RN summary: resident is impulsive, diagnosis of dementia, frequently stands, Unaware of own limitations, history of vertigo, orthostatic hypotension. New interventions implemented: offer theraband (A theraband is a latex resistance band or tube that is used for physical therapy and light strength training exercise) for resident to help exercise, keep busy. During the survey from 7/15/15, through 7//21/15, there were no therabands observed in R83's room, nor at the nurse's station. 7/6/15, at 6:45 a.m. R83 was in the solarium, got out of his wheelchair and fell, he stated he was trying to shut the windows. There were no injuries. Interventions in place at time of fall: chair alarm. RN assessment: resident is impulsive with no safety awareness. New interventions implemented: review walking program. On 7/16/15, at 8:10 a.m. RN-H was interviewed and verified R83 was not being ambulated per his walking program stating staff knows they are supposed to do it, but added she was not at the facility all of the time to make sure it was being done. 7/11/15, at 6:00 p.m. R83 was at the nurse's desk, fell and hit his head. R83 sustained a bump to his forehead. Interventions in place at time of fall: pressure alarm on wheelchair, low bed, motion sensor, fall mat. Resident has impaired mobility/balance. no safety awareness.	{F 323}		

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{F 323}	Continued From page 38 Frequently attempts to stand and walk which resulted in fall. New interventions implemented: consult provider regarding frequent falls. On 7/16/15, at 8:10 a.m. RN-H stated she remembered speaking with the nurse practitioner about R83, but did not know if any new interventions were put into place. 7/14/15, at 6:45 a.m. R83 was at the nurse's station, stood up out of wheelchair and fell. No injuries. Interventions in place at time of fall: pressure alarm in wheelchair, hip protectors, motion sensor in room and floor mats. RN summary: resident has no safety awareness/impaired balance/mobility. He is impulsive and will frequently attempt to get up. Believes he should be somewhere when dressed. New interventions implemented: (on 7/15/15) keep white board with resident at all times so he can have improved communications with staff, change to toilet every two hours (previously was toileted on arising, before and after meals, after an activity and before bed), bladder scan to rule out urinary retention. 7/15/15, at 3:50 p.m. According to the Post-Fall Assessment Form R83 fell in the dining room. No injury. Interventions in place at time of fall: toilet every two hours, chair and bed alarms, toilet before meals, at bedtime, in the morning and afternoon. RN summary: resident had been toileted at 3:30 p.m. and walked at 3:00 p.m. New interventions implemented: continue with interventions. After multiple requests, the facility was unable to provide an incident report for this fall. On 7/16/15, at 8:10 a.m. RN-H was interviewed, and verified she did not do a post fall analysis to determine causative factors as to why R83 was falling, nor did she consistently review current interventions in place or provide additional	{F 323}		

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{F 323}	Continued From page 39	{F 323}		

interventions for the aforementioned falls.
7/16/15, at 3:50 p.m. R83 at nurse's station, attempted to stand from wheelchair and fell. No injury. No injuries noted. Interventions in place at time of fall: wheelchair alarm. RN summary: facility did not provide RN summary. New interventions implemented: not documented.
7/17/15, at 4:50 a.m. R83 was found lying on the floor next to his bed. There were no injuries. Interventions in place at time of fall: not documented. RN summary: resident has vertigo/orthostatic hypotension. New interventions implemented: not documented.
7/17/15, at 8:30 a.m. R83 was found sitting on the floor in his bathroom. There were no injuries. Fall interventions in place at time of fall: not documented. RN summary: resident very agitated, busy over the last 24 hours. Medical workup in process, pain, depression, over-stimulation being evaluated. Has had two falls and one roll out of bed in less then 24 hours. New interventions implemented: not documented.
On 7/15/15, at 12:12 p.m. R83 was interviewed and stated he had some falls, and fell when he had to go to the bathroom. R83 said he had bumped his head many times, and he felt sad and frustrated. R83's room was observed at this time, and there were anti-rollbacks and a pressure alarm on his wheelchair, a motion detector was on the floor near the bathroom, and there were mats on both sides of the unmade bed.

On 7/15/15, at 1:32 p.m. R83 was observed wheeling himself from the dining room into his room. The sensor alarm sounded, staff went into the room and brought R83 out of his room. R83 wheeled himself to the nurse's station and read the paper. At 1:43 p.m. staff approached R83,

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{F 323}	Continued From page 40 told him she was going to take him to the bathroom, and brought him to his room. On 7/16/15, at 9:09 a.m. nursing assistant (NA)-G was interviewed and identified herself as R83's primary caregiver that day. NA-G stated she was not always able to ambulate R83 on her shift per his care plan, she does her best, but she was not able to get it done very often, "it's very busy." NA-G further stated she does not let the licensed nurses know when she has not walked R83, stating it was a busy place, and they don't have time to do everything. On 7/17/15, at 8:45 a.m. RN-H was interviewed, and stated R83 had three falls since yesterday (see falls 7/16/15-7/17/15). RN-H stated R83 did not receive any injuries from these falls, she had not implemented any new interventions, and she had not determined causative factors for these falls. Although there was a pattern to the times and locations to the self transfers, there was no attempt by the facility to determine why R83 was attempting to self transfer and what could be done to minimize his need to self transfer and falls. On 7/17/15, at 9:16 a.m. R83 was observed to be sitting at the dining room table with care assistant (CA)-A. CA-A stated he had just started a 1:1 with R83. R83 did not have the personal alarm on his wheelchair. At 1:42 p.m. observation of R83's room showed the motion sensor was no longer on the floor near the bathroom. On 7/21/15, at 10:48 a.m. RN-H stated she did not do an assessment on the removal of the alarms, she felt they were not preventing his falls, so she had them removed.	{F 323}		

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{F 323}	Continued From page 41 On 7/20/15, at 8:46 a.m. the the DON was interviewed. The DON stated staff was directed to start a 3 day bowel and bladder tracking form (to determine toileting pattern) with R83, however over the weekend it had not been filled out completely, and she would start it over today. The DON further stated R83 had been placed on a new walking program, staff was to walk him 4 times a day. However, the DON was unable to verify if staff had walked him as directed. The immediate jeopardy that began on 6/15/15, was removed on 7/21/15, when the facility implemented the following interventions to minimize the risk of falls for R83: 1:1 supervision with gradual removal plan 3 day bowel and bladder diary to assist in completing assessment medication review by pharmacist physical therapy evaluation sleep diary auditing plan to ensure interventions are implemented and revisions made as needed, and increased ambulation with restorative nursing, However, noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy because R83 received a series of 3 head injuries during 3 separate falls identifying him to be high risk for significant injury. R232's Admission Record identified diagnosis that included dementia, hypertension, history of fall, and long term use of anti-coagulants (medication that "thins" the blood and makes one susceptible to bleeding easily). The physician's	{F 323}		

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{F 323}	Continued From page 42 orders signed 7/20/15, directed warfarin (an anticoagulant medication) 5 milligrams (mg) daily. The quarterly MDS identified R232 as having severe cognitive deficits, and ambulated on the unit with supervision and one assist of staff. The MDS further identified R232's balance during transfers (moving from seated to standing) not steady, but able to stabilize without human assistance; moving on and off the toilet not steady, but able to stabilize without human assistance; surface-to-surface (transfers between bed and chair or wheelchair) not steady, but able to stabilize without human assistance. The care plan dated 6/25/15, identified R232 was at risk for falls, and directed staff to ensure environment was free of clutter, ensure resident had nonskid footwear on, offer rest periods id he appears tired, and to redirect resident if he is attempting to move furniture. On 7/16/15, a progress note identified R232 was at risk for falls due to syncope episodes unsteady at times with ambulation, does understand assistance with ambulation, and resistive to assistance with ambulation. The progress note further identified R232 had poor safety awareness, and the focus was on comfort cares. The progress note indicated the care plan was reviewed, and the current interventions were appropriate to promote the least restrictive environment and decrease behaviors. On 7/20/15, at 12:45 p.m. R232 was observed to be ambulating independently in the dining room. Summary of R232's falls sine 3/15:	{F 323}		

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{F 323}	Continued From page 43 3/22/15, at 8:30 a.m. R232 was walking in the dining room, tripped over his own feet and fell. R232 was in his stocking feet, and not wearing shoes. R232 hit his head sustaining a laceration, and was sent to the ER. A CT scan was done, and R232 was sent back to the facility. Interventions in place at time of fall: non-slip footwear. RN summary: make sure resident has shoes or gripper socks on as he was in stocking feet. New interventions implemented: not documented. 6/27/15, at 3:30 p.m. R232 was walking in the dining room and fell. R232 fell and hit the back of his head. While waiting for the ambulance to arrive, R232 got up, and fell a second time. R232 sustained a 1 cm open area to the back of his head. R232 was transported to the ER, the head laceration was cleansed, and he returned to the facility. Interventions in place at time of fall: none. RN summary: resident is independent with ambulation with a focus on comfort care, continue with current plan of care. Has significant cardiac issues with syncope. New interventions implemented: continue with current plan of care. 7/18/15, at 9:45 a.m. R232 R232 was in another resident's room using a walker that was not his, appeared to be staggering and fell. R232 received a skin tear on his left forearm, and a laceration to the back of his head. R232 was sent to the ER, and received sutures to the laceration, and was returned to the facility. Interventions in place at time of fall: room free of clutter, redirect. RN summary: resident ambulates independently, has cardiac history, pacemaker, dementia. New interventions implemented: 15 minute checks. On 7/20/15, at 12:45 p.m. RN-B was interviewed	{F 323}		

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{F 323}	Continued From page 44 and stated she was unaware if R232 was wearing shoes with the most recent fall. RN-B further stated she had not added any new interventions to the care plan, but had asked for R232 to get 250 milliliters (mls) of water with each medication pass to increase his blood pressure. RN-B also stated she thought maybe R232's medications should be reviewed, and maybe she should start checking his blood pressures. The facility policy and procedure on Accidents/Falls revised 2/14, directed staff to conduct a post-fall assessment following any fall episode with 24 hours post fall. The resident's individualized care plan is to be updated with any changes or new interventions post fall/incident/accident, communicated to appropriate staff, and implemented. R278 R278's admission MDS dated 5/9/15, indicated R278 had severe cognitive impairment, required extensive assistance of staff for transfers and did not ambulate. The MDS also identified R278 had a history of falls with a fracture within 6 months of admission. R278's Admission Record includes diagnoses of dementia, history of closed fracture to femur and restless legs syndrome. R278's admission Fall Risk Assessment dated 5/2/15, identified a history of 1-3 falls in the last 3 months, underlying condition of cardiac diagnosis, medication use of narcotics, and functional status of needing constant support, wheelchair, oxygen, weakness and receiving physical and occupational therapy. The areas addressing sensory/cognitive/psychological status was not filled out along with a missing summary of the data collected. The form was not signed or	{F 323}		

