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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DV7L

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 **01/19/2017** (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 :
Glenora Souther, HFE NEII 01/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/06/2017 (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
01/30/2017
(L33)

DETERMINATION APPROVAL

CCN: 24-5366

This facility has been designated at a Special Focus Facility (SFF)

On January 19, 2017 a Post Certification Revisit (PCR) was completed to verify that the facility has achieved and maintained compliance with deficiencies issued pursuant to a standard survey completed on December 1, 2016. Based on our revisit, we have found the facility corrected the deficiencies, issued pursuant to the December 1, 2016 standard survey, effective January 19, 2017. Refer to the notice for the results of this visit.

Effective January 19, 2017 the facility is certified for 170 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245366

April 6, 2017

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

Dear Ms. Porter:

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 January 19, 2017 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
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 31, 2017

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

RE: Project Number S5366027

Dear Ms. Porter:

On December 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On January 19, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, effective January 19, 2017 and therefore remedies outlined in our letter to you dated December 20, 2016, will not be imposed.

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
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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245366 Y1	A. Building B. Wing Y2	1/19/2017 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0164	Correction	ID Prefix	F0166	Correction	ID Prefix	F0279	Correction
Reg. #	483.10(h)(1)(3)(i); 483.70(i)(2)	Completed	Reg. #	483.10(j)(2)-(4)	Completed	Reg. #	483.20(d);483.21(b)(1)	Completed
LSC		01/19/2017	LSC		01/19/2017	LSC		01/19/2017
ID Prefix	F0280	Correction	ID Prefix	F0282	Correction	ID Prefix	F0309	Correction
Reg. #	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. #	483.21(b)(3)(ii)	Completed	Reg. #	483.24, 483.25(k)(l)	Completed
LSC		01/19/2017	LSC		01/19/2017	LSC		01/19/2017
ID Prefix	F0328	Correction	ID Prefix	F0329	Correction	ID Prefix	F0334	Correction
Reg. #	483.25(b)(2)(f)(g)(5)(h)(i)(j)	Completed	Reg. #	483.45(d)	Completed	Reg. #	483.80(d)(1)(2)	Completed
LSC		01/19/2017	LSC		01/19/2017	LSC		01/19/2017
ID Prefix	F0441	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		01/19/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒ x	GD/mm	01/31/2017	35993	01/19/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/1/2016

☐ 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: DV7L

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 **12/01/2016** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **170** (L18)
13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene, Jares, HFE NEII 01/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/30/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN: 24-5366

This facility has been designated at a Special Focus Facility (SFF)

At the time of the December, 1, 2016 survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. In addition at the time of the December 1, 2016 survey, an investigation of complaint numbers H5366070 and H5366071 were conducted and found to be unsubstantiated. The most serious deficiency is isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required. . 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.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 20, 2016

Ms. Amy Porter, Administrator
Chris Jensen Health & Rehabilitation Center
2501 Rice Lake Road
Duluth, MN 55811

RE: Project Number S5366027 & H5366070 & H5366071

Dear Ms. Porter:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On December 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 1, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5366070 & H5366071 that was found to be unsubstantiated.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be**

contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 1, 2017 (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 June 1, 2017 (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.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	12/01/2016

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 Chris Jensen Health and Rehab is a Special Focus Facility (SFF) and a recertification survey was conducted November 28th through December 1, 2016. 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. Along with the recertification survey, complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint, H5366070 was completed. The complaint was unsubstantiated. An investigation of complaint, H5366071 was completed. The complaint was unsubstanitated.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private	F 164		1/10/17

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

Electronically Signed | 12/29/2016

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 _____	12/01/2016

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 164	Continued From page 1 room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents	F 164	Submission of this Response and Plan of correction is not	

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F 164	Continued From page 2 (R221) reviewed for activities of daily living (ADLs) was provided privacy during personal cares; and failed to ensure 1 of 4 residents (R42) randomly observed during blood glucose checks was afforded privacy. Findings include: R221's care plan dated 6/2/16, indicated the resident required extensive assist of one female staff for care. The resident's diagnoses listing on the 11/16/16 quarterly Minimum Data Set (MDS) assessment included; adult failure to thrive, mild cognitive impairment, and diffuse large lymphoma. In addition to these diagnoses, the MDS indicated R221 had severely impaired cognition. On 12/1/16, from 8:20 a.m. to 8:45 a.m. R221's morning cares were observed. During the care nursing assistant (NA)-A knocked at the door and entered. NA-A asked R221 if it was time to get up. R221 nodded and stated "Yes." NA-A went to bathroom turned on the water and applied gloves. NA-A approached the resident's bed, pulled back the blankets off the resident, lowered the head of bed, and then applied R221's clean socks. NA-A put pants on R221 and pulled them up only to the knees. NA-A then went to the bathroom and brought a basin of water to the bedside and set it on a chair. NA-A did not pull up the resident's blankets again when she went to the bathroom to get the basin of water. When NA-A returned to the bedside, she removed the resident's gown which exposed R221's breasts then proceeded to wash the resident's face. NA-A informed the resident she was going to wash her armpits. NA-A was then observed to wipe the palms of R221's hands and between the fingers. NA-A	F 164	a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F164 Resident #221 is provided privacy during personal cares. Resident #42 is provided privacy for blood glucose checks.	

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F 164	Continued From page 3 then applied deodorant for the resident and told her she was going to take off her pad off and perform pericare. NA-A removed the soiled incontinent product and provided pericare then rolled the resident to the right to cleanse her buttock area. The resident's upper body remained uncovered when the NA was performing pericare. NA-A repositioned R221 to her back and applied a clean incontinent product. Then NA-A turned the resident again and washed R221's back prior to applying her shirt. Throughout the care, R221 was not draped for privacy and warmth. NA-A was interviewed at 9:03 a.m. on 12/1/16, regarding how to drape a resident while providing care. NA-A stated, "I get carried away, I wanted to do good." During interview with the unit manager, registered nurse (RN)-C, on 12/1/16 at 9:08 a.m., RN-C stated staff were supposed to drape areas of a resident's body with a sheet or blanket to help maintain a resident's dignity, when they were not providing cares for that part of the body. On 12/1/16, at 1:54 p.m., the director of nursing (DON) was interviewed. When asked about maintaining resident dignity with care, the DON stated staff were supposed to preserve the resident's dignity during care by draping whatever areas of the body they were not working on. R42 annual Minimal Data Set (MDS) dated 10/28/16, indicated R42 had moderate impaired cognition and had diagnoses of diabetes mellitus and Alzheimer's disease. R42 was randomly observed on 11/28/16, at 8:04	F 164	Other residents are provided privacy during personal cares and with treatments such as blood glucose checks. Nursing staff have been re-educated regarding facility expectations for privacy and confidentiality to include privacy during personal cares and privacy with treatments such as blood glucose checks. DON or designee will monitor for compliance through random observational audits. Audits will occur weekly x 4 and as directed by the QAPI council.	

