CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: EE86

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGEN	NCY	!	Facility ID: 00598
MEDICARE/MEDICAID PROVIDER NO. (L1) 245366 2.STATE VENDOR OR MEDICAID NO. (L2) 175040200).	3. NAME AND ADI (L3) CHRIS JENS (L4) 2501 RICE L (L5) DULUTH, M	SEN HEALTH & AKE ROAD		ITATION CENTER (L6) 55		4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 11/01/2009		7. PROVIDER/SUP	05 HHA	09 ESRD		22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 05/09/ 2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	170 (L18) 170 (L17)	B. Not in Comp	ce With quirements	n	And/Or Approved 2. Technica 3. 24 Hour 4. 7-Day R 5. Life Saf * Code: A	al Personnel RN (Rural SNF)	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room 9. Beds/Room (L12)	etor
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 170 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEET 1861 (e) (1) or 186		(L15)	
16. STATE SURVEY AGENCY REMARKS See Attached Remarks 17. SURVEYOR SIGNATURE	S (IF APPLICABLE S	SHOW LTC CANCELL Date :	ATION DATE):		18. STATE SURVEY	Y AGENCY APP	PROVAL	Date:
Patricia Halverson, U	nit Supervis	sor (05/21/2014	(L19)	Enforce		pecialist	06/25/2014 (L20
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SIN	GLE STATI	E AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Particle. 2. Facility is not Eligible.	cipate (L21)		PLIANCE WITH C	CIVIL	2. Own		al Solvency (HCFA-2572) atterest Disclosure Stmt (HCF	A-1513)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1986 (L24)	23. LTC AGREEM BEGINNING (L41)		4. LTC AGREEME ENDING DATE (L25)		26. TERMINATION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W.	00	<u>INVOLUN'</u> 05-Fail to M	(L30) <u>TARY</u> leet Health/Safety leet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involuntar 04-Other Reason for V		OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C.		(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION C 05/21/2014	DF APPROVAL DA	ΓΕ (L33)	DETERMINATI	ON APPROV	/AL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00598

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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



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 Weath

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245366	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/9/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
CI	HRIS JENSEN HEALTH & REHABILI	TATION CENTER	2501 RICE LAKE ROAD DUI UTH 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	Correction Completed 05/06/2014	ID Prefix	F0282		Correction Completed 05/06/2014		ID Prefix	F0309		Correction Completed 05/06/2014
Reg. # LSC	483.20(d)(3), 483.1	0(k)(2)	Reg. # LSC	483.20(k)(3)(ii)				Reg. # LSC	483.25		_
	F0311 483.25(a)(2)	Correction Completed 05/06/2014	ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 05/06/2014			F0325 483.25(i)		Correction Completed 05/06/2014
ID Prefix Reg. # LSC	F0431 483.60(b), (d), (e)	Correction Completed 05/06/2014	ID Prefix Reg. # LSC			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #			Correction Completed					Correction Completed —
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC								
- Daviewed F	Dec Door	awad Dy	Date								
Reviewed E	·	ewed By	Date:	Signature o		-				Date:	00/2014
State Agend Reviewed E CMS RO		M/PH ewed By	05/21/201 Date:	Signature of		835 veyor:				Date:	09/2014
Followup t	o Survey Complete 3/27/2014			Check for any Uncorrected					Summary of the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EE86 Facility ID: 00598

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MEDICARE/MEDICAID PROVID (L1) 245366 2.STATE VENDOR OR MEDICAID I (L2) 175040200		(L4) 2501 RICE 1	ISEN HEALTI LAKE ROAD	H & REHA	BILITATION CENTER (L6) 55811	4. TYPE OF ACT 1. Initial 3. Termination	2. Recertification 4. CHOW
5. EFFECTIVE DATE CHANGE OF (L9) 11/01/2009	OWNERSHIP	(L5) DULUTH, N 7. PROVIDER/SU 01 Hospital		GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	5. Validation 7. On-Site Visit 8. Full Survey Af	6. Complaint 9. Other Ster Complaint
6. DATE OF SURVEY 03/2' 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/2 014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	170 (L18) 170 (L17)	Complianc1. A X B. Not in Con	equirements be Based On:	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B *	6. Scope of7. Medical l	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDO)WN				15. FACILITY MEETS		
18 SNF 18/19 SNF 170 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM				DATE).			
See Attached Remarks	riicis (ii rii i Eicr	IBEE SHO WERE CI	ii (CEEE) ii TOT(DITTE).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Cheryl Johnson, HFE	E NEII		05/05/2014	(L19)	Mark Meath	, Enforcement Spe	ecialist 05/21//2014 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	, ,
DETERMINATION OF ELIGIBII 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Sta	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 08/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail	UNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination		to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		04-Other Reason for Withdrawal	OTHER	rider Status Change
(L27)	B. Rescind St	uspension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

