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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EE86

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 **05/09/2014** (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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Patricia Halverson, Unit Supervisor — 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Heath
Enforcement Specialist — 06/25/2014 (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
05/21/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5366

On May 9, 2014 a Post Certification Revisit (PCR) by review of the facility's plan of correction wsa completed as a result of th standare survey completed on March 27, 2014, Effective May 6, 2014. Refer to the CMS 2567b for the results of this revisit.

Effective May 6, 2014, the facility is certified for 120 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5366

June 25, 2014

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

Dear Mr. Babbitt:

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

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

Effective May 6, 2014 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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 21, 2014

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

RE: Project Number S5366024

Dear Mr. Babbitt:

On April 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 27, 2014. 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 May 9, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 27, 2014, effective May 6, 2014 and therefore remedies outlined in our letter to you dated April 16, 2014, 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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

5366r14epoc.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245366	A. Building B. Wing	5/9/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/06/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **05/06/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/06/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	05/21/2014	12835	05/09/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/27/2014

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: EE86

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 **03/27/2014** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **170** (L18)
13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Cheryl Johnson, HFE NEII 05/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/21//2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5366

On March 27, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an oppoturnity to correct before remedies would be imposed. Post Certification Revisit to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6800

April 16, 2014

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

RE: Project Number S5366024

Dear Mr. Babbitt:

On March 27, 2014, 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.

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;

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:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

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 May 6, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 June 27, 2014 (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 September 27, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5366s14.rtf

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

RECEIVED
APR 30 2014
MN Dept of Health
Division

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 _____	03/27/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS: 156	F 000	OK 5-5-14 PLW **Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F280-** - R-83 suffered no ill effects from the Plan of Care not being revised - All residents with significant weight loss, specifically 10% in 6 months and 5% in 30 days, will be reassessed and their Plan of Care revised as necessary - Education: DON met with dietary manager/Dietician and Nurse Mangers on 4/9/14 to assure communication is in place between the disciplines to assure weight loss is communicated to the dietician.	

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

Don Babbot | NHA | 4-29-2014

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	03/27/2014

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 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the plan of care for nutrition for 1 of 3 residents (R83) reviewed for weight loss Findings include: R83 was admitted on 10/14/12, with a diagnosis of dementia, dyspnea, anemia, esophageal reflux and depression. The annual Minimum Data Set (MDS) assessment dated 1/12/14, indicated weight loss without a planned weight loss program. R83 required setup and supervision with eating. R83's recorded weights were as follows: 12/18/13-139 pounds, 1/1/14-137 pounds, 2/26/14-133 pounds, and 3/19/14-126 pounds. The care plan dated 11/20/13, identified R83 as having a nutritional problem and goals were for the resident to have no more weight loss. The care plan did not address ongoing weight loss. The interventions included a regular diet, arrange place setting, cut meat, pour liquids and a magic cup at meals. The interventions included a nutritional supplement that was discontinued 1/30/14. The registered dietician (RD), interviewed on 3/27/14, at 9:17 a.m., stated awareness of R83's weight loss but not aware of current weight of 126 pounds. RD stated R83 refused the nutritional supplement so it was discontinued. Review of documented supplement intake for December	F 280	- The facility will maintain a log of all residents with significant weight loss and audit those charts to assure each Plan of Care has been revised as is necessary, correction to be completed by 5/6/2014. - The results of those audits will be presented to the Monthly QA committee for three months - The DON/Designee is responsible for submitting	