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F 164	Continued From page 4 p.m. RN-F was observed to complete a blood glucose check on R42 at the medication cart, in the hallway near the nurse's desk and resident dining room. During interview on 12/1/16, at 2:10 p.m., RN-G said, "Staff are not to check blood sugars in the hallway." During interview on 12/1/16 at 3:36 p.m., RN-F verified having checked R42's blood sugar in the hallway. RN-F stated, "I did not take her to her room where I should have done the Accu-check." On 12/1/16 at approximately 4:00 p.m., the director of nurses stated it was her expectation that blood sugar checks would be done in private, not the hallway.	F 164		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 166		1/10/17

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postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by

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F 166	Continued From page 6 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policies to follow up with individual residents regarding grievances for 2 of 3 resident (R14, R153) grievances reviewed. Findings include: R14 on 12/1/16, at 2:25 p.m. verified voicing a	F 166	The Executive Director responded to residents R14 and R135 and the grievances have been resolved to their satisfaction. All residents who have grievances have the potential to be affected by this practice. Grievance policy and role clarification and responsibility for follow up	

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F 166	Continued From page 7 grievance at the resident council meeting on 11/8/16. R14 verified the Grievance Form dated 11/8/16, indicated, "At night, the Aids are turning lights on and talking too loudly, interrupting her sleep." R14 stated, "No one has come back and talked with me about this. I wished they would have." R14 said that no one from administration had come and asked any follow-up questions, or said what was found out during the investigation or how they were going to resolve the issue. R14's quarterly Minimum Data Set (MDS) dated 10/27/16, indicated R14 was cognitively intact and did not have any behaviors. R14's care plan printed 12/1/16, indicated "[R14] displays loud disrupted behavior-yelling, screaming, swearing, negative attention seeking and is impatient." The care plan instructed staff to provide redirection when appropriate. The Progress Notes for R14 dated 11/2/16, indicated R14 complained of staff being too loud while caring for R14's roommate. The Grievance Form dated 11/8/16, indicated "Grievance Policy Notice Residents have the right to file grievances orally (spoken) or in writing or anonymously. You can expect to receive a review of the grievance within five working days. You have the right to request a written decision regarding the outcome of this grievance." The grievance resolution section of Grievance Form indicated, "Talk quieter and only turn on lights above the bed." The grievance resolution decision indicated the activities director discussed the concern with R14 on 11/8/16, as the director wrote out the grievance for R14. The steps taken to investigate the grievance were listed as, "spoke with Nurse Manager." The summary of	F 166	was reviewed with the leadership team. The grievance policy was updated effective 11/28/16 and all staff have been reeducated to the new policy. Grievances will be reviewed at morning stand up meetings to ensure thorough investigation and follow up with the residents. The Executive Director or designee will monitor for compliance. Grievances will be tracked and trended through Quality Council QAPI on a monthly basis. Grievance forms will be reviewed daily at morning stand up meetings. Grievance forms will be audited weekly by the social worker for 3 months and then as directed by QAPI council.	

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F 166	Continued From page 8	F 166		

conclusion was listed as, "Nurse manager will talk to NOC [night] shift and remind them to be quiet and only turn on head of bed lights." Corrective Action: "Will address at Dec. [December] meeting."

Review of Progress Notes from 10/24/16, through 12/1/16, and An email dated 11/15/16, at 11:17 a.m. from activity director to registered nurse (RN)-B indicated, "During resident council, [R14] complained that staff is turning her lights on at night and talking loudly, disturbing her sleep. Can you please look into this? Thank you." No return email was provided. A Care Conference Summary sheet dated 11/17/16, did not indicate facility staff had addressed R14's grievance with R14. Although the grievance form decision indicated they would discuss at the December meeting, the facility did not get back to the individual resident in a timely manner with the final decision of the grievance that was filed on 11/8/16, as the form indicated the facility would get back to the resident within five working days.

R135 verified on 12/1/16, at 2:50 p.m. he had said at resident council that food was cold at times, and that it was not tasty. R135 said, "no one has come and told me what is happening." R135 said he would like someone to update him. R135 stated, "I understand it may take a while to resolve but I would like to know what is being done about the issues."

R135's quarterly MDS dated 10/2/16, indicated R135 was cognitively intact and did not have any behaviors.

The Grievance Form dated 11/8/16, indicated

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"Grievance Policy Notice Residents have the right to file grievances orally (spoken) or in writing or anonymously. You can expect to receive a review of the grievance within five working days. You have the right to request a written decision regarding the outcome of this grievance." The grievance resolution section of Grievance Form indicated desired resolution was hot food and a variety of foods. The grievance resolution decision indicated the activity director had discussed the concern with R135 on 11/8/16, when the director had documented the grievance for R14. The steps taken to investigate the grievance were listed as, "spoke with dietary manager." The summary of conclusion was blank. The corrective action was "Dietary stated that there is a new process to heat up steam tables, salt and pepper and other seasonings and the resident has an alternate choice."

An email dated 11/15/16, at 11:19 a.m. from the activity director to the dietary manager indicated, "During resident council, [R135] said that the food has improved, but there is too many noodles ..." An email dated 11/15/16, at 11:53 a.m. from the dietary manager to the activity director indicated, "...new menu does have more pasta, noodles at meals. Residents can request mashed potatoes as we do have then [sic] available. We do not cook with salt and there is salt and pepper on the tables to season. We do use garlic powder, and other seasonings for cooking. For temperature we have changed the process for turning on steam tables in AM [morning] and the cooks are doing earlier now-however it is change and they are getting used to new process."

When R135's progress notes were reviewed from 11/1/16 through 12/1/16, there was no

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documentation to identify facility staff had followed up with R135 about the grievance, even though the facility's policy indicated they would get back to the resident within five working days.