Facility ID: 00598

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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 Weeth

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

PRINTED: 04/16/2014 FORM APPROVED

DEPARTM	ENT OF HEALTH AN	D HUMAN SERVICES		RECEIVED	OMB NO. 0938-0391
CENTERS	FOR MEDICARE & I	MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE SURVEY
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245366	B. WING	MN Dept of Health	03/27/2014
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				2501 RICE LAKE ROAD	
CHRIS JEN	ISEN HEALTH & REHA	BILITATION CENTER		DULUTH, MN 55811 PROVIDER'S PLAN OF CORREC	CTION (X5)
(X4) ID PREFIX TAG	(FAOU DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE
	THE FACILITY PLA WILL SERVE AS YOU COMPLIANCE UPO ACCEPTANCE. YOU BOTTOM OF THE CMS-2567 FORM YOU VERIFICATION OF UPON RECEIPT CONSITE REVISIT OF CONDUCTED TO SUBSTANTIAL CON REGULATIONS HACCORDANCE WOU CENSUS: 156 483.20(d)(3), 483. PARTICIPATE PLA The resident has incompetent or of incapacitated und participate in plan changes in care as A comprehensive within 7 days after	SON OF CORRECTION (POC) DUR ALLEGATION OF DUR ALLEGATION OF DUR THE DEPARTMENT'S PUR SIGNATURE AT THE FIRST PAGE OF THE MILL BE USED AS COMPLIANCE. OF AN ACCEPTABLE POC, AN DOF YOUR FACILITY MAY BE VALIDATE THAT DAY DUR THE THAT DAY DUR VERIFICATION. 10(k)(2) RIGHT TO ANNING CARE-REVISE CP The right, unless adjudged therwise found to be the right of the State, to and treatment. It care plan must be developed out the completion of the	FOO	Preparation, submission implementation of this Correction do not consumission of or agreed facts and conclusions the survey report. Our Correction is prepared as a means to continuate quality of care and with all applicable staregulatory requirements. F280- R-83 suffered of from the Planton being revised. All residents woweight loss, sponths and will be reasses. Plantof Care remecessary. Education: DC dietary managements.	Plan of stitute an ment with the set forth on r Plan of d and executed lously improve of the comply set and federal executed for the significant secifically 10% in 5% in 30 days, assed and their evised as
	interdisciplinary t	eam, that includes the attending stered nurse with responsibility		assure comm	unication is in
	for the resident	and other appropriate stall ill			n the disciplines
	disciplines as de	termined by the resident's needs,		to assure wei	
1	and, to the exter	nt practicable, the participation of resident's family or the resident's		communicate	ed to the
	logal representa	tive: and periodically reviewed		dietician.	1
	and revised by a each assessme	a team of qualified persons after			:
1	each assessine		ATUDE	TITLE	(X6) DATE

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

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.