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

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F 280	Continued From page 2 2013 and January 2014 indicated refusals only about 6 times a month. The policy titled Weight Loss dated on 1/2008 indicated residents would not fall below ideal body weight unless unavoidable. Weight loss would be assessed and interventions care planned.	F 280	F 282-	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care as directed by the care plan for 2 of 3 residents (R148, R202) reviewed for activities of daily living (ADL). Findings include: R148's annual Minimum Data Set (MDS) dated 2/14/14, indicated R148 had diagnosis of diabetes type II, history of cerebral vascular accident (CVA, commonly referred to as a stroke) and anxiety. R148 was cognitively intact and independent with personal hygiene after staff set up. The care plan dated 2/27/14, indicated R148 was independent with personal hygiene after staff set up. On 3/25/14, at 1:48 p.m. R148 was observed to have long fingernails with debris under them.	F 282	- Residents 148 and 202 suffered no ill effects from the alleged deficient practice. R148 and R202's Care Plan is followed. - All resident care plans regarding ADLs have been reassessed and are being followed - Education: Staff has completed education on need to update POC and to follow POC. - The facility will audit two residents per week times 12 weeks to assure their care Plan is being followed with respect to the ADLs. The results of those audits will be presented the Monthly QA committee, Corrective action to take place by 5/6/2014. - The DON/Designee is responsible for submitting the information to the QA committee	

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

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F 282	Continued From page 3 On 3/26/14, at 9:50 a.m. R148 stated she did not trim her own nails because she had diabetes and the licensed nurse is supposed to trim them on bath day. R148 stated she had a bath on Monday but her nails were not trimmed. R148 also stated it would be easier to clean under her nails if they were shorter. On 3/27/14, at 12:06 p.m. registered nurse (RN)-D was interviewed and stated the team lead nurse was responsible for trimming nails on resident's bath day. RN-D verified she would have expected R148's fingernails to be trimmed. R202's quarterly MDS indicated severe cognitive impairment, and required limited assistance of one staff for personal hygiene. The care plan dated 1/13/14 directed staff to shave daily. On 3/25/14, at 10:42 a.m. and 3/26/14, at 7:15 a.m. R202 was observed with several days growth of facial hair. On 3/27/14, at 9:41 a.m. nursing assistant (NA)-C was interviewed and stated R202 required total assistance of staff for shaving, and needed to be shaved daily. On 3/27/14, at 12:23 p.m. RN-C was interviewed, and stated he would expect R202 to be shaved daily. The facility was unable to provide a policy and procedure on care plans.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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

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F 309	Continued From page 4 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to coordinate hospice aide visits for 1 of 1 residents (R259) reviewed for hospice services. Findings include: A Hospice Team Care Plan dated 3/20/14, indicated R259's diagnosis included cancer of the colon. An admission Minimum Data Set (MDS) dated 2/21/14, indicated R259 was cognitively intact, required extensive assistance with bed mobility and transfers, toileting activities, dressing, personal hygiene, and was on hospice care. A Hospice Team Care Plan dated 3/20/14, indicated R90 was to receive home health aide services 1 time per week for 13 weeks. The Care Plan included the following home health aide activities: assisting with mouth care as needed, skin care every visit, toe nail care as needed, ostomy care as needed, change ben linens as needed, bath every visit, hair care every visit, finger nail care as needed, peri care every visit and as needed, foley care every visit, positioning every 2 hours, socialization every visit, and ask	F 309	**F309** - R259 did not suffer any ill effects from the alleged deficient practice. Coordination of care for hospice services is coordinated for the Hospice residents - NM has contacted Essentia Health and educated them on the need to have a weekly visit schedule for their Hospice visits of residents at CJNH. - All Hospice charts for coordination of care of Hospice service have been reviewed and audited for coordination of care. Corrected action to take place by 5/6/2014. - Findings will be presented to the QA committee monthly x 3 months. - DON/Designee is responsible	

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

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F 309	Continued From page 5 patient/family about pain every visit. On 3/26/14, at 7:30 a.m., and again at 9:08 a.m., nursing assistants (NA)-D and NA-E entered R259's room and were observed to reposition R259 from side to side in bed. On 3/26/14, at 9:15 am NA-D and NA-E stated they were not sure when the hospice staff came to visit R259. NA-D and NA-E further stated they thought the hospice nurse was at the facility yesterday. They thought R259 had a hospice aide but had never seen the aide visit R259. Both NA-D and NA-E further stated the hospice aide was to provide extra care for R259. On 3/27/14, at 8:19 a.m. licensed practical nurse (LPN)-C stated the hospice nurse usually calls first when planning to visit. LPN-C further stated the hospice aide would call ahead of planning to provide personal care. LPN-C was not sure if R259 was receiving hospice aide services/visits. On 3/27/14, at 9:14 a.m. registered nurse (RN)-D stated the hospice nurse visited R259 on Monday mornings and some times will return on Thursday. RN-D further stated the hospice aide services would be for extra care and facility staff were primary care providers. RN-D stated she was not aware of a hospice aide visiting R259. On 3/27/14, at 10:45 a.m. RN-D stated she had contacted the hospice agency to request a copy of hospice aide charting. RN-D stated the hospice agency was not sure R259 had hospice aid services and there was difficulty finding the charting. The faxed Visit History Information form dated from 2/27/14, to 3/20/14, indicated R259 had hospice aid visits on 3/20/14, 3/13/14,	F 309		