During interview with the activity director on 12/1/16 at 8:22 a.m., the activity director stated R14's grievance had been discussed with the nurse manager for follow up and the follow up should then have been documented on the form. The activity director said R135's grievance had been brought to the dietary supervisor's attention, that dietary had changed their process, and as a result dietary staff were turning the steam tables on earlier to ensure the tables got warm. The activity director stated, "The process is to fill out a grievance form and then bring it to the department head, afterward when things have been addressed it is brought back to resident council." When asked if the results of these grievance investigations had been brought back to R14 or R135 the activity director said, "No."

During interview on 12/1/16, at approximately 4:00 p.m. the director of nursing said, "I expect we follow up on any grievance made by residents within the time frame on top of the grievance form."

The Facility's Grievance Process reviewed November 2016, included:, "Residents have a right to voice grievances to the facility or other agencies or entity that hear grievances without discrimination or reprisal and without free of discrimination or reprisal...The facility will post the contact information of the grievance official, including his/her name, business address, email, and business phone number as well as a reasonable expected time frame for completing

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F 166	Continued From page 11 the review of the grievance, the right to receive a written decision, and contact information of independent entities with who grievance may be filed. Grievance forms can be completed whenever a concern is noted during the resident or family council meeting and care conferences. If the resident or family does not want to complete the grievance form, it is the responsibility of the staff member hearing the concern to complete the form and submit it for follow-up and resolution." Although the facility policy was for follow up with residents, neither R14 or R135 had been made aware of the outcome of their grievances.	F 166		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	F 279		1/10/17

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F 279	Continued From page 12 care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 279		

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F 279	Continued From page 13 Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 3 of 4 residents (R226, R149, R187) reviewed for pressure ulcers, accidents and pain. Findings include: R226's room was observed on 11/29/16, at 10:44 a.m. The resident's bed was observed to have side rails affixed to the frame of the bed on both sides of the bed. R226's Admission Record form dated 11/22/16, indicated R226 had been admitted to the facility on 10/22/16, with diagnoses including: osteoarthritis, muscle weakness, carpal tunnel, alcohol abuse, pain in left knee and weakness. R226's Fall Care Area Assessment (CAA) dated 11/3/16, indicated R226 was at risk for falls due to unsteady gait, anxiety and arthritis. However, the CAA did not indicate interventions and goals for how the functional status for falls would be addressed in the resident's care plan. During additional review of R226's medical record on 11/28/16, at 4:30 p.m., it was determined R226 had been at the facility for 38 days and had only a Short Term (temporary) Care Plan developed which was dated 10/22/16. The Short Term Care Plan indicated R221 was at risk for falls and directed staff to be sure the call light was within reach, and to use non-skid shoes. The care plan did not include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs which were identified in the comprehensive assessment.	F 279	Residents #226, 149 and 187 have comprehensive care plans completed and in their medical record. Other residents have had comprehensive care plans completed and placed in their medical record. MDS coordinators have been re-educated regarding facility expectations for completion of the comprehensive care plan within 21 days from admission. Nurse Managers have been re-educated regarding the need for comprehensive care plans developed and in the medical record within 21 days from admission. Audits have been completed to ensure that all current residents have comprehensive care plans in their medical record. The Director of Clinical Reimbursement, has reviewed and revised the system for comprehensive care plan development in a timely manner. The Director of Clinical Reimbursement or designee will monitor for compliance through weekly audits x 4 and then as directed by the QAPI council.	

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F 279	Continued From page 14 On 11/30/16, at 2:40 p.m. the director of clinical reimbursement verified R226's care plan had not been developed until 11/29/16, when the surveyor had first brought the concern to their attention. The director of clinical reimbursement stated the care plan had "been missed" so registered nurse (RN)-A had developed it on 11/29/16. When asked what the facility's expectation was, RN-A stated care plans were supposed to be developed within 21 days from admission, and that it would be corrected. On 12/1/16, at 1:54 p.m. the director of nursing (DON) was interviewed about the development of care plans. The DON stated the facility had up to 21 days to develop a resident's care plan, and when there were changes in the resident's condition, a temporary care plan would be developed until the issue resolved. R149's Admission Record indicated he had been admitted to the facility on 11/1/16. A Short Term Care Plan dated 11/1/16 and revised on 11/3/16, identified R149 had a risk for falls, required assistance to perform activities of daily living, and had impaired cognition. The care plan directed staff to provide R149 with a fall mat, a pressure alarm, and to conduct monitoring for orthostatic hypotension. The Falls CAA was completed on 11/10/16, and that fall intervention would be placed on the plan of care. A review of R149's medical record indicated there was no evidence a comprehensive care plan being developed which included measurable objectives and timetables to meet his medical and nursing needs.	F 279		

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F 279	Continued From page 15 R187's Admission Record indicated she had been admitted to the facility on 10/29/16. The facility Diagnosis Sheet identified diagnoses that included; unsteadiness, weakness, history of falls, sepsis, and urinary tract infections. A Short Term Care Plan dated 10/29/16, directed staff to keep her call light in reach, assist with toileting, and assist with activities of daily living. The Falls CAA was completed on 11/8/16, and that fall intervenetion would be placed on the plan of care. The medical record lacked evidence a comprehensive care plan being developed which included measurable objectives and timetables to meet the resident's medical and nursing needs. During an interview on 12/1/16, at 12:56 p.m. RN-E stated comprehensive care plans were supposed to be developed by the twenty first day after a resident's admission to the facility. RN-E stated comprehensive care plans were not completed by RN-A. During an interview on 12/1/16, at 1:00 p.m. RN-A confirmed she had not completed the comprehensive care plans for R149 and R187. The facility's policy, Care Plan-Comprehensive, dated April 1, 2008 included: "The facility uses the results of the resident assessments to develop and revise the resident's comprehensive plan of care. The facility develops a comprehensive care plan for each resident. This care plan includes measurable objectives and timetables designed to meet the resident's medical, nursing, mental, and psychosocial needs, as identified in the comprehensive assessments..."	F 279		