DEFAILT		ALDIOAID CEDVICES				OMB NO. 0936-039
STATEMENT O	S FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245366	B. WING			03/27/2014
	OVIDER OR SUPPLIER			25	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD DULUTH, MN 55811	
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)	D BE COMPLETION
F 280	This REQUIREMENty: Based on interview facility failed to revision for 1 of 3 residents Findings include: R83 was admitted of dementia, dyspin and depression. The (MDS) assessmenty weight loss without program. R83 requivith eating. R83's follows: 12/18/13-1 pounds, 2/26/14-15 pounds. The care plan date having a nutritional the resident to have care plan did not a The interventions place setting, cut cup at meals. The nutritional suppler 1/30/14.	and document review, the se the plan of care for nutrition (R83) reviewed for weight loss on 10/14/12, with a diagnosis ea, anemia, esophageal reflux e annual Minimum Data Set dated 1/12/14, indicated a planned weight loss ired setup and supervision recorded weights were as 39 pounds, 1/1/14-137 33 pounds, and 3/19/14-126 and 11/20/13, identified R83 as Il problem and goals were for we no more weight loss. The address ongoing weight loss included a regular diet, arrange meat, pour liquids and a magic interventions included a ment that was discontinued	F	280		significant lit those ch Plan of ed as is on to be 2014. e audits will e Monthly three
	3/27/14, at 9:17 a weight loss but no pounds. RD state supplement so it	etician (RD), interviewed on .m., stated awareness of R83's ot aware of current weight of 126 ed R83 refused the nutritional was discontinued. Review of olement intake for December				

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			Tura	DATE SURVEY
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION .	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		
		245366	B. WING			03/27/2014
NAME OF DD	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
		WATER STATES			2501 RICE LAKE ROAD	
CHRIS JEN	ISEN HEALTH & REHA	BILITATION CENTER		1	DULUTH, MN 55811 PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DESICIENT	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
F 280	Continued From page 2013 and January 2 about 6 times a more The policy titled We indicated residents weight unless unaverassessed and interested as 20(k)(3)(ii) SEP PERSONS/PER CATTHE SERVICES PROVING MUST BE PERSONS/PER CATTHE SERVICES PROVING PERSONS/PER CATTHE SERVICES PERSONS/PER CATTHE SERVICES PROVING PERSONS/PER CATTHE SERVICES PERSONS/PER PERSO	ge 2 014 indicated refusals only inth. ight Loss dated on 1/2008 would not fall below ideal body oidable. Weight loss would be ventions care planned. RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in each resident's written plan of ENT is not met as evidenced ation, interview and document failed to provide care as re plan for 2 of 3 residents ewed for activities of daily living nimum Data Set (MDS) dated d R148 had diagnosis of history of cerebral vascular commonly referred to as a stroke)	F	3	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 complete 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 Pis being followed with respet to the ADLs. The results of those audits will be present the Monthly QA committee Corrective action to take plants.	e e e e e e e e e e e e e e e e e e e
	and anxiety. R14 independent with	48 was cognitively intact and personal hygiene after staff set n dated 2/27/14, indicated R148 t with personal hygiene after staff			by 5/6/2014. The DON/Designee is responsible for submitting information to the QA	the
	On 3/25/14, at 1 have long finger	:48 p.m. R148 was observed to nails with debris under them.			committee	

		(X1) PROVIDER/SUPPLIER/CLIA		TPLE CONST		(X3) DATE SURVEY COMPLETED	
		0.45366	B. WING			0	3/27/2014
	OVIDER OR SUPPLIER	245366		2501 RIC	ADDRESS, CITY, STATE, ZIP COD EE LAKE ROAD H, MN 55811	DE	
HRIS JEN		ABILITATION CENTER		DOLOT	PROVIDER'S PLAN OF CO	ORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	TA OUL DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	DATE
F 282	Continued From pa	age 3	F	282			
	trim her own nails the licensed nurse bath day. R148 sta	D a.m. R148 stated she did not because she had diabetes and is supposed to trim them on ated she had a bath on Monday not trimmed. R148 also stated to clean under her nails if they					
	(RN)-D was interv	:06 p.m. registered nurse viewed and stated the team lead asible for trimming nails on ay. RN-D verified she would 148's fingernails to be trimmed.					
	impairment, and	MDS indicated severe cognitive required limited assistance of conal hygiene. The care plan rected staff to shave daily.					
	On 3/25/14, at 1 a.m. R202 was o growth of facial	0:42 a.m. and 3/26/14, at 7:15 observed with several days hair.					
	a interviewed	e:41 a.m. nursing assistant (NA)-C I and stated R202 required total aff for shaving, and needed to be					
	and stated he v daily.	12:23 p.m. RN-C was interviewed, vould expect R202 to be shaved					
1	procedure on o	DE CARE/SERVICES FOR		F 309			