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{F 323}	Continued From page 45 dated. On 7/16/15, at 7:57 a.m. DON reported the nurse, who filled out the initial Fall Risk Assessment dated 5/2/15, did not complete the assessment and could not provide a second page to the assessment. R278's care plan dated 6/22/15, listed safety as a focus area with the following interventions: -call light reminders to use assistance -non-skid footwear -low bed -do not leave unattended in the bathroom. -safety review per facility protocol -pressure alarm in wheelchair and bed -hip protectors -transfers extensive assistance of 1 -keep bed at transferable height Falls Risk Post-Fall Assessment identified the following falls: Previously R278 had 5 falls between May and June all falls were noted in the summary to be regarding self-transferring. 7/8/15, at 7:10 a.m. R278 was found at bedside. R278 stated I woke up on the floor. No injury was noted. Summary of the post fall findings included, resident rolled out of bed on to the fall matt despite current interventions. Interventions implemented included continue plan of care, low bed, mat, pressure alarm, has been successful in preventing injury. Form signed by interdisciplinary team (IDT) 7/10/15, at 9:00 a.m. R278 was found in the bathroom. No injury was noted. Summary of	{F 323}		

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{F 323}	Continued From page 46 post-fall findings included attempted to self-transfer after being left on the toilet alone. Intervention implemented included added to group sheet not to leave on toilet alone. Education with staff was given that anyone with alarms were not to be left on the toilet alone. Form signed by IDT 7/13/15, at 9:00 p.m. R278 was found in resident room last seen in R278's wheelchair in room. No injury noted. Summary of post fall findings included resident self-transferring and fell on bottom, no injury. Interventions implemented include anti roll backs applied to wheelchair, ask resident when R278 wants to go to bed starting at 7:00 p.m. Form signed by IDT. On 7/14/15, at 2:05 p.m. R278 was resting with eyes closed in a stationary rocker sitting on a pressure alarm cushion in R278's room. R278's all light was across the room on R278's bed. R278 could not have used the call light for help if R278 needed assistance. On 7/15/15, at 12:50 p.m. R278 reported that she uses her call light when she needs to. On 7/15/15, at 8:23 a.m. NAR-I reported that R278 was to have her call light by her and to have hip protectors on. NAR-I reported that R278's hip protectors were not on this a.m. because NAR-I could not find them and she needed to report it to the nurse. On 7/16/15, at 8:33 a.m. LPN-B reported that the team leaders fill out the fall paperwork, which includes an incident report, fall huddle and a post fall assessment. When completed they are given to the nurse manager to review.	{F 323}		

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{F 323}	Continued From page 47 On 7/16/15, at 8:40 a.m. RN-A verified that R278 was to have the call light within reach at all times and that R278's hip protectors were supposed to be on to reduce the risk of falls. RN-A reported the team leaders fill out the fall paperwork, which includes an incident report, fall huddle and a post fall assessment. RN-A states that the forms are reviewed for accuracy and that all needed notifications have been completed. RN-A reports IDT meetings are held usually the following day to discuss the falls. RN-A reports the DON usually charts on the IDT meetings regarding the falls. RN-A reports that nothing has changed with the facility fall process and fall follow ups are handled the same way they always have. RN-A feels she address' the cause of the falls although they are not getting on paper, and verified the Post Fall Assessment's does not address the cause of the falls. RN-A further reports that there is not enough staff to focus on the paperwork that needs to be completed. On 7/16/15, at 4:22 p.m. the DON confirmed the Post Fall Assessment summary does not address the cause of the R278's falls but rather it identified what the resident was doing at the time of the fall. The DON reports her expectations are for the nurse managers to address the root cause of falls and put in place an appropriate intervention to prevent future falls. R200 R200's quarterly MDS dated 4/26/15, indicated R278 had severe cognitive impairment, required extensive assistance with transfers and ambulation. The MDS also identified R200 as	{F 323}		

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having 2 or more falls without injury and 2 or more falls with injury prior to assessment. R200's Admission Record includes diagnoses of dementia, diabetes and hypertension.

R200's Fall Risk Assessment quarterly update dated 4/16/15, summarized R200 had had 4 falls this last quarter. R200 had an urinary tract infection with increased weakness. R200 had a diagnosis of Dementia with poor safety awareness. Alarms used to alert staff when resident is attempting to self transfer. R200 has an unsteady gait.

R200's care plan dated 6/25/15, listed safety as a focus area with the following interventions:

-assistive device
-bed in low position
-one way glide to wheelchair
-ensure environment is free of clutter
-fall mat next to bed
-fall review per facility protocol
-have common articles within easy reach
-reinforce need to use the call light for assistance
-safety devices
-scoop mattress to define edge of bed
-pressure alarm to the wheelchair and bed

Falls Risk Post-Fall Assessment identified the following falls:

7/11/15, at 10:40 a.m. R200 stood up at the nurses station and fell. No injury was noted. Summary of the post- fall findings included, resident has no safety awareness, has impaired mobility. Resident attempted to get up and walk resulting in fall. Delayed sounding of alarm. Intervention implemented was replaced the

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{F 323}	Continued From page 49 alarm. On 7/15/15, at 7:18 a.m. R200 was in bed supine the call light was with in reach, pressure pad in place and fall mat to outside of bed. The bed was in low position with a scooped mattress. On 7/15/15, at 9:38 a.m. NAR-G reports that R200 frequently tries to stand on her own and has had a few falls. On 7/16/15, at 3:17 a.m. RN-H verified that the summary to the cause of the fall on the Post Fall Assessment was not in depth and did not identify why R200 was attempting to stand at the desk. On 7/16/15, at 4:22 p.m. DON confirmed the Post Fall Assessment summary does not address the cause of R200's fall but rather identified what the resident was doing at the time of the fall. The DON reports her expectations are for the nurse managers to address the root cause of falls and put in place an appropriate intervention.	{F 323}		
{F 353} SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to 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. 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:	{F 353}		8/20/15

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	245366	A. BUILDING _____ B. WING _____	R 07/21/2015

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 353}	Continued From page 50 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) 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 provide sufficient staffing to ensure residents received the care and services in accordance to their assessed needs. This had the potential to affect all 160 residents residing in the facility. Findings include: Refer to F314 related to pressure ulcers for R165 who did not receive timely assistance with repositioning. Refer to F318 related to range of motion services for R127 who was not receiving range of motion services according to the plan of care. Refer to F323 related to accidents for R83 who has multiple falls without adequate assessment and interventions resulting in an immediate jeopardy situation. On 7/16/15, at 8:40 a.m. registered nurse (RN)-A stated unit team leaders filled out the resident falls paperwork which included an incident report, fall huddle and a post fall assessment. RN-A stated the forms were reviewed for accuracy and	{F 353}	Residents residing at Chris Jensen Health & Rehabilitation Center (CJH&R) will receive proper care with creative staffing solutions. R165 is turned and repositioned according to the plan of care. R127 is provided range of motion according to the plan of care. R83 has been re-assessed for fall risk. All falls within the last 30 days have been reviewed for trending and root cause; the care plan has been updated according to the findings. Resident is provided care according to the plan of care. R73 has been assessed and has no skin impairments related to toileting plan. Ambulation program is being completed according to the plan of care. Facility recruits for staff through the use of Smart Recruiters website (which posts to several other hiring websites), attends job fairs, encourages staff to recruit via word of mouth. Hiring has been conducted and will	

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{F 353}	Continued From page 51 that all needed notifications had been completed. RN-A stated the interdisciplinary team (IDT) meetings were usually held the following day to discuss the falls and the director of nursing (DON) documented in the resident charts following the meetings. RN-A stated nothing had changed with the facility resident fall process and fall follow ups were handled the same way they had always been. RN-A stated she felt she addressed the cause of each resident fall, however, it was not getting documented because there was not enough staff to focus on the paperwork that needed to be completed. RN-A stated she felt staff education was also lacking related to the facility falls process. On 7/13/15, 3:26 p.m. nursing assistant (NA)-C stated the facility frequently worked short staffed and that staff were frequently mandated to stay and work the following shift. NA-C stated basic personal cares were being completed, however, resident grooming was often forgotten. On 7/13/15, 3:31 p.m. NA-D stated staff had been really busy and were unable to answer resident call lights timely. On 7/13/15, 3:38 p.m. licensed practical nurse (LPN)-A stated over the past month, there had not been a change in the staffing patterns. LPN-A stated due to the facility's resident care acuity levels she felt the facility was not staffed with enough NAs. LPN-A stated the NAs were frequently pulled from the floor to work as trained medication assistants (TMA) which left the floor short of NAs. LPN-A stated it was difficult to complete her tasks such as changing out resident oxygen supplies and charting and stated those	{F 353}	continue ongoing. Facility has changed orientation schedule to occur weekly when there are new hires available to start. (Facility had previously held orientation bi-weekly) Turnover data is reviewed on monthly scorecard calls and in Facility QAA meetings with tracking/trending data and follow up action plans. Facility has an ongoing Employee Engagement Committee which has an active action plan and is exploring better ways to retain current employees. Facility Executive Director and Human Resources Director have met with the Union Field Rep and Union Steward to re-implement routine Labor Relations Committee meetings to assist with problem solving issues that derive from contract language that can lead to poor employee retention. Facility evaluated Pilot Program of using universal workers and has now expanded into a full program. These staff provide nursing support such as resident transport, room order; making beds, passing water and meal support with tray delivery. Their job duties include answering call lights and supplying residents with care within there scope of practice and obtaining other staff members to assist with duties they are not able to supply, thus freeing up direct care staff.	

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{F 353}	Continued From page 52 tasks frequently had not been done. LPN-A also stated the NAs frequently had not completed their end of shift charting either. On 7/14/15, at 1:47 p.m. NA-E and NA-F were interviewed. NA-E stated staffing had not improved since the standard survey 5/20/15. NA-E stated on the Cedar unit (a locked memory care unit) they usually had three nursing assistants (NAs) to care for about 30 residents on the day shift and the same amount on the afternoon shift. NA-E stated she was usually unable to get all of her work done. NA-F stated a few weeks ago they had two nursing assistants until 10:00 a.m., leaving two nursing assistants to get about 15 residents up and fed in the morning. NA-F stated they never get it all done. NA-E and NA-F both stated the Ceder unit never got assigned care assistants. On 7/14/15, 2:41 p.m. R73 stated she felt the facility was understaffed and that staff were not trained to the level they should be. R73 stated she has waited 60 to 90 minutes for assistance to use the bathroom. R73 stated she has had to "pee and poop" in her pants because of having to wait so long for help. In addition, R73 stated she required two staff assistance to ambulate and with the short staffing she has not ambulated as often as needed. R73 went on to explain that her cares were frequently interrupted by other staff seeking a co-workers help with other residents. R73 stated she had heard staff in the hallways talking about how short staffed the facility was. On 7/15/15, 9:27 a.m. NA-K stated the NAs were not able to answer resident call lights or provide toileting assistance timely. NA-K stated the facility worked short staffed 90% of the time.	{F 353}	The facility manager on duty program has been running since 7/11/15 and helps support nursing staff with guidance and oversight, assistance with meal delivery, answering call lights and meeting with families, thus freeing up direct care staff to provide cares. Weekend Nurse Manager program was implemented on 7/25/15 to help support House Supervisor and Nursing staff during high volume care times. Change in resident activity times on the Cedar Unit has been implemented to support line staff during heavy care times. This allows NARs to focus on patient care as residents stay engaged in an activity. Dining assistance is taking place with a Manager assisting with tray passing at various meals and weekend support so the NARS can focus on feeding residents. Staff also received education to reach out directly to their nurse manager when they feel they need assistance due to changes in patient care loads such as resident illnesses and increased behaviors. DON/Nurse Managers review/make changes to group assignments as needed based on feedback from staff and evaluation of resident care needs. DON/House Supervisor reviews and rearranges staffing levels per units and by shift based on resident census and acuity, new admissions, and	