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F 279	Continued From page 16 The Centers for Medicare and Medicaid MDS manual dated 10/16, gave direction to the facility staff to complete the care planning process. "The care plan completion date (Item V0200C2) must be either later than or the same date as the CAA completion date (Item V0200B2), but no later than 7 calendar days after the CAA completion date." All three residents did not have a comprehensive care plan developed seven days after the completion of CAAs.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		1/10/17

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F 280	Continued From page 17 right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 280		

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F 280	Continued From page 18 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update/revise the plan of care for 1 of 3 residents (R283) reviewed for impaired skin integrity. Findings include: R283's Diagnoses Listing dated 9/30/16, indicated R283 had diagnoses including; diabetes, history of strokes, peripheral vascular deficiency with a below the knee amputation of the left leg, and a history of right heel ulcers. The Admission Nursing Assessment dated 9/30/16, indicated R283 had no open areas, or noted deep tissue discoloration on the foot. There was a nursing order on the Treatment Administration Record (TAR) for October 2016 to check R283's foot daily and to conduct a weekly skin assessment. The admission Minimum Data Set (MDS) dated 10/7/16, indicated a history of pressure ulcers and indicated R283 was at risk to develop pressure ulcers. The Care Area Assessment for	F 280	Resident #283 no longer resides at Chris Jensen, and was reviewed as a closed record during the survey. Other residents with wounds have been reviewed to ensure that care plans have been updated with the current interventions. Nurse Managers and nursing staff have been re-educated regarding facility expectations for updating care plan with changes and with current interventions to include residents with wounds as well as other changes. The DON or designee will monitor for compliance through audits of care plans to ensure updates have been completed. These audits will occur weekly x 4 and then as directed by the QAPI council.	

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skin dated 10/7/16, indicated R283 needed a pressure reducing device for the bed and chair.

The comprehensive care plan dated 10/17/16, indicated the resident required a pressure relieving mattress, and cushion in wheelchair, float heels, monitor nutrition, and orthotics for shoes.

A wound assessment flow sheet indicated on 10/26/16, a suspected deep tissue injury (intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes) to the right heel measuring 3.5 by 1.5 centimeters (cm) and a dressing was applied. According to the flow sheet documentation, an orthotic in the right shoe was assessed to be the cause. The wound was assessed on the flow sheet on 11/3/16, 11/10/16, and 11/16/16, and remained a suspected deep tissue injury with intact skin.

The care plan was updated on 11/18/16, and indicated "a stage 2 pressure ulcer [a stage 2 ulcer is defined as partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater] to the right heel. The problem area description of the pressure ulcer was not congruent with the wound assessment dated 10/26/16, which identified a suspected deep tissue injury.

On 11/30/16, at 9:30 a.m. the registered nurse-B was interviewed and stated the care plan used for R283 was the initial care plan because a

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F 280	Continued From page 20 comprehensive care plan was not available. The nurse manager verified the area on R283's right heel had not opened, and was not a stage 2 ulcer. At 10:40 a.m. on 11/30/16, the assistant director of nursing (who was the the facility wound nurse) stated she had seen R283 on 11/10/16, and had changed the dressing used and applied a pressure relieving boot which was to be worn at all times. The wound nurse verified the care plan had not been revised to reflect these interventions. The facility policy titled, "Pressure Ulcers/Skin Integrity/Wound Management" dated 9/13/11, indicated a resident that developed pressure ulcers should have an individualized plan, and care plan interventions should be revised if there were recurring pressure ulcers.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 implement the plan of care for 1 of 1 resident (R209) reviewed for dialysis.	F 282	Resident #209 has had the care plan reviewed and updated as indicated, and is receiving services according to the plan of care. This includes dialysis care plan	1/10/17

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F 282	Continued From page 21 Findings include: During observation on 11/28/16, at approximately 12:00 p.m. R209 had just returned from dialysis. R209 stated after just a few bites, "I am not hungry just tired." Although R209 was observed holding his left arm against his chest with his right hand, he denied pain. R209's care plan printed 10/25/16, indicated a problem area of anemia related to renal insufficiency and included interventions for staff to observe for symptoms related to diagnosis, and review with doctor for recommendations. The dialysis care plan (same date) included interventions for staff to perform "access site checks every shift [auscultating bruit] palpating pulse of extremity and checking color and warmth of extremity, and if any abnormalities notify MD [medical doctor]." The Physician Orders signed 10/26/16, included orders initiated 5/22/16, for staff to check access site every shift for patency, auscultate bruit and palpate thrill, monitor color, motion, and sensation, and call if impaired. The October 2016, MAR lacked documentation of staff monitoring of the access site, or removing pressure dressing after return from dialysis. The MAR dated November 2016, lacked documentation of assessment of access site monitoring for 11 of 30 days. In addition another component of the plan for care for R209 was the Medication Administration Record (MAR). The MAR dated October 2016, instructed staff to check R209's vital signs every shift including: temperature, pulse, respirations and blood pressure (BP), due to R209 having a	F 282	interventions, vital signs monitoring, and pain monitoring and effectiveness. Other residents who receive dialysis care have had their plan of care reviewed and updated as indicated, and are receiving services according to their plan of care. Other residents with acute pain have been reviewed to ensure that care plan has been reviewed and updated if necessary, and they are receiving services according to their plan of care. Nurse Managers and nursing staff have been re-educated regarding facility expectations for following the resident plans of care. The DON or designee will monitor for compliance through audits of care plans and review of services provided. These audits will occur weekly x4 and then as directed by the QAPI council.	

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low hemoglobin. The MAR for October 2016 indicated no vital signs had been recorded on the night shift for 15 out of 30 nights, there were no vital signs documented for 10 out of 30 day shifts, and five of 30 evening shifts. The MAR reflected that R209 had been in the hospital for one day in October.

The November 2016 MAR reflected no vital signs had been recorded on the night shift for four of 30 night shifts, no vital signs were recorded for four of 30 day shifts, and no vital signs had been recorded for six of 30 evening shifts.

During interview on 12/1/16, at 9:19 a.m. licensed practical nurse (LPN)-D, "We check his vital signs every evening due to his low hemoglobin."

During interview on 12/1/16, at 9:52 a.m. registered nurse (RN)-G verified R209's MARs were missing documentation for vital signs and access site assessments. RN-G staff would be expected to complete vital signs every shift for R209 to monitor for possible side effects of the low hemoglobin including falls, dizziness, confusion or injury. RN-G said the reason for doing access site assessment was to ensure the resident was not bleeding, and to ensure the access site was not clotted off which would make it difficult to do dialysis.