TEMENT OF C PLAN OF CC	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CON	STRUCTION	(X3) DATE COMP	LETED
PLANOFOC	SKKLOWOW		B. WING _			03/	27/2014
	IVIDER OR SUPPLIER	245366 BILITATION CENTER	B. VIIIVE	2501 F	ET ADDRESS, CITY, STATE, ZIP CODE RICE LAKE ROAD JTH, MN 55811	ECTION	(X5)
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD DE	COMPLETION DATE
F 309	Continued From page Each resident must provide the necessor maintain the high mental, and psychological accordance with the and plan of care. This REQUIREME by: Based on observareview, the facility aide visits for 1 of hospice services. Findings include: A Hospice Team indicated R259's colon. An admission Mi 2/21/14, indicate required extension and transfers, to personal hygiene A Hospice Team indicated R90 w services 1 time Plan included the activities: assist skin care every ostended by the services and th			309	F309 - R259 did not sureffects from the deficient practice Coordination or hospice services for the Hospice NM has contact Health and eduthe need to has schedule for the visits of reside All Hospice che coordination of Hospice service reviewed and coordination of Corrected act by 5/6/2014 Findings will the QA commonths DON/Design	e alleged ce. f care for es is coording e residents cted Essentia ucated them ave a weekly heir Hospice ents at CJNH arts for of care of ce have been audited for of care. cion to take p	on visit n olace d to nly x 3

ENTERS	FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1		ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
D PLAN OF (CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			3/27/2014
		245366	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE		,0,2
IAME OF PR	OVIDER OR SUPPLIER				O1 RICE LAKE ROAD		
		DII ITATION CENTER			JLUTH, MN 55811		
CHRIS JEN	ISEN HEALTH & REHA				PROVIDER'S BLAN OF CORRECT	ON	(X5) COMPLETION
(X4) ID PREFIX TAG	- LOUIDELICIENI	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_U DE	DATE
F 309	Continued From page patient/family about On 3/26/14, at 7:30 nursing assistants (R259's room and wR259 from side to some continuous of the page of the	ge 5 pain every visit. a.m., and again at 9:08 a.m., NA)-D and NA-E entered ere observed to reposition side in bed. am NA-D and NA-E stated when the hospice staff came D and NA-E further stated they e nurse was at the facility lought R259 had a hospice aide in the aide visit R259. Both arther stated the hospice aide	F	= 309			
	On 3/27/14, at 9: stated the hospic mornings and so Thursday. RN-E services would be were primary ca was not aware of On 3/27/14, at 1 contacted the hospice aide hospice agency aid services and charting. The fadded from 2/2	14 a.m. registered nurse (RN)-D be nurse visited R259 on Monday of times will return on further stated the hospice aide of the for extra care and facility staff re providers. RN-D stated she of a hospice aide visiting R259. 10:45 a.m. RN-D stated she had ospice agency to request a copy charting. RN-D stated the was not sure R259 had hospice defined there was difficulty finding the axed Visit History Information form 7/14, to 3/20/14, indicated R259 divisits on 3/20/14, 3/13/14,					

PRINTED: 04/16/2014 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 03/27/2014 245366 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2501 RICE LAKE ROAD CHRIS JENSEN HEALTH & REHABILITATION CENTER DULUTH, MN 55811 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) **PREFIX** TAG F 309 Continued From page 6 F 309 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 311 483.25(a)(2) TREATMENT/SERVICES TO F 311 IMPROVE/MAINTAIN ADLS SS=D 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 bv: 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