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{F 353}	Continued From page 53 Interview with R83's power of attorney (POA)-A on 7/15/15, at 11:45 a.m. revealed concerns with staffing. She voiced concerns related to R83's falls and need for increased toileting but felt there was not enough staff available to meet his needs. POA-A believed R83 had a pattern with falls related to the need to self transfer to get to the toilet. POA-A stated there was not enough staff to get the cares done, R83's bed is never made until late in the afternoon, he "rarely" has dentures in his mouth, and if they are there was no poligrip on them. On 7/15/15, at 2:13 p.m. the administrator stated the facility had tried alternatives to low staffing levels such as with the use of care assistants which were staff who were not nursing assistants, but were able to do tasks such as making beds, pass linen, push wheelchairs and filling water. The administrator stated they currently employed four care assistants which were assigned to the units with a higher acuity level. The administrator stated each unit's acuity level was reviewed daily. On 7/17/15, at 10:06 a.m. NA-T stated she felt the facility was understaffed. NA-T stated three NAs was minimum staffing and four was ideal, but that "doesn't happen often." NA-T stated she picked up 2-3 extra shifts per pay period; she doesn't get mandated, but responds to text messages asking for shifts to be covered. On 7/17/15, at 10:35 a.m. NA-F stated three NAs normally worked the unit, which was not enough to get her work done. NA-F stated when there was four NAs the staff was able to get their work done.	{F 353}	abilities/qualifications of the staff scheduled. When call in's occur, calls are made to replace the individual. When situations present that a staff member who called in is unable to be replaced, other staff scheduled may be bumped to a different unit based on the needs of the unit at that time. In emergency situations, the facility has utilized the Nurse Managers or other Nurses (i.e. MDS, Admissions) to work on the floor, A nurse may be asked to work ina Nursing Assistant position/shift, Department Directors may be called in to assist with the non-direct care tasks allowing the direct care staff more time to complete those duties. ED/Assistant ED has attended past 2 family council meetings and given update on the programs implemented to support staff. ED/Assistant ED will continue attending monthly council meetings to evaluate the effectiveness of new programs and staffing changes with the Family Council. ED/Designee attended past 2 resident council meetings and gave updates on the programs implemented to support staff. ED/Designee will continue attending monthly council meetings to evaluate the effectiveness of new programs and staffing changes with the Resident Council. Executive Director/Designee will use questionnaires weekly with staff to evaluate effectiveness of of programs and	

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{F 353}	Continued From page 54 A policy and procedure on sufficient nursing staffing was requested and not provided.	{F 353}	staffing changes as it relates to staff being able to get tasks/duties completed. Social Service Director/Designee will use resident questionnaires weekly to evaluate effectiveness of programs and staffing as it relates to resident needs being met. Questionnaires/audits will be reviewed and directed through QAA.	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the administrator failed to provide adequate supervision of staff and facility protocols which resulted in an Immediate Jeopardy (IJ) being identified at F323 related to resident safety and supervision. The administrator also failed to ensure: residents were free from unnecessary restraints, treated with dignity and respect, dialysis residents were monitored, pressure ulcers were appropriately treated and prevented, toileting needs were met, range of motion services were provided, staffing was appropriate for meeting resident needs, personnel policies were followed and quality improvement programs ensured resident quality of life and quality of care	F 490	Administrator has been in her role for 6 weeks has the new responsibility of managing and overseeing the survey process for cited tags as listed on the 2567 from revisit survey 7/21/15. The Administer is ultimately responsible for the day to day functions and oversight of the facility and assure the facility remains in compliance to ensure adequate supervision of staff and that facility policy and procedures. A plan of correction has been developed from the revisit survey of 7/21/15 and the	8/20/15

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F 490	Continued From page 55 needs were met. These administrative failures had the potential to effect all 160 of 160 residents residing in the facility. Findings include: The facility remained out of compliance with 4 regulatory requirements cited on the initial recertification survey exited 5/20/15. In addition, lack of compliance at F314, pressure ulcer treatment and prevention, was recited at a severity level of 3, actual harm for R165. In addition, the facility was found to be out of compliance with 7 additional regulatory requirements. F323, accidents and supervision, was found to be out of compliance at a severity level of 4, immediate jeopardy (IJ) for R83. The facility remained in an immediate jeopardy from 7/16/15 through 7/21/15 when the IJ was removed. On 7/21/15, at 1:30 p.m. the administrator stated since the standard survey on 5/20/15, the facility had one quality assurance (QA) committee meeting which was held 6/24/15. The administrator stated the committee had not discussed audits to ensure compliance with the deficiencies cited on the initial survey. The facility was in the process of developing audit tools. For specific areas the administrator failed to manage appropriately: Refer to F221 reciting for physical restraints Refer to F241 related to dignity Refer to F309 reciting for dialysis Refer to F314 reciting at actual harm for pressure ulcers Refer to F318 for range of motion/splints	F 490	alleged deficient practices have had a plan of correction developed and will be sustained per the administrators oversight. The Administrator is responsible to oversee that survey audits and plan of correction results are reviewed through a revised QAA weekly to monitor systems and programs in place to assure the deficient practices are being corrected and sustained. Systems and programs will be revised as needed through this process.	

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F 490	Continued From page 56 Refer to F323 for an immediate jeopardy related to accidents and supervision Refer to F353 reciting for sufficient staffing Refer to F520 for Quality Assurance	F 490		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance evaluations were completed for 5 of 12 nursing assistants (NA-AG, NA-AH, NA-AI, NA-AK, NA-AM) who were reviewed for performance evaluations. Findings include: In a review of personnel files, the following was found: Nursing assistant (NA)-AG, employed since	F 497	HR has completed a full house audit of all employee files for performance evaluations. Evaluations are currently being completed for all employees with priority given to: all FT/PT nursing assistants, then casual, then on-call. The same applies to all employees with anniversary month of August. Employees on an LOA will have performance evaluations completed upon their return. Going forward, performance evaluations will be conducted within the anniversary	8/20/15

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F 497	Continued From page 57 2/7/11, no evaluations on file NA-AH, employed since 4/94, last evaluation was in 2012 NA-AI, employed since 7/11/13, no evaluations on file. NA-AK, employed since 11/11/14, no evaluation since 2011 NA-AM, employed since 2/26/13, no evaluations on file. During an interview on 7/20/15, at 4:30 p.m. the director of human resources confirmed performance evaluation/reviews were not being done at the facility In a follow-up interview on 7/21/15, at 8:14 a.m., the director of human resources provided a policy that stated performance reviews were done on an annual basis. The director of human resources stated this was an area the facility "needs to work on."	F 497	month of each employee. The Human Resources Director/Designee will audit evaluation completion monthly to ensure performance evaluations are being completed by the perspective manager. Audits will be reviewed and directed through QAA.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		8/20/15

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F 520	Continued From page 58 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee reviewed an acted upon resident quality of life and quality of care concerns identified during the standard survey on 5/20/15, and failed to develop action plans and a monitoring system following the identification of the concerns. This had the potential to effect all 160 residents residing in the facility. Findings include: The facility failed to act on the following identified deficient practices: Refer to F221 related to physical restraints. Refer to F309 for dialysis. Refer to F314 for pressure ulcers. Refer to F323 for accidents. Refer to F353 for sufficient staffing. On 7/21/15, at 1:30 p.m. the administrator stated	F 520	The facility QAA team has received education on the QAPI process from Health Dimensions Group Management Company. This education included how to run an effective Quality Council to ensure systematic approaches of issues are being analyzed and addressed. Data from most recent survey 2567, plan of correction, and audits have been analyzed and addressed through the QAA process. The Administrator will be responsible to oversee that survey audits and plan of correction results are reviewed through a revised QAA weekly to monitor systems and programs in place to assure the deficient practices are being corrected and sustained. Systems and programs will be revised as needed through this process. The full Quality Council Committee will continue meeting on a monthly basis.	

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F 520	Continued From page 59 since the standard survey, the facility had one QA&A meeting which was held on 6/24/15. The administrator stated, at the meeting, they had not discussed facility audits (to ensure compliance with the deficiencies on the standard survey) and that they were in the process of developing audit tools. The administrator stated the facility had reviewed the citations and their plan of correction.	F 520		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245366	01 - MAIN BUILDING 01	7/9/2015

Name of Facility	Street Address, City, State, Zip Code
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/29/2015	ID Prefix Reg. # NFPA 101 LSC K0130	Correction Completed 06/11/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/mm	07/22/2015	03005	07/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/19/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 94G4

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 **05/20/2015** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, HFE NEII — 06/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 06/24/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5366

On May 20, 2015 a standard survey was completed by the Departments of Health and Public Safety. In addition, on May 20, 2015 an abbreviated standard survey was complete by the Departments Office of Health Facility Complaints to investigate complaint number H5366063, which was found to be substantiated. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Electronically delivered
June 4, 2015

Mr. John Doughty, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, Minnesota 55811

RE: Project Number S5366025, H5366063

Dear Mr. Doughty:

On May 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health 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.

In addition, on May 20, 2015 an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, to investigate complaint H5366063 that was found to be substantiated.

The standard survey and the abbreviated standard 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), whereby corrections are required.