During interview on 12/1/16, at 4:00 p.m. the director of nursing (DON) said staff were expected to complete and document vital signs and access site assessments for R209 as ordered.

The facility's Dialysis Policy originated 12/23/13, included: "It is the policy of this facility to provide

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coordination of care with resident s dialysis provider. f. Dialysis center's expectation of care to be completed by SNF (skilled nursing facility)... such as: Checking thrills/bruit of grafts and fistulas, documented on TAR [Treatment Administration Record] when to remove dressing from the access site placed on from the dialysis center."

R209 also had a plan of care related to pain which had been updated 10/27/16. The care plan indicated R209 was at risk for pain related to prostate cancer, hemodialysis, osteoarthritis, chronic right knee pain and fractured left wrist. Staff interventions included to give medications as ordered, observe effectiveness, if ineffective after following MD's orders need to review symptoms with MD for recommendations. Staff were also directed to seek the resident's interpretation of pain and pain management in order to evaluate effectiveness of medications because according to chart documentation, R209 was severely cognitively impaired.

The October 2016 MAR indicated Tramadol (an analgesic) 50 milligrams (mg) had been given six times; and the November 2016 MAR indicated Tramadol 50 mg had been given 39 times. Both the October and November 2016 MARs lacked documentation of the pain level, or pain assessment at the time of Tramadol administration. In addition, for 27 of 39 doses administered in November, there was no documentation as to whether the medication had been effective.

The November 2016 MAR indicated staff were to complete weekly pain assessments 11/4/16, 11/11/16, 11/18/16, and 11/25/16. The weekly

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F 282	Continued From page 24 pain assessments were signed as completed for 11/4/16, and 11/25/16. The weeks of 11/11 and 11/18/16, pain assessments could not be located. Review of Progress Notes for November 2016 did not reflect weekly pain assessments having been completed. During interview on 12/1/16, at 9:52 a.m. the nurse manager, RN-G, reviewed R209's October and November MARs and Progress Notes with the surveyor. RN-G verified the MARs were missing documentation of the effectiveness of the as needed (PRN) Tramadol. RN-G said, "We do a pain assessment upon admission, quarterly and when there is an acute change in pain control. If someone is able, we use the 1-10 pain level scale but most of this unit's resident are not able to use the scale. We have a Pain Assessment in Advanced Dementia form for use with our resident(s) but we did not use it with [R209] and I don't know why. I believe staff are good at identifying if he is in pain - he holds it [Left arm], he gets agitated, and he removes the sling/splinting." RN-G said the number of Tramadol doses given and the effectiveness would be part of the determination whether the Tramadol is working." RN-G said the effectiveness of all PRN medications was expected to be documented on the MAR. The Care Plan policy origination date 4/1/08, instructed staff, "The care plan describes the following: Services that are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial wellbeing..."	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		1/10/17

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F 309	Continued From page 25 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R209) reviewed for dialysis, received appropriate monitoring of his dialysis access, and adequate pain management. Findings include: During observation on 11/28/16, at approximately 12:00 p.m. R209 had just returned from dialysis. R209 stated after just a few bites, "I am not hungry just tired." Although R209 was observed holding his left arm against his chest with his right	F 309	The plan of care for Resident #209 has been reviewed in the areas of dialysis care and pain management. Pain has been reassessed for R #209. R209 is receiving services according to the plan of care. The dialysis unit has been contacted to collaborate with plan for facility provided dialysis related services. This information has been utilized in revision of the plan of care for R209, and the resident is receiving	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26 hand, he denied pain. R209's care plan printed 10/25/16, indicated a problem area for dialysis care plan and interventions for staff to utilize included; "access site checks every shift [auscultating bruit] palpating pulse of extremity and checking color and warmth of extremity, and if any abnormalities notify MD [medical doctor]." The Physician Orders signed 10/26/16, included orders initiated 5/22/16, for staff to check access site every shift for patency, auscultate bruit and palpate thrill, monitor color, motion, and sensation, and call if impaired. The October 2016, MAR lacked documentation of staff monitoring of the access site, or removing pressure dressing after return from dialysis. The MAR dated November 2016, lacked documentation of assessment of access site monitoring for 11 of 30 days. During interview on 12/1/16, at 9:52 a.m. registered nurse (RN)-G verified R209's MARs were missing documentation of dialysis access site assessments. RN-G said the reason for doing access site assessment was to ensure the resident was not bleeding, and to ensure the access site was not clotted off which would make it difficult to do dialysis. During interview on 12/1/16, at 4:00 p.m. the director of nursing (DON) said staff were expected to complete access site assessments for R209 as ordered. The facility's Dialysis Policy originated 12/23/13, included: "It is the policy of this facility to provide coordination of care with resident s dialysis	F 309	services according to the plan of care. R209 has had a comprehensive pain re-assessment, and consult with the physician, and this information has been utilized in revision of the plan of care. The resident is receiving services according to the plan of care. Other residents who receive dialysis, have had their dialysis provider contacted to collaborate with plan of care for facility provided dialysis related services. The care plans have been updated as indicated, and the residents are receiving services according to the plan of care. Other residents with acute pain have had their pain assessments reviewed and re-assessed if necessary. The care plans have been updated if indicated, and they are receiving services according to plan of care. Nursing staff have been re-educated regarding facility expectations for providing assessment, monitoring, and services according to the plan of care. DON or designee will monitor compliance through audits of care plan and services provided. These audits will be conducted weekly x4, and then as directed by the QAPI council.	

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provider. f. Dialysis center's expectation of care to be completed by SNF (skilled nursing facility)... such as: Checking thrills/bruit of grafts and fistulas, documented on TAR [Treatment Administration Record] when to remove dressing from the access site placed on from the dialysis center."

R209 also had a plan of care related to pain which had been updated 10/27/16. The care plan indicated R209 was at risk for pain related to prostate cancer, hemodialysis, osteoarthritis, chronic right knee pain and fractured left wrist. Staff interventions included to give medications as ordered, observe effectiveness, if ineffective after following MD's orders need to review symptoms with MD for recommendations. Staff were also directed to seek the resident's interpretation of pain and pain management in order to evaluate effectiveness of medications because according to chart documentation, R209 was severely cognitively impaired.