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	1		STRUCTION	(X3) DATE S COMPL	SURVEY LETED
TATEMENT OF ND PLAN OF (DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	1G		03/	27/2014
	OVIDER OR SUPPLIER	245366	B. WING	2501 l	ET ADDRESS, CITY, STATE, ZIP CODE RICE LAKE ROAD JTH, MN 55811		
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	diabetes type II, his accident (CVA, cor and anxiety. R148 independent with rup. The care plan was independent set up. On 3/25/14, at 1:4 have long fingern On 3/26/14, at 9: trim her own nails the licensed nurs bath day. R148 sut her nails wer it would be easie were shorter. On 3/27/14, at 1 (RN)-D was intenurse is respon resident's bath have expected The facility was procedure on A 483.25(a)(3) A DEPENDENT A resident who	story of cerebral vascular mmonly referred to as a stroke) was cognitively intact and was personal hygiene after staff set dated 2/27/14, directed R148 with personal hygiene after staff 48 p.m. R148 was observed to ails with debris under them. 50 a.m. R148 stated she did not as because she had diabetes and se is supposed to trim them on stated she had a bath on Monday the not trimmed. R148 also stated are to clean under her nails if they 2:06 p.m. registered nurse erviewed and stated the team lead sible for trimming nails on day. RN-D verified she would R148's fingernails to be trimmed. Sunable to provide a policy and ADL care. DL CARE PROVIDED FOR RESIDENTS Dis unable to carry out activities of serves the necessary services to Inutrition, grooming, and personal	F	F 311	F311- R148 suffered no from not receiving R148 has received. All residents have reassessed and lappropriate nail necessary. Staff education and nail care with 5/6/2014. The facility will residents per with weeks to assure appropriate in results will be monthly QA of DON/Designary.	ng nail care. Id nail care. Id nail care. Ie been Inave receiv Icare as is In audit two I	ed ng ce by 12 eive e I to the
	This REQUIF	REMENT is not met as evidenced			Facility ID: 00598	If continu	ation sheet Page

NIERS	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONS		(X3) DATE S	LETED
TEMENT OF D PLAN OF C	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	1G			07/0044
		245366	B. WING _			03/	27/2014
		243300			ADDRESS, CITY, STATE, ZIP CODE		
	OVIDER OR SUPPLIER				CE LAKE ROAD		
CHRIS JEN	ISEN HEALTH & REHA	BILITATION CENTER		DULU	TH, MN 55811	STION	(X5)
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OLD BE	COMPLETION DATE
F 312	Continued From parby: Based on observatoreview, the facility fassistance for 1 of for activities of daily. The quarterly Mining R202 had severe or required limited as personal hygiene. directed staff to shoot of the continue of the contin	ge 8 sion, interview and document ailed to provide shaving 3 residents (R202) reviewed y living (ADL). mum Data Set (MDS) indicated cognitive impairment and sistance of one staff for The care plan dated 1/13/14, have daily. 42 a.m. and 3/26/14, at 7:15 inserved with several days air. 41 a.m. nursing assistant (NA)-C and stated R202 required total ff for shaving, and needed to be considered and stated he would be shaved daily. unable to provide a policy and DL care. TAIN NUTRITION STATUS		312 F 325	F312- R202 suffered no from not having a with shaving. R20 provided assistant shaving. Residents — when have been reassibeing provided in shaving. Staff education and nail care with 5/6/2014. The facility will residents per with weeks. The residents per with weeks. The residents per with committee, count to be completed. DON/Designed	essistance is is being ice with e appropria essed and a with assista on groomir Il take place audit two week times ults will be ne Monthly rrective act ed by 5/6/2	nce ng e by QA ion 014.

NTERS FOR MEDICARE & EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245366	B. WING _		THE CORE	03/2	7/2014
CHRIS JENSEN HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811 ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S P				(X5) COMPLETION
(A4) ID (EACH DESICIENT	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
by: Based on observatoreview, the facility finterventions to add 1 of 3 residents (Richards include: R83's admission of included dementiatoreflux and depress Set (MDS) assess R83 had weight lot loss program. R83 supervision with elever as follows: 1 1/1/14-137 pound 3/19/14-126 pound R83's care plan of nutritional problet loss. The intervet arrange place set a magic cup at mote was discontinued. On 3/26/14 at 12 during meal time not hungry and of the registered of the facility of the facility of the registered of the facility of the f	NT is not met as evidenced tion, interview and document railed to provide appropriate dress significant weight loss for 83) reviewed for nutrition. iagnoses list on 10/14/12 and description. The annual Minimum Data at the annual Minimum	F	325	R202, R192, R83 suffered not effects from the facility not identifying significant weight R202, R192, and R83 have be identified as having significate weight loss. - Any residents noted to be significant weight loss been reassessed by the dietician. - The DON educated and serviced the RN Unit Managers on following facility's systems and pregarding identifying residents with significate weight loss. Completed 2014 - The Inter Disciplinary which includes the diet Manager meets weekly review any residents wisignificant weight loss, corrective action to taby 5/6/2014.	int loss. Deen ant anave a has in the process ant d 4-9- Team, tary y to yith a	