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

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

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

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

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

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 a "F" tag (**standard survey, project number S5366025**)), i.e., the plan of correction should be directed to:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

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

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag (**abbreviated standard survey, complaint investigation number H5366063**)), i.e., the plan of correction should be directed to:

Sarah Grebenc, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
Sarah.grebenc@state.mn.us

Phone: (651) 201-4135
Fax: (651) 281-9796

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 June 29, 2015, 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 June 29, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (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, Office of Health Facility Complaints 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 August 20, 2015 (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 November 20, 2015 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	05/20/2015

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 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 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R73) reviewed voicing concerns was informed of a change in her medications Findings include: According to her 2/11/15 quarterly Minimum Data Set (MDS), R73 is cognitively intact. According to	F 154	Medication change was reviewed with resident #73 and resident is satisfied with current medication plan. Interviewable residents were interviewed to assure notification of medication changes occur and that they are aware of current medication regime. All residents and/or responsible party are notified with	6/29/15

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

Electronically Signed — 06/12/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 154	Continued From page 1 her care plan printed on 5/17/15, R73 had diagnoses including a history of CVA (cardiovascular accident or stroke), and depression. In an interview on 5/18/15, at 1:42 p.m., R73 stated the pharmacy decided to reduce her antidepressant (fluoxetine) from 60 mg to 40 mg without telling her. According to R73, this was her "primary issue" right now. R73 stated she had post traumatic stress disorder (PTSD), anxiety and depression and this change had her upset. In an interview on 5/19/15, at 1:30 p.m., registered nurse (RN)-C stated R73's Fluoxetine was reduced from 60 mg to 40 mg on 5/5/15. RN-C stated she did not tell R73 about the change because she wanted to see if there was a noticeable difference in symptoms. RN-C said, "I don't know who told her." In an interview on 5/20/15, at 12:39 p.m., RN-H stated she started a discussion of R73's medication reduction during her care conference on 5/12/15. RN-H stated she did not know that R73 was not aware of her fluoxetine reduction. RN-H stated she did not think R73 would be upset with the decrease, but she was. RN-H stated that the facility's standard procedure was to fax a pharmacist's recommendation to the physician. If the physician signed the order and returned it, then the facility would follow physician recommendations and let family know when they get the signed order by return fax from the physician. RN-H stated that if a resident was cognitively intact, as was R73, then they would let the resident know instead of the family. RN-H stated it is not facility procedure to change a medication dose without notifying the resident or	F 154	medication changes as they occur. Education provided to Nurses regarding notifying residents of medication changes. Auditing of resident notification of medication changes weekly by Nurse Manager/Designee. Audits will be reviewed at QAA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 154	Continued From page 2 the family. RN-H stated, "It was missed." RN-H stated that either the cart nurse or the nurse manager can notify the resident or family. Progress notes dated 5/6/15, 5/7/15, 5/9/15 and 5/13/15 indicated that R73 had no signs or symptoms of depression noted. A progress note dated 5/15/15 read R73 had called her primary care physician and psychiatrist as she was upset about the fluoxetine reduction. A note on 5/16/15 indicated that R73 remained upset about the fluoxetine reduction. On 5/8/15, a progress note read that R73 was going through a "mini anxiety withdrawal because they messed with my Prozac (fluoxetine) by cutting it a 1/3 dose." The note stated no signs or symptoms of depression or anxiety. During a record review on 5/20/15, at 12:30 p.m., RN-C asked "who are you looking at?" and looked at the chart being reviewed. RN-C, upon seeing R73's name stated sarcastically, "Oh, she's a colorful person." In a follow-up interview on 5/20/15, at 3:01 p.m., R73 said there's reason she is on Prozac (fluoxetine), "I have depression, anxiety and PTSD." R73 said in the past they've tried other medications and this one works best; R73 said they should taper slowly, not "reduce by 1/3". R73 stated she has been having dizzy spells. She has been told dizzy spells can be a side effect from tapering too fast. R73 started crying and said she has been in and out of hospitals and rehab centers since Labor Day of last year, and no one has every "played" with her medications before.	F 154		
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF	F 156		6/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156 SS=E	Continued From page 3 RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 4 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 5 such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice in a timely manner prior to termination of Medicare skilled services for 1 of 3 residents (R15) reviewed for liability notice and beneficiary appeal rights. In addition, the facility failed to ensure resident rights were periodically reviewed. Findings include: R15 was admitted to the facility on 1/23/15. R15 therapy and Medicare services were discontinued on 2/13/15. On 2/13/15, the facility provided the Skilled Nursing Facility Advance Beneficiary Notice and the notice of Medicare Non-Coverage to R15, without the required two day notice. On 5/20/15, at 3:12 p.m. registered nurse (RN)-E was interviewed, and verified R15 was not provided the information and given a timely notice. The facility was unable to provide a policy and procedure on Skilled Nursing Facility Advance Beneficiary Notice and notice of Medicare Non-Coverage. The facility failed to ensure resident rights were periodically reviewed. In a review of resident council meeting minutes from 5/20/14 through 4/21/15, the no Resident Rights discussion were conducted.	F 156	Resident #15 has been discharged from facility. MDS Coordinators were re-educated on the proper two day notice period required when residents are ending Medicare services. SS staff educated on reviewing Resident Rights periodically. Resident rights will be routinely discussed at Resident Council Meetings. Resident rights are reviewed with each new resident upon admission and at each resident council meeting. Audits of Medicare Denial notices will be conducted weekly by the Business Office Manager for proper notification. Audits will be reviewed at QAA.	

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F 156	Continued From page 6 In an interview on 5/20/15, at 3:24 p.m., R19 stated the facility does not bring up resident rights at meetings, but they will point out where they are hanging, on a bulletin board, if a resident brings up rights. In an interview on 5/20/15, at 3:58 p.m., social services director (SSD)-A stated they used to review some rights at every resident council meeting, but haven ' t done that recently. They provide a resident rights booklet to residents upon admission and upon request. In a follow up interview on 5/20/15, at 4:32 p.m., SSD-A stated that informally rights issues may arise at a care conference or if there is a missing item. SSD-A identified that other than at admission, no other consistent review of resident rights was being done.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess a resident's ability to safely self administration medications for 1 or 1 residents (195) observed with self administration of nebulizers. Findings include:	F 176	Resident #195 was assessed for self-administration of medications. All residents who receive nebulizer treatments were reviewed for self-administration assessment. Self-administration assessments will be completed upon admission on any	6/29/15

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F 176	Continued From page 7 R195's quarterly Minimum Data Set (MDS) dated 4/25/15, indicated R195 was cognitively intact. Diagnosis listed on the Patient Report from professional portable x-ray dated 5/10/15, was pneumonia. Physicians Orders sheet included medication of Duoneb four times a day for two weeks. On 5/20/15, at 9:18 a.m. licensed practical nurse (LPN)-C listened to R195's lungs and obtained R195's oxygen saturation level and announced to R195 the reading was 91%. LPN-C then administered R195 a Duoneb breathing treatment via nebulizer machine by placing the medication in the nebulizer machine and placing the mask on R195's face. LPN-C turned on the machine and told R195 that she would be back in ten minutes to check on the medication administration and would be right outside R195's room. LPN-C washed her hands and returned to the medication cart that was one room down from R195's room and faced the opposite direction of R195's room. LPN-C did not have constant observation of the nebulizer treatment from the medication cart. On 5/20/15, at 9:23 a.m. LPN-C looked on the medication administration record (MAR) and reported that there was not an order for R195 to self administer a nebulizer treatment. LPN-C reported she could hear the nebulizer machine running and was right outside the door. LPN-C verified she could not visualize the entire nebulizer administration process from the location of the medication cart but could peak in.` On 5/20/15, at 9:29 a.m. registered nurse (RN)-B verified an assessment was not completed on R195 to self administer nebulizer treatments.	F 176	resident who wishes to self administer meds and will be reviewed quarterly. Nurses educated on proper procedure for self-administration of medications. DON/Designee will complete weekly Audits of nurse med pass, including nebulizer treatments to ensure self administration of medication system is being followed.	

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F 176	Continued From page 8 RN-B stated that the nurses are to be peaking in on the resident's receiving nebulizer treatments until the treatment was completed. On 5/20/15, at 10:17 a.m. director of nursing (DON) verified an assessment needs to be completed for self administration of a nebulizer treatment and if the resident has not been assessed or is unsafe the nurse needs to have constant visualization of the administration of the nebulizer treatment. The facility policy and procedure on Self Administration of Medications dated 4/1/08, directed residents who wish to self administer medications may do so, if it is determined after assessment that they are capable of safely doing so.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide ongoing monitoring/evaluation and care planning for use of a restraint for 1 of 1 residents (R172) reviewed for physical restraints. Findings include:	F 221	Resident #172 was reassessed for necessity of physical restraints. Careplan updated to reflect current restraint device in use. Order clarified with the appropriate diagnosis/medical symptom for use of restraint device. All other residents with a restraint were reviewed for necessity of the restraint, care plan, and proper diagnosis. Nursing staff educated on	6/29/15

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F 221	Continued From page 9 R172's Admission Record identified diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 4/9/15, indicated R172 had severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS also identified R172 required extensive assistance for all activities of daily living (ADLs), had not fallen in the past quarter, and had a trunk restraint which was used daily. On 4/14/15, the nurse practitioner (NP) ordered a self-releasing seat belt. The NP order lacked the presence of a medical symptom for use of the seatbelt. On 5/19/15, at 1:40 p.m. R172 was observed being fed lunch in the dining room. R172 was sitting in her wheelchair, and was observed to have a seatbelt secured around her waist. At 1:44 p.m. nursing assistant (NA)-M stated he forgot to release the seatbelt during lunch. On 5/19/15, at 1:58 p.m. registered nurse (RN)-D stated the seatbelt was used for R172's safety. RN-D was unaware if an assessment for use of the seatbelt had been completed. RN-D further stated that R172 had previously had a Velcro belt, but she had been able to release it, so they used the current seatbelt, which R172 was unable to release upon command. RN-D stated the staff is to release the seatbelt at meal time, and to walk R172 every two hours when she is awake. RN-D stated staff was to document when they released the seatbelt, and when they walked R172, however this was not being done consistently. RN-D was not sure if the seatbelt was the least restrictive restraint that could be used, and stated they had no plans to decrease or remove the	F 221	facility policy for residents using restraints. Weekly audits by DON/Designee to assure that facility restraint policy is being followed. Audits will be reviewed at QAA.	

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F 221	Continued From page 10 restraint. RN-D verified there was no care plan for the use of the seatbelt. On 5/20/15, at 3:27 p.m. the director of nursing (DON) verified the use of a restraint should be assessed, and on the care plan. The DON further stated the seatbelt should be released during meals, and staff should be walking R172 every two hours. R172's medical records were reviewed, and lacked evidence of an assessment for the restraint, and there were no indications of a gradual process toward reducing the restraint. The facility policy and procedure on Restrain Free Care dated 4/09, directed physical restraints are used only when they are used appropriately - to treat the resident's medical symptoms and to promote an optimal level of function for the resident. If a resident is restrained, an assessment will be completed by a licensed nurse or therapist upon admission and thereafter, quarterly and/or prior to an application of any restraint, to determine the appropriateness. The least restrictive device should be used with documentation of all other alternatives tried prior to the implementation of a restraint. There must be a physician's order for the use of the restraint which includes medical symptoms for use, frequency of use, type of restraint, release protocols, and plan for reduction, when applicable.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		6/29/15

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F 248	Continued From page 11 the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 1 of 2 residents (R87) reviewed for activities. Findings include: R87's family member (FM)-C was interviewed on 5/17/15, at 7:01 p.m. and stated R87 does not participate in activities. FM-C stated she visits R87 every other day, and has not seen her family member involved in any activities. R87's admission Minimum Data Set (MDS) dated 3/25/15, identified diagnoses that included dementia. The MDS also identified R87 was severely cognitively impaired, and required extensive assistance of staff for bed mobility, transfers, locomotion on and off the unit, toileting, dressing and personal hygiene. R87's care plan dated 3/27/15, indicated R87 made independent choices for daily activities, and to encourage her participation in activities of interest which included word games, trivia, sports, reading, writing, talking, shopping, walks, watching TV, listening to the radio, watching movies, cooking, baking, cards, gardening, and community outings. R87 was not observed in individual or group activities during the survey from 5/17/15, through	F 248	For resident #87, family interview was conducted on activity preferences. Careplan was updated to reflect preferences. Resident #87 is offered meaningful activities. All residents are offered individual and group activities. Residents choosing not to participate in group activities are offered 1 to 1 activities. Residents will be interviewed upon admit and quarterly to ask what type of activities they are interested in. Individual Activity logs will indicate what activities residents wish to participate in and whether they are individual, group activities or 1 to 1 visits for each resident. Activity department has been educated on this system. ED/Designee will audit resident activity logs weekly to assure they have been individualized as per admission or quarterly interview. Audits will be reviewed at QAA.	