The October 2016 MAR indicated Tramadol (an analgesic) 50 milligrams (mg) had been given six times; and the November 2016 MAR indicated Tramadol 50 mg had been given 39 times. Both the October and November 2016 MARs lacked documentation of the pain level, or pain assessment at the time of Tramadol administration. In addition, for 27 of 39 doses administered in November, there was no documentation as to whether the medication had been effective.

The November 2016 MAR indicated staff were to complete weekly pain assessments 11/4/16, 11/11/16, 11/18/16, and 11/25/16. The weekly pain assessments were signed as completed for

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F 309	Continued From page 28 11/4/16, and 11/25/16. The weeks of 11/11 and 11/18/16, pain assessments could not be located. Review of Progress Notes for November 2016 did not reflect weekly pain assessments having been completed. During interview on 12/1/16, at 9:52 a.m. the nurse manager, RN-G, reviewed R209's October and November MARs and Progress Notes with the surveyor. RN-G verified the MARs were missing documentation of the effectiveness of the as needed (PRN) Tramadol. RN-G said, "We do a pain assessment upon admission, quarterly and when there is an acute change in pain control. If someone is able, we use the 1-10 pain level scale but most of this unit's resident are not able to use the scale. We have a Pain Assessment in Advanced Dementia form for use with our resident(s) but we did not use it with [R209] and I don't know why. I believe staff are good at identifying if he is in pain - he holds it [Left arm], he gets agitated, and he removes the sling/splinting." RN-G said the number of Tramadol doses given and the effectiveness would be part of the determination whether the Tramadol is working." RN-G said the effectiveness of all PRN medications was expected to be documented on the MAR. The facility's Dialysis Policy originated 12/23/13, included: "It is the policy of this facility to provide coordination of care with resident s dialysis provider. f. Dialysis center's expectation of care to be completed by SNF (if any) such as: Checking thrills/bruit of grafts and fistulas, documented on TAR [Treatment Administration Record] when to remove dressing from the access site placed on from the dialysis center."	F 309		

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F 328	Continued From page 29	F 328		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328		1/10/17

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F 328	Continued From page 30 (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate administration of insulin for 1 of 4 residents (R262) who was observed to receive insulin from an insulin pen. This had the potential to affect 25 residents who utilized insulin pens in the facility. Findings include: R262 had a Chris Jensen Physician Order form dated October 2016, which indicated an order for Novolog 50 units prior to meals. During an observation on 11/28/16, at 4:59 p.m. licensed practical nurse (LPN)-B administered insulin to R262 using an insulin pen. LPN-B was not observed to prime the insulin pen prior to use. During an interview on 11/2/16, at 5:00 p.m.	F 328	Resident #262 is receiving insulin correctly through the insulin pen, with priming prior to administration. Other residents with insulin pens are receiving insulin through insulin pens with priming prior to each injection. Nursing staff have been re-educated regarding proper administration of insulin through the insulin pens, to include priming prior to each injection. DON or designee will monitor compliance through observational audits of administration of insulin via the insulin pens. These audits will be conducted weekly x4 and as directed by the QAPI council.	

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F 328	Continued From page 31 LPN-B stated he did not prime the insulin pen and stated, "I thought that was old practice." During an interview on 12/1/16, at approximately 4:00 p.m., the director of nursing (DON) stated insulin pens should be used according to the manufacturer's instructions and the facility policy. The facility provided manufacturer's insulin pen instructions from Eli Lilly and Company dated 2015, directed the user to "Prime before each injection. priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too to too little insulin." A facility policy was requested but not received.	F 328		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329		1/10/17

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F 329	Continued From page 32 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R209) received adequate pain management and monitoring of medication efficacy. Findings include: R209 was not adequately monitored for pain as the facility did not follow their own policy for using either the dementia or cognitively impaired form for pain interpretation. In addition, the facility did not monitor the effectiveness of R209's pain medications when pain medications were administered. During observation on 11/28/16, at approximately 12:00 p.m. R209 had just returned from dialysis. R209 stated after just a few bites, "I am not hungry just tired." Although R209 was observed holding his left arm against his chest with his right hand, he denied pain. R209 had a plan of care related to pain which had been updated 10/27/16. The care plan indicated R209 was at risk for pain related to prostate cancer, hemodialysis, osteoarthritis, chronic right knee pain and fractured left wrist. Staff interventions included to give medications as ordered, observe effectiveness, if ineffective after following MD's orders need to review symptoms with MD for recommendations. Staff were also directed to seek the resident's interpretation of pain and pain management in order to evaluate effectiveness of medications because according	F 329	Resident #209 has had pain comprehensively reassessed. The physician has been contacted regarding pain medication, and the resident is receiving treatment of pain according to assessment, with physician involvement. Pain medication is monitored as indicated for effectiveness. Other residents with acute pain and/or prn medication pain use have been reviewed and are receiving services according to the plan of care. Nursing staff have been re-educated regarding pain assessment, documentation and monitoring for pain medication effectiveness. DON or designee will monitor compliance through audits of pain assessment, plan of care and documentation follow up. These audits will be conducted weekly x4 and then as directed by the QAPI council.	

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F 329	Continued From page 33	F 329		

to chart documentation, R209 was severely cognitively impaired. The activity of daily living care plan printed 10/25/16, indicated R209 denied pain and care plan instructed staff Pain observation weekly and prn. Medications as ordered. Note effectiveness if ineffective review with medical doctor (MD).

The October 2016 MAR indicated Tramadol (an analgesic) 50 milligrams (mg) had been given six times; and the November 2016 MAR indicated Tramadol 50 mg had been given 39 times. Both the October and November 2016 MARs lacked documentation of the pain level, or pain assessment at the time of Tramadol administration. In addition, for 27 of 39 doses administered in November, there was no documentation as to whether the medication had been effective.

The November 2016 MAR indicated staff were to complete weekly pain assessments 11/4/16, 11/11/16, 11/18/16, and 11/25/16. The weekly pain assessments were signed as completed for 11/4/16, and 11/25/16. The weeks of 11/11 and 11/18/16, pain assessments could not be located. Review of Progress Notes for November 2016 did not reflect weekly pain assessments having been completed.