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE S COMPL	
		245366	B. WING			03/2	27/2014
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, 0 2501 RICE LAKE RO DULUTH, MN 558			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	nutritional supplement and January 2014 indicated of magic cup of continued weight loss. The policy titled Weight indicated residents who body weight range, unviewed as unavoidable assessed and interversed address weight loss. 483.60(b), (d), (e) DF LABEL/STORE DRU The facility must emperal licensed pharmacis of records of receipt controlled drugs in sufficiency are in order a controlled drugs is more controlled drugs is more conciled. Drugs and biologicals.	e supplement was 83 refused it. Documented it intake for December 2013, dicated about six refusals per be evidence of documented ir interventions to avoid it. 15. 16. 16. 17. 18. 18. 18. 18. 18. 18. 18		will be for 1: are be result month. - DON. F431 - No the regulation regulation regulation.	udit of weekly weight be completed each we 2 weeks to assure weight being documented. The lits will be presented to the ly QA committee ly Designee responsible or residents were affected alleged deficient presented to the ly QA committee ly Designee responsible or residents were affected alleged deficient presented to the ly QA committee alleged deficient prese	ted by actice aff and and	
	instructions, and the applicable. In accordance with S facility must store all locked compartment.	expiration date when tate and Federal laws, the drugs and biologicals in s under proper temperature only authorized personnel to		pat the	e disposal of fentanyl tches will be presente e Director of Education 6/2014.	•	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OMB NO. 0938-0391					
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245366	B. WING			03/	27/2014	
	ROVIDER OR SUPPLIER	BILITATION CENTER		250	REET ADDRESS, CITY, STATE, ZIP CODE 11 RICE LAKE ROAD LUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	permanently affixed controlled drugs liste Comprehensive Drug Control Act of 1976 a abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMEN by: Based on observation a clear of the facility fawere stored in a clear for 4 of 9 medication used Fentanyl patch medication) were not accepted standards Findings Include: Medication carts on observed to contain tablets in the bottom During the medication and the practical nurse (LPN drawers of the medication cards we and multi-colored ta scattered in between	vide separately locked, compartments for storage of d in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced on, interview and document illed to ensure medications an and sanitary environment carts reviewed. In addition, es (controlled narcotic t disposed of according to of practice.	F	431	- The med carts were clear Completed 4-9-2014. Finanches are destroyed Licenses staff nurses, a documented in the narrecord. Completed 4-9-200N/Designee will consudits of the narcotic destruction log will be completed each week weeks to assure two Licenses to assure two Licenses of fentanyl properties of the monthly QA consumers. The facility will audit carts once a week for weeks to assure the lare clear of debris. The will be presented to monthly QA committed.	entanyl by two and rcotic 2-2014 mplete for 12 cicense r catches. ake place esented committee two med r 12 med carts he results the		

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245366	B. WING			03,	/27/2014
	ROVIDER OR SUPPLIER NSEN HEALTH & REHAE	BILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE COMPLETION	
F 431	going through the car them as needed. On 3/27/14, at 11:50 a medication cart was of second and third draw many loose, multi-cold were scattered in between the dividers and behind the both drawers. LPN-B suppose to be cleane. On 3/27/14, at 12:50 pmedication cart was of second and third draw many loose, multi-cold were scattered in between the dividers and behind the both drawers. LPN-B nurse was responsible each night and cleaning needed. On 3/27/14, at 1:15 pmedication cart was on nurse (RN)-H. In the the medication cart, must the medication card don the bottom of both carts were supposed through each night. A medication cart clear requested and none was provided and indivision as was provided and indivisions.	a.m. the Birch unit Team 1 beserved with LPN-B. In the vers of the medication cart, ored tablets and capsules ween the medication card he cards on the bottom of stated the carts are d and gone through nightly. b.m. the Elm unit Team 1 beserved with LPN-B. In the vers of the medication cart, ored tablets and capsules ween the medication card he cards on the bottom of repeated the night shift for going through the cart hig out the drawers as m. the Elm unit Team 2 beserved with registered second and third drawers of hany loose, multi-colored were scattered in between hidders and behind the cards drawers. RN-H stated the to be cleaned and gone	F	431			