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F 248	Continued From page 12 5/20/15. R87's activity log completed from 3/18/15, through 5/19/15, indicated R87 participated in activities on 3/18, 23, 28, 4/1, 4, 5, 11,18, 19, 27, 29, 5/1, and 13/15. The activity logged lacked the activities R87 participated in, and whether they were individual or group actives. On 5/20/15, at 8:40 p.m. the activities director (A)-A was interviewed and stated R87 was fairly new to the facility, and they were still trying to get to know her, and find her niche. A-A verified the activity sheets lacked what activities R87 had participated in, and whether they were individual or group activities. R87's activity assessment and activity notes were requested, but not provided. A policy and procedure on activities was requested and not provided.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272		6/29/15

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F 272	Continued From page 13 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to complete a positioning device assessment which included safety for 1 of 3 residents (R125) reviewed for accidents. R125's quarterly Minimum Data Set (MDS) dated 3/8/15, indicated R125 had severe cognitive impairment and required extensive assistance of two people for bed mobility. R125's Admission Record listed diagnoses that included glaucoma, osteoporosis and osteoarthritis.	F 272	Positioning assessment for safety was completed on resident #125 and body pillow was removed. Education has been provided to nursing staff on process for assessing the need of a positioning device for a resident to assure the device is safe and best possible option. Nurse managers/Designee will complete weekly audits on their units to assure residents using assistive devices for positioning have proper assessment and care plans in place. Audits will be reviewed at QAA.	

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F 272	Continued From page 14 R125 was observed on 5/18/15 at 8:22 a.m. lying in bed with a body pillow on the edge of the bed tucked under the bottom fitted sheet. On 5/20/15, at 12:26 p.m. nursing assistant (NA)-P reported that the body pillow is used for positioning and it is placed under the bottom fitted sheet so the pillow doesn't fall off the bed. On 5/20/15, at 12:30 p.m. registered nurse (RN)-F confirmed an assessment was not completed on the use of the body pillow in bed. RN-F did not complete an assessment. She stated she did not believe it was not a restraint, because it did not restrict R125. On 5/20/15, at 12:34 p.m. director of nursing (DON) verified a safety assessment should have been completed for a bed pillow in bed to ensure the safety of the resident. The facility did not have a policy on bed pillows for positioning.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		6/29/15

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F 279	Continued From page 15 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan based on the comprehensive assessment for 1 of 2 residents reviewed for pain (R106), for 1 of 3 residents reviewed for falls (R87). and 1 of 2 residents reviewed for pressure ulcers (R198). Findings include: R106 did not have care plan for pain. Interview with R106 on 5/17/15 at 6:00 p.m. the resident indicated she had chronic pain and took scheduled pain medication. The quarterly Minimum Data Set (MDS) assessment dated 3/8/15 indicated the resident received scheduled pain medication and had pain almost constantly. Diagnoses included gout and degenerative joint disease. The May 2015 medication administration record (MAR) indicated the resident was on Tramadol (a pain medication) three times a day, and acetaminophen three times a day for pain.	F 279	Careplan for pain was completed on resident #106. Careplan was updated for resident #87 for falls, history of falls, causative factors, and fall interventions. Careplan for pressure ulcers was completed for resident #198. Any residents whose CAA's trigger for pain, falls, or pressure ulcers upon admission, change of condition as reviewed at clinical IDT meeting, and with quarterly review will have appropriate care plans addressed for each aforementioned item. MDS nurses and Nurse Mangers have been given educated related to development of initial plan of care and updating plan of care quarterly, with Sig change and as needed. DON/Designee will audit 3 resident charts weekly to assure that these areas of resident specific concerns are addressed with any sig change, quarterly and prn. Audits will be reviewed at QAA.	

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F 279	Continued From page 16 The resident's record lacked a pain related care plan. Interview with RN-F on 5/19/15 at 10:08 a.m. indicated the resident should have a care plan for pain, and stated there was not a care plan for pain. The policy Care Plans-Comprehensive, dated April 2008, indicated assessments were used to develop a comprehensive care plan that would include measurable objectives to meet the residents needs. R87's care plan lacked her history of falls, causative factors for falls, and fall interventions. R87's admission record identified diagnoses that included history of fall, and hip fracture. R87's admission Minimum Data Set (MDS) dated 3/25/15, identified R87 was severely cognitively impaired, required extensive assistance of staff for transfers, and indicated R87 did not ambulate. The MDS also identified R87 had a history of falls and fracture related to a fall in the six months prior to her admission to the facility. R87's fall risk assessment dated 3/19/15, indicated R87 was at risk for falls due to dementia with recent fall/hip fracture. R87's Incident Reports with corresponding dates included falls on 4/16/15, 5/3/15, and 5/18/15. On 5/20/15, at 12:54 p.m. RN-D stated R87 lacked a care plan for falls. On 5/20/15, at 3:27 p.m. the director of nursing (DON) was interviewed and stated falls were reviewed initially after the fall, and daily during the facility's stand up meeting. Interventions to prevent further falls were to be looked at by the nurse who filled out the initial report, then the RN,	F 279		

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F 279	Continued From page 17 and they were also to be reviewed during the daily stand up meeting. The DON stated she would expect falls and interventions to prevent further falls be on the care plan. R198's Admission Record identified diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, indicated R198 was severely cognitively impaired, and required extensive assistance of two staff for for bed mobility and transfers. The MDS further identified R198 did not have a pressure ulcer, but was at risk for the development of a pressure ulcer. R198's skin risk assessment dated 10/6/14, indicated R198 was at greater risk for skin impairment related to her cognitive and functional ability losses, incontinence, pain and dependence on staff for repositioning. The skin assessment also included interventions to use pillows or blue boots to elevate heals, use a lift for transfers, do pericare after each incontinent episode, use a pressure reducing mattress, and check and change every two hours. R198's care plan dated 4/6/15, directed skin will remain clean, dry and intact, and had interventions to follow facility skin protocol, pressure reduction - cushion in wheelchair and mattress on bed. The care plan lacked a current pressure ulcer obtained on 3/22/15. On 5/20/15, at 2:05 p.m. R198 was observed lying in bed with a pressure reducing mattress, and blue boots on both feet. On 5/20/15, at 12:50 p.m. registered nurse (RN)-D verified no new assessments were put into place following the development of the	F 279		

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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 279	Continued From page 18 pressure ulcer on R198's heel. RN-D also verified the lack of a care plan. On 5/20/15, at 3:27 p.m. the director of nursing (DON) verified pressure ulcers should be addressed on the care plan. The facility policy and procedure on Pressure Ulcers/Skin Integrity/Wound Management dated 9/13/11, directed all care plan interventions should be revised if there is recurring pressure ulcers, a lack of progress toward healing, or if the resident acquires a new ulcer.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan regarding ambulation, nutrition, activities of daily living (ADLs), range of motion, and behavioral and emotional status for 5 of 10 residents (R172, R174, R188, R145, R278) whose care plans were reviewed. Findings include: R172's Admission Record identified diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 4/9/15, indicated R172 had severely impaired cognitive skills for	F 282	Resident #172 careplan was reviewed and an appropriate plan of care developed for ambulation. Resident #174 has received proper grooming assistance. Resident #188 received psychiatry evaluation and order for use of Nuedexta medication. Resident # 278 has had weights obtained and documented. All residents requiring grooming assistance are offered proper assistance, all residents on a walking program are being offered walking per their plan of care. Refusals are being documented. Resident weights are being	6/29/15

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F 282	Continued From page 19 daily decision making (never/rarely made decisions). The MDS also identified R172 required extensive assistance of two staff for ambulation. The physician's order dated 4/15/15, directed walk for short distance three times a day. Please document if unable to walk. R172's care plan dated 12/4/14, directed ambulation: extensive assistance of two with gait belt. Resident will just sit down when she is walking. Wheelchair to follow. On 5/19/15, at 1:58 p.m. registered nurse (RN)-D was interviewed, and verified R172 was not ambulated every two hours hours when she was awake. RN-D stated she believed the ambulation was not completed because of the low level of staffing. RN-D further stated she periodically spot checked the ambulation program to see if it was being completed. On 5/20/15, at 3:27 p.m. the director of nursing (DON) was interviewed and verified the facility does not have consistency with the ambulation programs. The DON stated her expectations would be ambulation should be done by the nursing assistants, with the nurse managers reviewing. The DON further stated she felt it got tossed by the wayside when the nursing assistants don't have enough time to complete ambulation. The facility policy and procedure on Mobility - Ambulation dated 3/1/14, directed residents assessed to be mobile will be provided ambulation opportunities either through therapy or assistance by nursing staff. R174 did not have personal hygiene completed.	F 282	obtained/documented per policy. All residents who have order for psychiatric consult will have it implemented timely. Nursing staff educated to provide proper ADL assistance and to report to nurse for further instructions if refusing and to attempt reapproach. Education to staff provided on documentation of refusals. Education provided to nursing staff on current weight documentation system. Nurse Managers/Designees will audit three care plans a week to assure proper implementation of interventions are taking place. Focus areas will be on weight recording, grooming, ambulating and documentation or refusal of services provided. Audits will be reviewed at QAA.	