During interview on 12/1/16, at 9:52 a.m. the nurse manager, RN-G, reviewed R209's October and November MARs and Progress Notes with the surveyor. RN-G verified the MARs were missing documentation of the effectiveness of the as needed (PRN) Tramadol. RN-G said, "We do a pain assessment upon admission, quarterly and when there is an acute change in pain control. If someone is able, we use the 1-10 pain level scale

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F 329	Continued From page 34 but most of this unit's resident are not able to use the scale. We have a Pain Assessment in Advanced Dementia form for use with our resident(s) but we did not use it with [R209] and I don't know why. I believe staff are good at identifying if he is in pain - he holds it [Left arm], he gets agitated, and he removes the sling/splinting." RN-G said the number of Tramadol doses given and the effectiveness would be part of the determination whether the Tramadol is working." RN-G said the effectiveness of all PRN medications was expected to be documented on the MAR. During interview with the director of nurses (DON) on 12/1/16 at 4:00 p.m., the DON said, "I believe my staff do a good job assessing pain." The DON verified staff were expected to document pain assessments prior to giving a PRN pain medication, and to document the effectiveness of the pain medications about an hour after it was given. DON verified staff were to follow physician orders and facility policy for pain management. The facility's Pain Management Policy dated April 2009, included: "there is a system in place to identify, monitor and evaluate resident's pain. In addition, the policy instructed staff to use: 3. A numerical pain scale and/or a non-verbal pain scale will be used to measure pain. For residents with advanced dementia, complete either pain assessment in advanced dementia form or the assessment for pain in cognitively impaired.... 8. The reason for PRN (as needed) pain medication administration as well as effectiveness of the administration will be reordered on the medication administration record (MAR)...	F 329		

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F 329	Continued From page 35 13. Pain that is unresolved or worsening will be reported to the physician."	F 329		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334		1/10/17

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F 334	Continued From page 36 (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the current standards of immunization for pneumonia for 3 of 5 residents (R85, R111, R239), over 65 years old, whose vaccination histories were reviewed. Findings include:	F 334	Residents #85, #111, #239 have all received PCV 13 immunization. Current residents have been reviewed to determine immunization status, and have been offered the appropriate immunization and/or have received the appropriate pneumonia	

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F 334	Continued From page 37 The Center for Disease Control and Prevention identified "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of pneumococcal 13-valent Conjugate Vaccine (PCV13). The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose." R85's record indicated the resident had resided at the facility since July 2012. R85's immunization record indicated the Pneumovax had been given 12/9/08, however there was no documentation to indicate a PCV13 had been offered or administered. R111's record indicated the resident had resided at the facility since December 2012. R111's immunization record indicated R111 had received a Pneumovax on 9/26/06, however there was no documentation to indicate a PCV13 had been offered or administered. R239's record indicated the resident had resided at the facility since 6/14/16. R239's immunization record indicated a Pneumovax had been given 7/8/15 however, there was no documentation to indicate a PCV13 had been offered or administered. The nurse manager, registered nurse (RN)-D, was interviewed at 3:00 p.m. on 11/29/16. RN-D stated the facility was in the process of obtaining orders to provide the PCV13. The infection control nurse further clarified at 10 a.m. on 11/30/16, that the facility had not completed offering or providing the PCV13 to eligible	F 334	vaccine. The system of ensuring immunization ongoing has been reviewed and revised. The immunization status regarding influenza and pneumonia vaccines are reviewed with admissions. Nursing staff have been re-educated regarding facility expectations for monitoring and tracking influenza and pneumonia immunizations. Nurse Managers will maintain logs of immunization status of current and admitted residents. ADON will monitor compliance through monthly audits of immunization records. These audits will be conducted weekly x4 and then as directed by the QAPI council	

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F 334	Continued From page 38 residents. The facility's policy for Pneumococcal Vaccine dated November 2014, indicated that each resident's vaccine history was to be obtained on admission, and residents age 65 or over, who have previously received one dose of the pneumococcal vaccine should receive a dose of PCV13 one year after administration.	F 334		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		1/10/17

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	245366	A. BUILDING _____ B. WING _____	12/01/2016

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 441	Continued From page 39 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 441	Resident #221 is receiving care	

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F 441	Continued From page 40 review, the facility failed to ensure proper hand hygiene and gloving was maintained for 1 of 3 residents (R221) reviewed for isolation precautions. In addition, the facility failed to ensure proper glove usage and hand hygiene were implemented during blood glucose checks to prevent the spread of blood borne pathogens for 1 of 4 residents (R42). Findings include: On 12/1/16, continuous observations of R221's care were made from 8:20 a.m. to 8:56 a.m. A sign posted on R221's room indicated the resident was on isolation precautions. On 12/1/16, from 8:20 a.m. to 8:40 a.m. R221's morning cares were observed. During the care nursing assistant (NA)-A knocked at the door and entered. NA-A asked R221 if it was time to get up. R221 nodded and stated "Yes." NA-A went to bathroom turned on the water and applied gloves, then brought back the basin of water and set it on the chair. NA-A removed the resident's gown and proceeded with cares. NA-A then told R221 she was going to remove her soiled incontinent product and provide pericare. NA-A then un-fastened the urine soaked incontinent pad, provided pericare, turned the resident to the right, and then cleansed the resident's buttock area. NA-A applied a clean incontinent product. NA-A then got a clean towel, dampened it, turned the resident and washed R221's entire back between the neck and the top of the buttocks, wearing the same gloves she'd worn while cleansing the resident's perineal and buttock areas. R221 was then dressed by NA-A who continued to wear the same gloves. NA-A was observed to handle the bed remote to lower the bed, then took the basin	F 441	according to appropriate hand hygiene and gloving process. Resident #42 is receiving blood glucose checks according to appropriate hand hygiene and glove use. Licensed nurses have been re-educated regarding the correct process for completion of blood glucose checks, to include hand hygiene and glove use. Nursing staff have been re-educated regarding facility expectations for completing cares and treatments with appropriate infection control process, including hand hygiene and glove use. ADON or designee will monitor compliance through observational audits completed weekly x4, and then as directed by the QAPI council.	

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F 441	Continued From page 41	F 441		

of water to the bathroom and discarded the soiled water in the toilet. NA-A then helped R221 put on her shoes and told the resident she was going to get help to get her up. NA-A took the soiled linens and garbage from R221's room. NA-A had not yet washed her hands. She was observed to enter the soiled utility room where she disposed of the soiled items, and was then observed to wash her hands.