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

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION		(X3) DATI	E SURVEY PLETED
	~	245366	B. WING			03	3/27/2014
	ROVIDER OR SUPPLIER NSEN HEALTH & REHAE			STREET ADDRESS, CITY, STATE 2501 RICE LAKE ROAD DULUTH, MN 55811	, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI: TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 431	During medication adi 3/27/14, at 8:15 a.m. I (LPN)-B stated used f medication) patches who one licensed nurse. The Drug Enforcement recommend Fentanyl the toilet by a licensed licensed nurse as a will the toilet by a licensed licensed nurse as a will the facility policy and used Fentanyl patches disposal of used Fentated down the toilet. The production for the number present. The director of nursing 8:23 a.m., stated Fentated sizes and sizes and sizes are the sizes and sizes are the sizes and sizes are the sizes	ministration observed on icensed practical nurse Fentanyl (a narcotic vere flushed down the toilet of Administration guidelines patches be flushed down	F	431			

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

F536023

Printed: 03/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245366

B. WING

03/24/2014

NAME OF PROVIDER OR SUPPLIER

CHRIS JENSEN HEALTH & REHABILITATION (

STREET ADDRESS, CITY, STATE, ZIP CODE

2501 RICE LAKE ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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	K 000		
	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.			

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

IIILE

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

Printed: 03/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	JRVEY TED
		245366		B. WING		03/2	4/2014
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH &	REHABILITATION (ICE LAKE 'H, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI F BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1		K 000			
	The requirement at MET.	t 42 CFR Subpart 48	3.70(a) is				
			8				
					-		
					#1		
					^		
							5



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 Weeth

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/		, ,	CONSTRUCTION	(X3) DATE SUF	
				A. BUILDING: _			
		00598		B. WING		03/27/	/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHRIS JE	NSEN HEALTH & REHAE	BILITATION CENTER	2501 RICE DULUTH, N	LAKE ROAD IN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****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						
	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.						
	that may result from rorders provided that a	earing on any assessmand compliance with the written request is made a 15 days of receipt of a for non-compliance.	ese de to				
	Department's staff, vis the following correction corrections are completed make a copy of these original to the Minnes	8/27/14, surveyors of the sited the above provide on orders are issued. We ted, please sign and the sign are sign and the sign are	er and When date, alth,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw. Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

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

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00598		B. WING		03/27/	2014
	ROVIDER OR SUPPLIER	BILITATION CENTER 2		RESS, CITY, STA LAKE ROAD IN 55811	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000		; 11 East Superior Street;		2 000	The assigned tag number appears in far left column entitled "ID Prefix Tag. The state statute/rule out of compliance listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction order This column also includes the findings which are in violation of the state state after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Correction and Time period for Correct PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION IN VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	ce is e "To er. s ute met ors ction. G OF	
2 565	Plan of Care; Use Subp. 3. Use. A commust be used by all p care of the resident.	Subp. 3 Comprehensive apprehensive plan of care ersonnel involved in the	1	2 565			
	by:	n, interview and documen					

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 2 of 13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00598	B. WING		03/27/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
CHRIS JE	NSEN HEALTH & REHA	BILITATION CENTER 2501 RICE DULUTH, I	LAKE ROAD WN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
2 565	Continued From page	e 2	2 565		
		olan for 2 of 3 residents ed for activities of daily living			
	Findings include:				
	2/14/14, indicated R1 diabetes type II, histo accident (CVA, command anxiety. R148 w independent with persup. The care plan dat	um Data Set (MDS) dated 48 had diagnosis of bry of cerebral vascular nonly referred to as a stroke) as cognitively intact and sonal hygiene after staff set and 2/27/14, indicated R148 an personal hygiene after staff			
		.m. R148 was observed to with debris under them.			
	trim her own nails bed the licensed nurse is bath day. R148 stated but her nails were not	.m. R148 stated she did not cause she had diabetes and supposed to trim them on d she had a bath on Monday t trimmed. R148 also stated clean under her nails if they			
	nurse was responsibl resident's bath day. F	p.m. registered nurse red and stated the team lead e for trimming nails on RN-D verified she would s fingernails to be trimmed.			
	impairment, and requ	S indicated severe cognitive ired limited assistance of hygiene. The care plan d staff to shave daily.			
		a.m. and 3/26/14, at 7:15 ved with several days			