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F 309	Continued From page 6 3/6/14, and 2/27/14. The faxed document lacked time and initials/signatures to validate the care provided. RN-D stated she did not recall the hospice aide being in the facility on those dates. RN-D further stated the hospice aide needs to document in the facility medical record. On 3/27/14, at 1:40 p.m. the director of nursing (DON) stated hospice care should be coordinated, the hospice nurses and aides need to identify themselves, communicate with staff and document activities. A Hospice Care policy dated 4/1/08, indicated treatments and intervention would focus on palliative and supportive measures and would be documented in the medical record. The policy further indicated the facility's care plan should be integrated with the hospice agency's plan of care.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care for 1 of 3 residents (R148) reviewed for activity of daily living (ADL). Findings include: R148's annual Minimum Data Set (MDS) dated 2/14/14, indicated R148 had diagnoses of	F 311		

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

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F 311	Continued From page 7 diabetes type II, history of cerebral vascular accident (CVA, commonly referred to as a stroke) and anxiety. R148 was cognitively intact and was independent with personal hygiene after staff set up. The care plan dated 2/27/14, directed R148 was independent with personal hygiene after staff set up. On 3/25/14, at 1:48 p.m. R148 was observed to have long fingernails with debris under them. On 3/26/14, at 9:50 a.m. R148 stated she did not trim her own nails because she had diabetes and the licensed nurse is supposed to trim them on bath day. R148 stated she had a bath on Monday but her nails were not trimmed. R148 also stated it would be easier to clean under her nails if they were shorter. On 3/27/14, at 12:06 p.m. registered nurse (RN)-D was interviewed and stated the team lead nurse is responsible for trimming nails on resident's bath day. RN-D verified she would have expected R148's fingernails to be trimmed. The facility was unable to provide a policy and procedure on ADL care.	F 311	**F311-** - R148 suffered no ill effects from not receiving nail care. R148 has received nail care. - All residents have been reassessed and have received appropriate nail care as is necessary - Staff education on grooming and nail care will take place by 5/6/2014. - The facility will audit two residents per week times 12 weeks to assure they receive appropriate nail care. The results will be submitted to the monthly QA committee - DON/Designee responsible	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		

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

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F 312	Continued From page 8 by: Based on observation, interview and document review, the facility failed to provide shaving assistance for 1 of 3 residents (R202) reviewed for activities of daily living (ADL). The quarterly Minimum Data Set (MDS) indicated R202 had severe cognitive impairment and required limited assistance of one staff for personal hygiene. The care plan dated 1/13/14, directed staff to shave daily. On 3/25/14, at 10:42 a.m. and 3/26/14, at 7:15 a.m. R202 was observed with several days growth of facial hair. On 3/27/14, at 9:41 a.m. nursing assistant (NA)-C was interviewed and stated R202 required total assistance of staff for shaving, and needed to be shaved daily. On 3/27/14, at 12:23 p.m. registered nurse (RN)-C was interviewed, and stated he would expect R202 to be shaved daily. The facility was unable to provide a policy and procedure on ADL care.	F 312	**F312-** - R202 suffered no ill effects from not having assistance with shaving. R202 is being provided assistance with shaving. - Residents –where appropriate- have been reassessed and are being provided with assistance in shaving - Staff education on grooming and nail care will take place by 5/6/2014. - The facility will audit two residents per week times 12 weeks. The results will be presented to the Monthly QA committee, corrective action to be completed by 5/6/2014. - DON/Designee is responsible	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