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F 282	Continued From page 20 R174's care plan dated 3/13/15, indicated the resident had a self care deficit with grooming and would be neat,clean and odor free on a daily basis. Interventions included were assistance of one with grooming. On 5/17/15, at 6:44 p.m. R174 was observed in the hallway in R174's wheelchair to have white long whiskers on R174's chin and above the lip area. On 5/19/15, at 2:08 p.m. R174 was observed in bed resting R174 was observed to have long white whiskers on R174's chin and above the lip area. On 5/20/15, at 7:45 a.m. R174 was observed in the hallway in R174's wheelchair to have long white whiskers on R174's chin and area above the lip area. On 5/20/15, at 7:34 a.m. R174 confirmed the long whiskers on R174's chin and above lip area were bothersome. R174 reported that someone needed to shave them and that they don't do it very often. On 5/20/15, at 7:35 a.m. nursing assistant (NA)-R who provided morning assistance for grooming to R174 the morning of 5/20/15, confirmed that shaving was not provided for R174. NA-R reported that shaving was to be provided during am cares for residents that had a grooming dependency. NA-R reported the task of shaving did not get completed the morning of 5/20/15, due to being scheduled on two different units. NA-R further explained this happens when the facility is short staffed and shaving residents is a task that is often missed due to working short staffed. On 5/20/15, at 7:48 a.m. registered nurse (RN)-B reported that shaving was a part of morning cares if the resident allows it, and the nursing assistants	F 282		

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F 282	Continued From page 21 are aware. On 5/20/15, at 8:08 a.m. director of nursing (DON) verified shaving is expected to be completed with morning cares. R188 did not receive physician ordered services for behaviors. On 5/19/15 at 7:45 a.m. and 8:38 a.m. and on 5/20/15 at 8:39 a.m. R188 was observed laying in bed, her eyes were closed and she was making repetitive laughing noises, she did not respond when spoken to. A care plan for cognition indicated the resident had periods of time when she cries and in inconsolable. Interventions included to observe for change in cognition, review changes with physician or nurse practitioner, observe for mood symptoms and review with physician for recommendations. Nursing notes indicated the following: 4/21/15- has "uncontrollable emotional incontinence", music is calming, nurse manager to review emotional issues with physician and resident will start to see psychiatry as well. 5/5/15- received order from primary physician to work with psychiatry and possible use of Nuedexta (a medication used to treat crying and laughing outbursts with certain neurological disorders), "Contacted family and rcvd verbal consent to start [with] having resident be seen by rounding psychiatrist and to try Neudexta." The record indicated R188 did not take any psychoactive medications. The May 2015 medication administration record indicated there	F 282		

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F 282	Continued From page 22 were 21 medications circled as refused or spit out. The record also lacked evidence the resident had been evaluated by psychiatry or if Nuedexta had been started. Interview with RN-B on 5/19/15 at 8:27 a.m. indicated she was waiting for consents to be signed by the residents POA (power of attorney. She spoke to the rounding psychiatrist about adding the resident, but was waiting on consent forms. She was aware the order was written on 5/5/15 and indicated it should not take over two weeks to obtain consents and start services. R145 did not receive treatment for contracture management as ordered. On 5/17/15 at 6:34 p.m. R145 was observed seated near the nurses station. Her left hand was contracted, there was no splint device or rolled washcloth in her hand. On 5/18/15 at approximately 12:30 p.m. the resident was observed in the dining room, she did not have a rolled washcloth in her left hand. On 5/19/15 at 7:12 a.m., 12:21 p.m. and 3:11 p.m. the resident was observed and did not have a rolled washcloth in her left hand. A physician order dated 3/9/15 indicated the resident was to have a rolled washcloth in the left hand and to change daily. The May 2015 treatment record indicated the resident was to have a rolled washcloth in the left hand. The treatment was signed out as completed each day. Interview with NAR-Q on 5/19/15 at 3:11 p.m. indicated the resident used to wear a splint, but	F 282		

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F 282	Continued From page 23 that had been discontinued. The NAR was unclear if the resident was supposed to have a rolled washcloth in her hand, but thought it would be a good idea. She further indicated she did not put rolled washcloths in the resident's hand. R278's weekly weights were not monitored as recommended. R278 was admitted on 5/2/15. A nutritional assessment dated 5/8/15 indicated the resident was underweight with a body mass index (BMI) less than 19. The nutritional assessment recommended weights to be taken weekly and monitored for changes. The May 2015 treatment record indicated weights were to be checked weekly and documented on the vitals flowsheet. The medical record contained no weights for R278. Interview with RN-G on 5/19/15 at 2:02 p.m. indicated the weights had not been taken as ordered. The Weight Loss policy dated 3/1/14 indicated residents who enter the facility will not fall below their ideal body weight unless unavoidable. The policy procedures included, "4. Dietary consult completed and suggestions implemented".	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		6/29/15

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F 309	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement ordered fluid and protein restrictions for dialysis for 1 of 1 residents (R165) reviewed for dialysis. In addition, the facility failed to provide timely scheduled pain medication for 1 of 3 residents (R106) reviewed for pain. R165's significant change Minimum Data Set (MDS) dated 3/30/15, indicated R165 had severe cognitive impairment, with total dependence of one staff to eat. MDS indicated the following diagnoses: renal failure, diabetes mellitus, and congestive heart failure. R165's breakfast was observed on 5/19/15, at 9:44 a.m. R165 was being fed breakfast by an unidentified nursing assistant student. The breakfast consisted of two hard boiled eggs and a piece of bread along with 120 milliliters (mL) of juice, 120 mL of milk 240 mL of coffee and 240 mL of Ensure (supplement with increased protein) R165's lunch was observed on 5/20/15, at 12:41 p.m. being fed by unidentified nursing assistant student. The lunch consisted of ground chicken, mashed potatoes and gravy, yams, fruit, Magic Cup (supplement with increased calories and protein) along with 120 mL of juice 240 mL of milk, 240 mL of coffee and 240 mL of Ensure. R165's Nutritional Assessment dated 3/24/15, did address R165 is to be on a renal diet. Daily nutritional needs were noted to be the following; calories 2302 calories, protein greater than 69	F 309	Resident #188 has had psychiatric consult. Resident #165 diet and fluid restriction were implemented. Resident's dialysis program was discontinued on 6/3/15. Care plan has been revised. Resident #106 received pain medication for her complaint of pain and her med regime has been reviewed and updated. Medication pass times for all residents receiving analgesics reviewed for time appropriate administration with adjustments made as needed. All psych consults will be implemented in a timely manner from receiving order or Nurse Manager will be notified to intervene and insist with implementation of order. Residents requesting pain medication will receive pain medication in a timely manner. All dialysis patients have been reviewed to ensure proper fluid and protein restrictions are in place. Nursing has received education on Dialysis policy and communication, timeliness of completing psychiatric consults and pain management education including timely response to residents requests for pain management. DON/designee will complete audits three times a week to assure referrals are completed timely for specialized services such as psychiatric services. Nurse Manager will complete three resident interviews a week to assure pain medications are administered timely. DON/Designee will complete weekly audits of Dialysis residents to assure	

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F 309	Continued From page 25 grams and fluids 2302 mL. No orders from a practitioner for fluid restriction or protein limits were in the medical record. On 5/20/15 at 3:19 p.m. registered nurse (RN)-B reported she was unaware if R165 had fluid or protein restrictions. RN-B further stated dietary handles all fluid and protein orders and calculates what dietary and nursing will provide. RN-B stated she communicates with the dialysis unit after every visit. RN-B called the dialysis unit and they faxed over the order for fluid and protein restrictions. The physician's order dated 3/26/15, indicated the following; a fluid restriction of 1200 mL per day, protein 1.2 grams per kilogram per day, sodium 3 grams per day, potassium 2 grams per day with no diabetic features. On 5/20/15 at 2:42 p.m. dietary manager (DM)-F reported she was not aware of any fluid or protein restrictions for R165 and the Ensure was added to R165's diet per family request. DM-F looked through the dieticians records for R165 and could not find an order for fluid or protein restrictions. The policy titled Dialysis dated 12/23/13, includes a communication tool is to be utilized to receive a report on the resident to the facility after each dialysis session. A verbal report is accepted and the licensed nurse will document this in the residents record. It further includes the facility will coordinate care with the dialysis provider in developing an appropriate plan of care to include,	F 309	proper communication between facility and dialysis is occurring. Audits will be reviewed at QAA.	

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F 309	Continued From page 26 but limited to fluid restrictions. R106 did not receive necessary care and services related to pain management. Interview with R106 on 5/17/15 at 6:00 p.m. the resident indicated she had chronic pain and took scheduled pain medication. The quarterly minimum data set (MDS) assessment dated 3/8/15 indicated the resident received scheduled pain medication and had pain almost constantly. Diagnoses included gout and degenerative joint disease. The May 2015 medication administration record (MAR) indicated the resident was on Tramadol (a pain medication) 50 milligrams (mg) three times a day, and acetaminophen 650 mg three times a day for pain. Both medications were administered together at 8:00 a.m., 12:00 p.m. and 4:00 p.m. Interview with R106 on 5/19/15 at 9:30 a.m. indicated her shoulders were hurting her because she had not received her morning medication yet. Review of the MAR on 5/19/15 at 9:35 a.m., indicated R106's 8:00 a.m. medications had not yet been given. Interview with LPN-D on 5/19/15 at 10:02 a.m., she stated she was preparing R106's medication at that time. She further indicated she was behind schedule. She stated she had notified her nurse manager she was behind schedule with her medication pass but had not received assistance. Interview with RN-F on 5/19/15 at 10:08 a.m. indicated the resident should receive the	F 309		

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F 309	Continued From page 27 scheduled medication on time. She further indicated she was not aware the LPN was behind schedule. R188 did not receive necessary care and services related to behavior and emotional status. On 5/19/15 at 7:45 and 8:38 a.m. and on 5/20/15 at 8:39 a.m. R188 was observed laying in bed, her eyes were closed and she was making repetitive laughing noises, she did not respond when spoken to. A care plan for cognition indicated the resident had periods of time when she cries and in inconsolable. Interventions included to observe for change in cognition, review changes with physician or nurse practitioner, observe for mood symptoms and review with physician for recommendations. Nursing notes indicated the following: 4/21/15- has, "uncontrollable emotional incontinence", music is calming, nurse manager to review emotional issues with physician and resident will start to see psychiatry as well. 5/5/15- received order from primary physician to work with psychiatry and possible use of Nuedexta (a medication used to treat crying and laughing outbursts with certain neurological disorders), "Contacted family and rcvd verbal consent to start [with] having resident be seen by rounding psychiatrist and to try Neudexta." 5/14/15- refused medications, spit out, aggressive with staff. 5/15/15- crying most of shift, weeps inconsolable at other times, joyful and laughing. 5/18/15- wanders into others room, not easily redirected, becomes combative.	F 309		

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F 309	Continued From page 28 The record indicated R188 did not take any psychoactive medications. The record also lacked evidence the resident had been evaluated by psychiatry or Nuedexta had been initiated as indicated on 5/5/15 nursing note. Interview with RN-B on 5/19/15 at 8:27 a.m. indicated she was waiting for consents to be signed by the residents POA (power of attorney), she stated she had called HIT (health information) last week for the consent forms but had not received them yet. The resident was currently being seen by a psychologist. She spoke to the rounding psychiatrist about adding the resident, but was waiting on consent forms. She was aware the order was written on 5/5/15 and indicated it should not take over two weeks to obtain consents and start services.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dressing assistance for 1 of 1 residents (R167). Findings include: R167's face sheet indicated her diagnoses included dementia and Stage IV chronic kidney disease. According to her 3/25/15 quarterly	F 311	Resident #167 has been provided assistance with dressing. Plan of care has been updated to direct staff to assist with clothing changes and document refusals. All residents requiring dressing assistance have received appropriate dressing assistance. Nursing staff was educated on providing assistance with ADL¿s as needed or requested. NARS	6/29/15