At 8:45 a.m., NA-A returned to R221's room with another NA and they transferred the resident to the wheelchair. The second NA left R221's room without washing her hands. NA-A then adjusted R221's clothing, combed the resident's hair and applied compression gloves to R221's hands. At 8:51 a.m. NA-A made R221's bed and lowered the bed. At 8:54 a.m. NA-A stated she was finished with the resident's care. NA-A was observed to remove soiled linens from the room and went to the utility room down the hallway, put the linens in the appropriate receptacle and washed her hands. At 8:56 a.m. NA-A again returned to R221's room with toothettes and stated to resident she had forgotten to clean her mouth. NA-A was observed to clean R221's mouth with three toothettes she'd soaked in mouthwash. She did not wear gloves while providing the oral care. In addition, NA-A was observed to wipe secretions from around R221's mouth and nose with a Kleenex. NA-A then gathered the trash and wheeled R221 out of the room. NA-A was not observed to wash her hands prior to leaving the resident's room. Instead, NA-A went down the hallway as far as the utility room, entered the utility room and disposed of the trash, then washed her hands. NA-A then wheeled the resident the rest of the way to the dining room table.

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R221's plan of care initiated 10/10/16, indicated R221 had been diagnosed as having vancomycin-resistant enterococci (VRE) in the urine, and that contact isolation had been initiated. According to the plan of care, staff were to supposed to wear gowns and masks when handling contaminated linen. The care plan was void of staff wearing gloves for protection from potential VRE contamination and the possible spread of VRE to others.

The Cedar Group #1 NA assignment sheet dated 12/1/16, was void of documentation that R221 had VRE in the urine and that staff were to use isolation precautions.

On 12/1/16, at 9:03 a.m. NA-A was interviewed and stated "I got carried away. I wanted to do good," when asked about the hand hygiene and gloving observations made during resident cares. When asked if she was supposed to have washed hands after removing gloves and before leaving resident after cares, NA-A stated she was not sure if she was supposed to wash her hands before leaving the room because she was going to the utility room. In addition, NA-A verified she should have worn gloves during the oral hygiene care, and hadn't.

On 12/1/16, at 9:08 a.m. the unit manager, registered nurse (RN)-C, was interviewed and stated she expected staff to wash hands before leaving a resident's room and expected staff to change their gloves and wash hands following cares. RN-C stated staff should perform hand hygiene when they were touching things in a resident's room and confirmed R221 had VRE in the urine. RN-C stated staff were to follow

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appropriate precautions with cares and wear appropriate personal protective equipment.

On 12/1/16, at 1:54 p.m. the director of nursing was interviewed about hand washing and glove use and she stated staff are supposed to go from clean to dirty during care, and once staff had cleaned the peri-area they should have removed their gloves, washed their hands, and applied another pair of gloves prior to continuing with cares.

The facility's Hand Washing policy dated April 1, 2008, included: "The facility requires staff to wash hands after each direct resident contact for which hand-washing is indicated by accepted professional practice. Hand-washing is also conducted as per recommendations from the CDC [Centers for Disease Control and Prevention] guidelines..." In addition, the policy directed, "Gloves should be worn to protect the employee from exposure to blood borne pathogens and other contaminants, as defined in the standard precautions...
3. While wearing gloves, avoid handling personal items such as combs and pens that could become soiled and contaminated.
4. Gloves that have become contaminated with blood or other body fluids for which standard precautions apply are removed as soon as possible, taking care to avoid skin contact...
8. Wash hands upon removal of gloves."

The CDC information on VRE dated 5/10/11, indicated: "VRE is often passed from person to person by the contaminated hands of caregivers. VRE can get onto a caregiver's hands after they have contact with other people with VRE or after contact with contaminated surfaces. VRE can

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also be spread directly to people after they touch surfaces that are contaminated with VRE. VRE is not spread through the air by coughing or sneezing."

Review of an undated facility form provided 11/29/16, revealed R221 was identified as in contact isolation however did not indicate the specific issue.

R42 was randomly observed on 11/28/16, at 8:04 p.m. RN-F was observed to complete a blood glucose check on R42 at the medication cart, in the hallway near the nurse's desk and resident dining room. RN-F gathered equipment and placed it on top of the cart. RN-F did not put on gloves, or wash hands. RN-F wiped off R42's finger with an alcohol pad and poked R42's finger with a lancet. RN-F wiped off the first drop of blood then inserted the test strip into the glucometer and obtained a sample of blood. RN-F applied pressure to the finger using a fresh cotton ball. RN-F obtained the results from the machine, pulled out the soiled test strip and tossed it into the trash on the cart. RN-F did not wash her hands nor use hand sanitizer prior to pushing R42 to their room. RN-F came back to the medication cart and was not observed to use an alcohol based hand rub or to perform handwashing. RN-F then started setting up medications for an unidentified resident.

During interview on 12/1/16, at 2:10 p.m., RN-G said, "Staff are not to check blood sugars in the hallway." RN-G also verified staff are to wear gloves when performing blood sugars.

During interview on 12/1/16, at 3:36 p.m., RN-F stated "R42 has own glucometer." RN-F stated, "I

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F 441	Continued From page 45 put the stick into the glucometer and then poked [R42] wiped off the first spot of blood, then placed the blood on the stick." RN-F verified checking R42's blood sugar in the hallway. RN-F stated, "I did not take her to her room where I should have done the Accu-check." RN-F verified she had not worn gloves while doing the blood sugar check. On 12/1/16 at approximately 4:00 p.m., the director of nurses stated it was her expectation that blood sugar checks would be done in private, not the hallway and that staff would wear gloves when doing blood sugar checks. The facility's Glucometer Blood Sugar Testing Policy dated April 1, 2008, included: "Blood sugars will be monitored for diabetic residents per physician's order or if, through nursing judgment [sic], condition warrants. Procedure: 1. Wash hands...3. Apply gloves...13. Dispose of puncture device in Sharps containers, without recapping. 14. Dispose of blood-contaminated supplies in contaminated area according to blood-contaminated supply disposal procedures...16. Remove gloves. 17. Wash hands."	F 441		

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	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 - Main Building: A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Chris Jensen Health and Rehabilitation Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2016

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 The facility has a licensed capacity of 170 beds and had a census of 151 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		