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

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F 325	Continued From page 9 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate interventions to address significant weight loss for 1 of 3 residents (R83) reviewed for nutrition. Findings include: R83's admission diagnoses list on 10/14/12 included dementia, dyspnea, anemia, esophageal reflux and depression. The annual Minimum Data Set (MDS) assessment dated 1/12/14, indicated R83 had weight loss without a planned weight loss program. R83 required setup and supervision with eating. R83's recorded weights were as follows: 12/18/13-139 pounds, 1/1/14-137 pounds, 2/26/14-133 pounds, and 3/19/14-126 pounds. R83's care plan dated 11/20/13, indicated nutritional problems with a goal of no more weight loss. The interventions included a regular diet, arrange place setting, cut meat, pour liquids and a magic cup at meals. A nutritional supplement was discontinued on 1/30/14. On 3/26/14 at 12:30 p.m. R83 was observed during meal time. R83 stated at times she was not hungry and denied any mouth pain. The registered dietician (RD) interviewed on 3/27/14, at 9:17 a.m., stated awareness of R83's weight loss but unaware of current weight of 126	F 325	**F325-** R202, R192, R83 suffered no ill effects from the facility not identifying significant weight loss. R202, R192, and R83 have been identified as having significant weight loss. - Any residents noted to have a significant weight loss has been reassessed by the dietician. - The DON educated and in serviced the RN Unit Managers on following the facility's systems and process regarding identifying residents with significant weight loss. Completed 4-9-2014 - The Inter Disciplinary Team, which includes the dietary Manager meets weekly to review any residents with a significant weight loss, corrective action to take place by 5/6/2014.	

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F 325	Continued From page 10 pounds. RD stated the supplement was discontinued when R83 refused it. Documented nutritional supplement intake for December 2013, and January 2014 indicated about six refusals per month. There was no evidence of documented intake of magic cup or interventions to avoid continued weight loss. The policy titled Weight Loss dated on 1/2008 indicated residents will not fall below their ideal body weight range, unless the weight loss is viewed as unavoidable. Weight loss was assessed and interventions care planned to address weight loss.	F 325	- An audit of weekly weight logs will be completed each week for 12 weeks to assure weights are being documented. The results will be presented to the monthly QA committee - DON/Designee responsible	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**F431** - No residents were affected by the alleged deficient practice - A mandatory licensed staff education / in service regarding the proper care and cleaning of the med cart and the proper documentation requiring two licensed staff for the disposal of fentanyl patches will be presented by the Director of Education by 5/6/2014.	

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F 431	Continued From page 11 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored in a clean and sanitary environment for 4 of 9 medication carts reviewed. In addition, used Fentanyl patches (controlled narcotic medication) were not disposed of according to accepted standards of practice. Findings Include: Medication carts on 2 resident units were observed to contain multiple loose pills and tablets in the bottoms of the drawers. During the medication storage observations on 3/27/14, at 11:35 a.m. the Birch unit Team 2 medication cart was observed with licensed practical nurse (LPN)-D. In the second and third drawers of the medication cart where the resident medication cards were located, multiple loose and multi-colored tablets and capsules were scattered in between the metal card separators and behind the cards. LPN-D stated the night shift was responsible for maintaining the carts,	F 431	- The med carts were cleaned. Completed 4-9-2014. Fentanyl patches are destroyed by two Licenses staff nurses, and documented in the narcotic record. Completed 4-9-2014 - DON/Designee will complete audits of the narcotic destruction log will be completed each week for 12 weeks to assure two License staff document proper disposal of fentanyl patches. Corrected action to take place by 5/6/2014. - The results will be presented to the monthly QA committee - The facility will audit two med carts once a week for 12 weeks to assure the med carts are clear of debris. The results will be presented to the monthly QA committee.	