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F 311	Continued From page 29 Minimum Data Set (MDS), R 167 is severely cognitively impaired and does not require staff assistance with the task of dressing. Review of R167's care plan and nursing assistant worksheet indicate she dresses independently. The nursing assistant worksheet also indicated R167 had poor judgement, was forgetful and anxious. On 5/20/15, at 8:41 a.m., R167 was observed in the same outfit as she had on when observed on 5/19/15. In an interview on 5/20/15, at 10:45 a.m., Family member (FM)-A stated that she typically visits daily. She said R167 only gets a bath once a week, and she gets changed then, so she is only getting her clothes changed once a week. FM-A stated R167 had been in the same top for 3 days. FM-A said she encouraged R167 to change her top today. FM-A stated R167 had been in the same pants for 3-4 days. FM-A states that R167 usually sleeps in her clothes and she wears a "pull-up" for some bladder leaking. FM-A stated R167 needs help getting cleaned up or changing clothes. The facility activities of daily living policy states a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal hygiene.	F 311	educated on re-approaching after refusals and resistance and notifying nurse to document refusals. Weekly audits by DON/Designee to assure residents are receiving assistance with ADL¿s per plan of care. Audits will be reviewed at QAA.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		6/29/15

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F 312	Continued From page 30 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal hygiene services for 1 of 3 residents (174) reviewed for ADL's Findings include: R174's quarterly Minimum Data Set (MDS) dated 3/7/15, indicated R174 was not cognitively intact and required extensive assistance of one staff to complete personal hygiene tasks. The MDS included diagnoses of heart and respiratory failure. On 5/17/15, at 6:44 p.m. R174 was observed in the hallway in R174's wheelchair to have white long whiskers on R174's chin and above the lip area. On 5/19/15, at 2:08 p.m. R174 was observed in bed resting R174 was observed to have long white whiskers on R174's chin and above the lip area. On 5/20/15, at 7:45 a.m. R174 was observed in the hallway in R174's wheelchair to have long white whiskers on R174's chin and area above the lip area. R174's care plan dated 3/13/15, indicated the resident had a self care deficit with grooming and would be neat,clean and odor free on a daily	F 312	Resident #174 has received proper grooming assistance. All residents requiring grooming assistance have received appropriate grooming assistance. Nursing staff educated to provide proper ADL assistance and to report to nurse and document refusals. Nurses educated on careplanning for refusal of care and documenting with refusals. Weekly audits by DON/Designee to assure residents are receiving assistance with ADL¿s. Audits will be reviewed at QAA.	

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F 312	Continued From page 31 basis. Interventions included were assistance of one with grooming. The undated Birch Group aid assignment sheet indicated R174 required assistance of one person for grooming. On 5/20/15, at 7:34 a.m. R174 confirmed the long whiskers on R174's chin and above lip were bothersome. R174 reported that someone needed to shave them and that they don't do it very often. On 5/20/15, at 7:35 a.m. nursing assistant (NA)-R who provided morning assistance for grooming to R174 the morning of 5/20/15, confirmed that shaving was not provided for R174. NA-R reported that shaving was to be provided during am cares for residents that had a grooming dependency. NA-R reported the task of shaving did not get completed on the morning of 5/20/15. NA-R stated it was due to being scheduled on two different units. NA-R further explained this happens when the facility is short staffed and shaving residents is a task that is often missed due to working short staffed. On 5/20/15, at 7:48 a.m. registered nurse (RN)-B reported that shaving was a part of morning cares if the resident allows it, and the nursing assistants are aware. On 5/20/15, at 8:08 a.m. director of nursing (DON) verified shaving is expected to be completed with morning cares. The facility policy titled Activities of Daily Living-ADL dated 4/1/08, directed staff, for residents unable to carry out activities of daily living, receive	F 312		

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F 312	Continued From page 32 the necessary services to maintain good grooming.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess, identify and provide interventions to prevent the development of pressure ulcers for 1 of 2 residents (R198) reviewed for pressure ulcers. Findings include: R198's Admission Record identified diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 3/25/15, indicated R198 was severely cognitively impaired, and required extensive assistance of two staff for for bed mobility and transfers. The MDS further identified R198 did not have a pressure ulcer, but was at risk for the development of a pressure ulcer. R198's skin risk assessment dated 10/6/14, indicated R198 was at greater risk for skin impairment related to her cognitive and functional	F 314	Resident # 198 has received a new skin assessment and her POC has been reviewed and revised. All residents with skin impairments have had assessment and care plans reviewed and revised as necessary. Nurse Manager has received education on properly care planning and assessments on residents related to skin impairments. DON/Designee will audit residents with skin impairments to assure care plans and assessments are in place. Audits will be reviewed at QAA	6/29/15

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F 314	Continued From page 33 ability losses, incontinence, pain and dependence on staff for repositioning. The skin assessment also included interventions to use pillows or blue boots to elevate heals, use a lift for transfers, do pericare after each incontinent episode, use a pressure reducing mattress, and check and change every two hours. On 3/22/15, R198's Wound Assessment Flowsheet indicated a 2 centimeter (cm) by 2 cm unstageable pressure ulcer to the outer aspect of the right ankle. The progress notes on 3/23/15, indicated unstageable wound found on 3/22/15, on right outer ankle, black scabby appearing area approximately 2 x 2 cm. The physician's orders on 3/23/15, directed hydrogel to wound, cover with foam dressing and change every day. The pressure ulcer was measured weekly with the most recent documentation on 5/19/15, measuring 2 cm x 2.5 cm x 0.8 cm depth. R198's care plan dated 4/6/15, directed skin will remain clean, dry and intact, and had interventions to follow facility skin protocol, pressure reduction - cushion in wheelchair and mattress on bed. The care plan lacked the current pressure ulcer identified on 3/22/15. On 5/20/15, at 2:05 p.m. R198 was observed lying in bed with a pressure reducing mattress, and blue boots on both feet. On 5/20/15, at 12:50 p.m. registered nurse (RN)-D verified no new assessments were completed following the development of the pressure ulcer on R198's heel. On 5/20/15, at 3:27 p.m. the director of nursing (DON) verified pressure ulcers should be	F 314		

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F 314	Continued From page 34 addressed on the care plan. Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. The facility policy and procedure on Pressure Ulcers/Skin Integrity/Wound Management dated 9/13/11, directed all resident are preventatively placed on pressure reduction mattresses and cushions in wheelchairs based on skin assessments. Those residents who represent a high risk will have further preventative interventions put in place. All care plan interventions should be revised if there is recurring pressure ulcers, a lack of progress toward healing, or if the resident acquires a new ulcer.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to evaluate/re-assess potential	F 323	R87 has had a new fall assessment completed and his careplan has been	6/29/15

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F 323	Continued From page 35 causative factors for multiple falls for 1 of 2 residents (R87) reviewed for falls. Findings include: R87's admission record identified diagnoses that included history of fall, and hip fracture. R87's admission Minimum Data Set (MDS) dated 3/25/15, identified R87 was severely cognitively impaired, required extensive assistance of staff for transfers, and indicated R87 did not ambulate. The MDS also identified R87 had a history of falls and fracture related to a fall in the six months prior to her admission to the facility. R87's fall risk assessment dated 3/19/15, indicated R87 was at risk for falls due to dementia with recent fall/hip fracture. R87's care plan lacked her history of falls or fall interventions. Incident Reports for R87 identified the following falls: On 4/16/15, at 4:30 a.m. R87 was found on the floor in her room. R87 stated she was getting up to go to the bathroom and fell. R87 sustained skin tears to her right elbow and her left ankle. The registered nurse (RN) summary was to include key factors contributing to fall indicated dementia with improved mobility status post hip fracture. Corrective measures initiated: first incident here, continue plan of care, has prevented major injury. On 5/3/15, at 3:00 p.m. R87 was observed to be ambulating independently in her room, and she fell forward and fell onto the floor. R87 sustained a cut above her right eyebrow. The RN summary to include key factors contributing to fall, and	F 323	reviewed and revised. All residents at risk for falls or that have had falls have the potential to be affected by this practice. Any resident who falls will have assessment thoroughly completed, including causative factors by a licensed nurse and careplan updated. Nursing staff has received education on documentation of resident falls, proper intervention for falls and care planning of said interventions. NM/Designee shall review residents at risk for falls to assure POC in place with resident specific interventions. DON/Designee to audit three charts a week to assure fall care plans are UTD and have resident specific falls. Audits will be reviewed at QAA.	

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F 323	Continued From page 36 corrective measures initiated but was blank. On 5/18/15, at 4:00 p.m. R87 was found on the floor in her room. R87 sustained skin tears on both elbows, and complained of right hip pain. R87 was sent to the ER for evaluation. R87 returned to the facility that evening (a hip x-ray was negative). The RN summary including key factors contributing to fall, and corrective measures initiated was again incomplete. On 5/20/15, at 12:54 p.m. RN-D stated the facility does a fall review, and discusses if there are additional interventions that should be put into place. RN-D verified R87 was lacking key factors contributing to her falls, and corrective measures to prevent further falls were not initiated. On 5/20/15, at 3:27 p.m. the director of nursing (DON) was interviewed and stated falls were reviewed initially after the fall, and daily during the facility's stand up meeting. Interventions to prevent further falls were to be looked at by the nurse who filled out the initial report. They were also to be reviewed during the daily stand up meeting. The DON stated she would expect falls and interventions to prevent further falls be on the care plan. The facility policy and procedure on Accidents/Falls dated 2/14, directed the facility to provide appropriate supervision and interventions to prevent avoidable accidents. An immediate/initial care plan for fall risk will be developed for any newly admitted residents whose assessment indicated the resident was at greater risk for falls/accidents. Documentation of the risks and interventions, with the focus on prevention and maintaining a safe environment,	F 323		

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F 323	Continued From page 37 should be made. Each incident/accident or fall must be investigated and/or assessed to determine the cause of the episode to prevent any further injury.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) 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 provide sufficient staffing to ensure residents received the care and assistance they needed. This had the potential to affect all 165 residents residing in the facility.	F 353	Residents residing at Chris Jensen Health & Rehabilitation Center (CJH&R) will receive proper care with creative staffing solutions. CJH&R implements mandatory OT when staff shortages occur. Staffing is evaluated on a daily	6/29/15

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F 353	Continued From page 38 Findings include: On 5/17/15, at 7:06 p.m. family member (FM)-C stated she felt the facility did not have enough staff to care for her loved one. FM-C stated about two weeks ago her loved one fell, and had to go to the emergency room (ER). Upon return from the ER, FM-C asked staff if she could get supper for her loved one. Staff replied there was only one nursing assistant on, and they didn't have time. FM-C stated the facility finally got her loved one a meal. On 5/20/15, at 3:27 p.m. the director of nursing (DON) stated the facility would normally have four nursing assistants for day and afternoon shifts on all units, with the exception of Cedar unit which should have five. The night shift always had two nursing assistants on each unit. A review of the daily scheduling sheets from 5/1/15, through 5/17/15, indicated only 3 of 17 shifts had the amount of nursing assistants the DON stated they should normally have: on 5/11/15, the day shift on the Cedar unit had five nursing assistants; on 5/13/15, the day shift on Cedar unit had five nursing assistants; and on 5/14/15, the day shift on Cedar unit had five nursing assistants. In an interview on 5/17/15, at 1:34 p.m., nursing assistant (NA)-B said she gets a call or text to pick up shifts almost every day. NA-B stated she doesn't have enough time to get her tasks done. In an interview on 5/19/15, at 7:21 a.m., NA-D stated if she is feeding someone in the dining room, no one else will pick up call lights from her group. The other aides will tell the resident,	F 353	basis by the staffing coordinators and Department Managers following a grid based on census and acuity. A new program has been developed to provide non nursing care with universal workers. These staff will provide nursing support such as resident transport, room order; making beds, passing water and meal support with tray delivery. Their job duties include answering call lights and supplying residents with care within there scope of practice and obtaining other staff members to assist with duties they are not able to supply, thus freeing up direct care staff. The facility has implemented a manager on duty program that can support nursing staff with guidance and oversight and assist with meal delivery, answering call lights and meeting with families, thus freeing up direct care staff to provide cares. Staff education has been provided on these two new developments. Staff also received education to reach out directly to their nurse manager when they feel they need assistance. Nurse Managers have been educated on providing support to the direct line staff when requested or assist in organizing staff work flow. Executive Director/designee will attend staff meetings to follow up on effectiveness on new programs implemented to assure staff is getting relief due to staffing concerns that have been present throughout the state. Social Services and Human Resources to provide staff support for any concerns about burnout and assisting with staff frustrations on the staffing crisis noted throughout the state.	