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F 431	Continued From page 12 going through the carts each night, and to clean them as needed. On 3/27/14, at 11:50 a.m. the Birch unit Team 1 medication cart was observed with LPN-B. In the second and third drawers of the medication cart, many loose, multi-colored tablets and capsules were scattered in between the medication card dividers and behind the cards on the bottom of both drawers. LPN-B stated the carts are suppose to be cleaned and gone through nightly. On 3/27/14, at 12:50 p.m. the Elm unit Team 1 medication cart was observed with LPN-B. In the second and third drawers of the medication cart, many loose, multi-colored tablets and capsules were scattered in between the medication card dividers and behind the cards on the bottom of both drawers. LPN-B repeated the night shift nurse was responsible for going through the cart each night and cleaning out the drawers as needed. On 3/27/14, at 1:15 p.m. the Elm unit Team 2 medication cart was observed with registered nurse (RN)-H. In the second and third drawers of the medication cart, many loose, multi-colored tablets and capsules were scattered in between the medication card dividers and behind the cards on the bottom of both drawers. RN-H stated the carts were supposed to be cleaned and gone through each night. A medication cart cleaning schedule was requested and none was provided. A Medication Administration from a Cart policy dated 4/1/08, was provided and indicated medication carts were to be cleaned and restocked after each use.	F 431		

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 _____	03/27/2014

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 431	Continued From page 13 During medication administration observed on 3/27/14, at 8:15 a.m. licensed practical nurse (LPN)-B stated used Fentanyl (a narcotic medication) patches were flushed down the toilet by one licensed nurse. The Drug Enforcement Administration guidelines recommend Fentanyl patches be flushed down the toilet by a licensed nurse with a second licensed nurse as a witness. The facility policy and procedure on disposal of used Fentanyl patches dated 4/1/12, directed disposal of used Fentanyl patches by flushing down the toilet. The policy and procedure lacked direction for the number of staff that should be present. The director of nursing interviewed on 3/27/14, at 8:23 a.m., stated Fentanyl patches should be disposed by two licensed nurses and the facility policy was incorrect.	F 431		

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

F5366023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Chris Jensen Health & Rehabilitation Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Chris Jensen Health and Rehabilitation Center is a 2-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1974 & 85 an addition(s) was constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected, by a complete automatic fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 170 beds and had a census of 155 at the time of the survey. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1.	K 000		

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

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6800

April 16, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5366024

Dear Mr. Babbitt:

The above facility was surveyed on March 24, 2014 through March 27, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to Duluth District office at:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson at the number above.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Original - Facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	03/27/2014

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/24/14, through 3/27/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 11 East Superior Street; Suite 290, Duluth, MN 55802	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care as	2 565		

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2 565	Continued From page 2 directed by the care plan for 2 of 3 residents (R148, R202) reviewed for activities of daily living (ADL). Findings include: R148's annual Minimum Data Set (MDS) dated 2/14/14, indicated R148 had diagnosis of diabetes type II, history of cerebral vascular accident (CVA, commonly referred to as a stroke) and anxiety. R148 was cognitively intact and independent with personal hygiene after staff set up. The care plan dated 2/27/14, indicated R148 was independent with personal hygiene after staff set up. On 3/25/14, at 1:48 p.m. R148 was observed to have long fingernails with debris under them. On 3/26/14, at 9:50 a.m. R148 stated she did not trim her own nails because she had diabetes and the licensed nurse is supposed to trim them on bath day. R148 stated she had a bath on Monday but her nails were not trimmed. R148 also stated it would be easier to clean under her nails if they were shorter. On 3/27/14, at 12:06 p.m. registered nurse (RN)-D was interviewed and stated the team lead nurse was responsible for trimming nails on resident's bath day. RN-D verified she would have expected R148's fingernails to be trimmed. R202's quarterly MDS indicated severe cognitive impairment, and required limited assistance of one staff for personal hygiene. The care plan dated 1/13/14 directed staff to shave daily. On 3/25/14, at 10:42 a.m. and 3/26/14, at 7:15 a.m. R202 was observed with several days	2 565		

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2 565	Continued From page 3 growth of facial hair. On 3/27/14, at 9:41 a.m. nursing assistant (NA)-C was interviewed and stated R202 required total assistance of staff for shaving, and needed to be shaved daily. On 3/27/14, at 12:23 p.m. RN-C was interviewed, and stated he would expect R202 to be shaved daily. The facility was unable to provide a policy and procedure on care plans. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a system to ensure all resident care plans are followed by staff and complete monitoring to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required	2 570		