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F 353	Continued From page 39 "You'll have to wait for your person". In an interview on 5/19/15, at 2:53 p.m., NA-F stated 75-80% of the time restorative isn't getting done. NA-F also said that if they do get restorative done, they don't have time to document. NA-F stated she volunteers to work about 3 extra shifts a pay period. In an interview on 5/19/15, at 1:34 p.m., registered nurse (RN)-C stated, "We feed, lay down and clean bottoms. We show up and do the best we can." In a review of resident council meeting minutes, the following concerns were identified: · 4/21/15, "would like more staff for weekends for meal service". Activities staff now assists with meals on all units. · 7/15/14, "breakfast runs late on weekends." · 8/19/14, "staffing is a problem-there doesn't seem to be enough, especially in the a.m. and on weekends." Action for this item listed the group wanted someone from staffing to attend the next meeting. Review of additional minutes did not show that this action was implemented. · 9/26/14, "staff is not consistent on units especially on the afternoon shifts." In an interview on 5/20/15, at 3:10 p.m., R73 stated she recently had to wait an hour for her call light to get answered. R73 said she then called the health unit coordinator (HUC) line to ask for help, and they "got mad at her." R167's face sheet indicated her diagnoses	F 353	ED/Designee will attend resident/family council to given an update on the programs implemented to support staff. A questionnaire has been developed as a tool to review resident concerns with staffing and will be utilized as an audit. Questionnaires will be completed by SS/designee 3 times a week for review. Questionnaires/audits will be reviewed at QAA.	

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F 353	Continued From page 40	F 353		

included dementia. On 5/20/15, at 8:41 a.m., R167 was observed in the same outfit as she had on when observed on 5/19/15.

In an interview on 5/20/15, at 10:45 a.m., Family member (FM)-A stated that she typically visits daily. She said R167 only gets a bath once a week, and she will get changed then, so she is only getting her clothes changed once a week. FM-A stated R167 had been in the same top for 3 days. FM-A said she encouraged R167 to change her top today. FM-A stated R167 had been in the same pants for 3-4 days. FM-A states that R167 usually sleeps in her clothes and she wears a "pull-up" for some bladder leaking. FM-A stated R167 needs help getting cleaned up or changing clothes.

According to the quarterly minimum data set (MDS), with a target date of 4/22/15, R190 was cognitively intact. In an interview on 5/17/15, at 11:59 p.m., R190 said because he had a history of methicillin resistant staphylococcus aureus (MRSA), a contagious bacteria, in his urine, the facility wants him to use a urinal instead of using the bathroom he shares with his roommate. R190 states that because the facility is short of staff, his urinals do not always get emptied. One time he used his cell phone to take a picture of 5 full urinals sitting on his bedside table. The date on the cell phone picture was 3/9/15 at 8:53 a.m.

R197 is cognitively intact, according to a 4/5/15, significant change minimum data set (MDS). R197 is frequent incontinent of bladder and occasionally incontinent of bowel. R197 is not on a toileting program for bladder or bowel. According to the MDS, R197 requires extensive assistance with bed mobility, transfers,

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F 353	Continued From page 41 locomotion, and toileting. In the interview on 5/17/15, at 11:59 p.m., R190 stated NA-S took his roommate's urinal away and put it in the bathroom. his room mate was unable to get to the urinal without assistance. R190 then stated NA-S told R197 "it's a lot easier if you just go in your pad." According to R190, NA-S also said she didn't care what happened after ten o'clock, but "until I leave" the urinal is staying in the bathroom. R190 stated he heard NA-S say this more than once to R197. In a follow-up interview on 5/20/15, at 2:51 p.m., R190 stated his room mate put his call light on at 1:30 or so in the morning. At 2:15 a.m., his room mate started yelling. Then the aides came to help him. The staff said they were on the other end of the hallway, making their rounds and got to him when they could. This happens often-they don't answer R197's light, so he starts yelling and to get help. R190 said the aides are "always short" of staff and the nurses get roped into doing doubles as well. R173's quarterly Minimum Data Set (MDS), dated 4/18/15 indicated that she had severely impaired cognition and was totally dependent upon staff for most activities of daily living (ADL'S). R173 did not walk in the assessment period for the 4/18/15 MDS, nor for the previous Quarterly MDS, dated 1/23/15. In an interview on 5/17/15, at 6:16 p.m., family member (FM)-B said that she has been visiting R173 in this facility for almost eight years. FM-B stated for a while, R173 wasn't even getting one bath a week, let alone the requested 3 baths a week. FM-B was able to secure a doctor's order	F 353		

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F 353	Continued From page 42	F 353		

for three baths a week to guarantee the baths. FM-B stated the staff are so short staffed, she trims R173's finger nails and cleans her ears; if she didn't perform these tasks, they would not get done.

In the same interview, FM-B stated the aides aren't checking routinely to see if R173's perineal area is clean and dry. She said R173 was a fall hazard, so the facility wanted her in a wheelchair. FM-B agreed, as long as R173 was on a walking program. This did not continue, and now R173 cannot walk. FM-B stated, "the aides do the best they can with the limited staff."

On 5/20/15, at 7:35 a.m. nursing assistant (NA)-R who provided morning assistance for grooming to R174 the morning of 5/20/15, confirmed that shaving was not provided for R174. NA-R reported that shaving was to be provided during am cares for residents that had a grooming dependency. NA-R reported the task of shaving did not get completed the morning of 5/20/15, due to being scheduled on two different units. NA-R further explained this happens when the facility is short staffed and shaving residents is a task that is often missed due to working short staffed.

On 5/17/15, at 12:10 p.m. licensed practical nurse (LPN)-A reported that when the facility is short staffed the nursing assistants miss shaving residents and straightening up rooms.

On 5/17/15, at 12:18 p.m. licensed practical nurse (LPN)-B reported that most days the facility is short staffed and nursing and rehabilitation charting is not always getting done.

On 5/7/15 at 12:35 p.m. trained medication

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F 353	Continued From page 43 assistant (TMA)-A reports that the facility is always working short staffed. TMA-A stated the facility is"short changing residents" by working with not enough staff. TMA-A reports that toileting is a struggle to get done while the staff are trying to assist residents to eat, answer call lights and do scheduled tasks. TMA-A reports some causes of falls and toileting accidents are because there are not enough staff on duty. Interview on 5/18/15 at 8:43 a.m. with RN- that wished to remain anonymous, indicated she had been pulled from her position 12 days of the past 20, to do medication passes because of staffing issues. She was then unable to complete the requirements of her primary position. Interview with R205's family member on 5/18/15 at 10:46 a.m. indicated he visited almost every morning for breakfast. He stated R205 was often still in bed, including this past Sunday he arrived at 8:55 a.m. and the resident was just getting up for breakfast. He said he had discussed the concern with social services and was told they were doing the best they could, but were short of staff. R106 received pain medication late related to staffing. Interview with R106 on 5/19/15 at 9:30 a.m. indicated her shoulders were hurting her because she had not received her morning medication yet. The May 2015 medication administration record (MAR) indicated R106 was on Tramadol (a pain medication) three times a day, and acetaminophen three times a day for pain. Both medications were scheduled for administration at 8:00 a.m., 12:00 p.m. and 4:00 p.m.	F 353		

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F 353	Continued From page 44 Review of the MAR on 5/19/15 at 9:35 a.m., indicated R106's 8:00 a.m. medications had not yet been given. Interview with LPN-D on 5/19/15 at 10:02 a.m., identified she was preparing R106's medication at that time. She further indicated she was behind schedule. She stated she had notified her nurse manager she was behind schedule with her medication pass but had not received assistance. See corresponding tags at F282, F309, F311, F312, F314, F323.	F 353		

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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 FORM 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101-5145, and By email to: Marian.Whitney@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.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2015

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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Chris Jensen Health & Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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. 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 165 at the time of the survey.	K 000		

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K 000	Continued From page 2 It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1.	K 000		
K 050 SS=F	The requirement at 42 CFR Subpart 483.70(a) is NOT met as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all occupants of the building in a fire emergency. Findings include:	K 050	Fire drill schedule has been updated to include varying times throughout all three shifts.Schedule has been followed immediately. ED/Designee will audit fire drill completion for varying times x 3 months to ensure adherence to this policy. Audits will be reviewed at QAA.	6/29/15

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K 050	Continued From page 3 At the conclusion of the facility tour on 5-29-15 at 10:30AM, documentation revealed that fire exit drills are not being conducted at varying times within the shifts. All drills are being conducted within 2 hours of each other during the shfts. Nor, does the facility record the staff that took part in the drill. This deficient practice was confirmed by the Director of Facility Maintenance (MS) and the Administrator (JD)) at the time of exit, and further confirmed via phone with Assistant Administrator (LH) after the inspection.	K 050		
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview the facility does not provide proper receptacles for the disposal of smoking materials at the entry points to the building in accordance with NFPA 101, section 19.7.4 and MSFC(07), section 310.7. This deficient practice could effect all occupants of the building. Findings Include: Upon entry to the building on 5-19-15 at 8:00AM it was observed, that at the Northwest entry to the building, no proper receptacles were in place for the disposal of smoking materials, prior to building entry. Based on interview with the Facility Maintenance Director (MS) they were once in place but he was instructed by the owner	K 130	Smoking receptacle for the disposal of smoking materials were provided at the entry points of the building. Maintenance will conduct weekly audit to ensure receptacles remain in place. Audits will be reviewed at QAA.	6/29/15

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K 130	Continued From page 4 to relocate them, to the outdoor smoking area. The doors to the facility are posted "No Smoking Within 25 Feet". This deficient practice was confirmed by the Administrator (JD) and Maintenance Director (MS) at the time of exit. It was also further confirmed with the Assistant Administrator (LH) via phone later in the day.	K 130		