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2 570	Continued From page 4 by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the plan of care for nutrition for 1 of 3 residents (R83) reviewed for weight loss Findings include: R83 was admitted on 10/14/12, with a diagnosis of dementia, dyspnea, anemia, esophageal reflux and depression. The annual Minimum Data Set (MDS) assessment dated 1/12/14, indicated weight loss without a planned weight loss program. R83 required setup and supervision with eating. R83's recorded weights were as follows: 12/18/13-139 pounds, 1/1/14-137 pounds, 2/26/14-133 pounds, and 3/19/14-126 pounds. The care plan dated 11/20/13, identified R83 as having a nutritional problem and goals were for the resident to have no more weight loss. The care plan did not address ongoing weight loss. The interventions included a regular diet, arrange place setting, cut meat, pour liquids and a magic cup at meals. The interventions included a nutritional supplement that was discontinued 1/30/14. The registered dietician (RD), interviewed on 3/27/14, at 9:17 a.m., stated awareness of R83's weight loss but not aware of current weight of 126 pounds. RD stated R83 refused the nutritional supplement so it was discontinued. Review of documented supplement intake for December 2013 and January 2014 indicated refusals only about 6 times a month.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 5 The policy titled Weight Loss dated on 1/2008 indicated residents would not fall below ideal body weight unless unavoidable. Weight loss would be assessed and interventions care planned. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a system to ensure all resident care plans are revised in a timely manner and complete monitoring to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to coordinate hospice aide visits for 1 of 1 residents (R259) reviewed for	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 6 hospice services. Findings include: A Hospice Team Care Plan dated 3/20/14, indicated R259's diagnosis included cancer of the colon. An admission Minimum Data Set (MDS) dated 2/21/14, indicated R259 was cognitively intact, required extensive assistance with bed mobility and transfers, toileting activities, dressing, personal hygiene, and was on hospice care. A Hospice Team Care Plan dated 3/20/14, indicated R90 was to receive home health aide services 1 time per week for 13 weeks. The Care Plan included the following home health aide activities: assisting with mouth care as needed, skin care every visit, toe nail care as needed, ostomy care as needed, change ben linens as needed, bath every visit, hair care every visit, finger nail care as needed, peri care every visit and as needed, foley care every visit, positioning every 2 hours, socialization every visit, and ask patient/family about pain every visit. On 3/26/14, at 7:30 a.m., and again at 9:08 a.m., nursing assistants (NA)-D and NA-E entered R259's room and were observed to reposition R259 from side to side in bed. On 3/26/14, at 9:15 am NA-D and NA-E stated they were not sure when the hospice staff came to visit R259. NA-D and NA-E further stated they thought the hospice nurse was at facility yesterday. They thought R259 had a hospice aide but had never seen the aide visit R259. Both NA-D and NA-E further stated the hospice aide was to provide extra care for R259.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 7 On 3/27/14, at 8:19 a.m. licensed practical nurse (LPN)-C stated the hospice nurse usually calls first when planning to visit. LPN-C further stated the hospice aide would call ahead of planning to provide personal care. LPN-C was not sure if R259 was receiving hospice aide services/visits. On 3/27/14, at 9:14 a.m. registered nurse (RN)-D stated the hospice nurse visited R259 on Monday mornings and some times will return on Thursday. RN-D further stated the hospice aide services would be for extra care and facility staff were primary care providers. RN-D stated she was not aware of a hospice aide visiting R259. On 3/27/14, at 10:45 a.m. RN-D stated she had contacted the hospice agency to request a copy of hospice aide charting. RN-D stated the hospice agency was not sure R259 had hospice aid services and there was difficulty finding the charting. The faxed Visit History Information form dated from 2/27/14, to 3/20/14, indicated R259 had hospice aid visits on 3/20/14, 3/13/14, 3/6/14, and 2/27/14. The faxed document lacked time and initials/signatures to validate the care provided. RN-D stated she did not recall the hospice aide being in the facility on those dates. RN-D further stated the hospice aide needs to document in the facility medical record. On 3/27/14, at 1:40 p.m. the director of nursing (DON) stated hospice care should be coordinated, the hospice nurses and aides need to identify themselves, communicate with staff and document activities. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could work with	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 8 hospice staff to develop a system to ensure coordination of care is maintained between the facility and all hospice staff who provide services in the facility. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming for 2	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	03/27/2014

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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2 915	Continued From page 9 of 3 residents (R148, R202) reviewed for activities of daily living (ADL). Findings include: R148's annual Minimum Data Set (MDS) dated 2/14/14, indicated R148 had diagnoses of diabetes type II, history of cerebral vascular accident (CVA, commonly referred to as a stroke) and anxiety. R148 was cognitively intact and was independent with personal hygiene after staff set up. The care plan dated 2/27/14, directed R148 was independent with personal hygiene after staff set up. On 3/25/14, at 1:48 p.m. R148 was observed to have long fingernails with debris under them. On 3/26/14, at 9:50 a.m. R148 stated she did not trim her own nails because she had diabetes and the licensed nurse is supposed to trim them on bath day. R148 stated she had a bath on Monday but her nails were not trimmed. R148 also stated it would be easier to clean under her nails if they were shorter. On 3/27/14, at 12:06 p.m. registered nurse (RN)-D was interviewed and stated the team lead nurse is responsible for trimming nails on resident's bath day. RN-D verified she would have expected R148's fingernails to be trimmed. The facility was unable to provide a policy and procedure on ADL care. R202's quarterly MDS indicated R202 had severe cognitive impairment and required limited assistance of one staff for personal hygiene. The care plan dated 1/13/14, directed staff to shave	2 915		

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2 915	Continued From page 10 daily. On 3/25/14, at 10:42 a.m., and 3/26/14 at 7:15 a.m. R202 was observed with several days growth of facial hair. On 3/27/14, at 9:41 a.m. nursing assistant (NA)-C was interviewed and stated R202 required total assistance of staff for shaving, and needed to be shaved daily. On 3/27/14, at 12:23 p.m. RN-C was interviewed and stated he would expect R202 to be shaved daily. The facility was unable to provide a policy and procedure on ADL care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents are assisted with grooming needs as required to maintain or improve activities of daily living (ADL) abilities. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 915		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as	2 965		

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2 965	Continued From page 11 determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate interventions to address significant weight loss for 1 of 3 residents (R83) reviewed for nutrition. Findings include: R83's admission diagnoses list on 10/14/12 included dementia, dyspnea, anemia, esophageal reflux and depression. The annual Minimum Data Set (MDS) assessment dated 1/12/14, indicated R83 had weight loss without a planned weight loss program. R83 required setup and supervision with eating. R83's recorded weights were as follows: 12/18/13-139 pounds; 1/1/14-137 pounds; 2/26/14-133 pounds; and 3/19/14-126 pounds. R83's care plan dated 11/20/13, indicated nutritional problems with a goal of no more weight loss. The interventions included a regular diet, arrange place setting, cut meat, pour liquids and a magic cup at meals. A nutritional supplement was discontinued on 1/30/14. On 3/26/14 at 12:30 p.m. R83 was observed during meal time. R83 stated at times she was not hungry and denied any mouth pain. The registered dietician (RD), interviewed on 3/27/14, at 9:17 a.m., stated awareness of R83's	2 965		

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2 965	Continued From page 12 weight loss but unaware of current weight of 126 pounds. RD stated the supplement was discontinued when R83 refused it. Documented nutritional supplement intake for December 2013, and January 2014 indicated about six refusals per month. There was no evidence of documented intake of magic cup or interventions to avoid continued weight loss. The policy titled Weight Loss dated on 1/2008 indicated residents will not fall below their ideal body weight range, unless the weight loss is viewed as unavoidable. Weight loss was assessed and interventions care planned to address weight loss. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the registered dietician (RD) could develop, review, and/or revise policies and procedures to ensure a system is in place to decrease the risk of weight loss and to identify weight loss in a timely manner so interventions can be implemented. The DON and RD could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 965		