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 3 of 13

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00598	B. WING		03/27/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	
CHRIS JE	NSEN HEALTH & REHAE	BILITATION CENTER	CE LAKE ROAD H, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
2 565	Continued From page	3	2 565		
	growth of facial hair.				
	was interviewed and	.m. nursing assistant (NA)-C stated R202 required total shaving, and needed to be			
		p.m. RN-C was interviewed, expect R202 to be shaved			
	The facility was unable procedure on care plant	e to provide a policy and ans.			
	The director of nursin				
	TIME PERIOD FOR ((21) Days	CORRECTION: Twenty One			
2 570	MN Rule 4658.0405 S Plan of Care; Revision	Subp. 4 Comprehensive n	2 570		
	care must be reviewe interdisciplinary team physician, a registere for the resident, and odisciplines as determined, to the extent praparticipation of the reguardian or chosen requarterly and within s	that includes the attending d nurse with responsibility other appropriate staff in ned by the resident's needs, acticable, with the sident, the resident's legal			

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 4 of 13

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, ,	E SURVEY PLETED
		00598		B. WING		03	3/27/2014
	ROVIDER OR SUPPLIER NSEN HEALTH & REHA	BILITATION CENTER		RESS, CITY, STA L AKE ROAD IN 55811	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 570	Continued From pag by part 4658.0400, s			2 570			
	by: Based on interview a facility failed to revise for 1 of 3 residents (F Findings include: R83 was admitted or of dementia, dyspner and depression. The	nt is not met as evidence and document review, the e the plan of care for nut R83) reviewed for weight an 10/14/12, with a diagno an anemia, esophageal re annual Minimum Data S	e trition t loss osis eflux				
	weight loss without a program. R83 require with eating. R83's re follows: 12/18/13-139 pounds, 2/26/14-133 pounds.	ed setup and supervision corded weights were as pounds, 1/1/14-137 pounds, and 3/19/14-12	26				
	having a nutritional p the resident to have care plan did not add The interventions inc place setting, cut me cup at meals. The int	11/20/13, identified R83 roblem and goals were find more weight loss. The lress ongoing weight los luded a regular diet, arrat, pour liquids and a materiventions included a fit that was discontinued.	for e s. ange agic				
	3/27/14, at 9:17 a.m. weight loss but not a pounds. RD stated F supplement so it was documented supplen	ian (RD), interviewed on, stated awareness of Roware of current weight on R83 refused the nutrition of discontinued. Review of the intake for December 114 indicated refusals on the	83's f 126 al of er				

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 5 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED				
		00598		B. WING		03/27/2014		
	ROVIDER OR SUPPLIER NSEN HEALTH & REHAI	BILITATION CENTER	2501 RICE	DDRESS, CITY, STATE, ZIP CODE CE LAKE ROAD I, MN 55811				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
2 570	indicated residents w weight unless unavoidassessed and interved SUGGESTED METH The director of nursindevelop a system to eplans are revised in a complete monitoring compliance.	tht Loss dated on 1/200 ould not fall below idea dable. Weight loss wountions care planned. OD OF CORRECTION of (DON) or designee consure all resident care timely manner and	al body ald be l: could	2 570				
2 830	receive nursing care custodial care, and stindividual needs and the comprehensive replan of care as described as much as powritten order from the	eneral. A resident must and treatment, personal upervision based on preferences as identification assessment and ribed in parts 4658.040 g home resident must be estible unless there is attending physician the in bed or the resident	al and ed in d 0 and pe out a	2 830				
	by: Based on observation review, the facility fail	t is not met as evidence n, interview, and docum ed to coordinate hospic esidents (R259) review	nent ce					

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 6 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	(2) MULTIPLE ((X3) DATE SURVEY COMPLETED			
		00598	В.	WING		03/27/2	014
	ROVIDER OR SUPPLIER	25 BILITATION CENTER	TREET ADDRES 501 RICE LAP ULUTH, MN	KE ROAD	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETE DATE
2 830	colon. An admission Minimu 2/21/14, indicated R2 required extensive as and transfers, toileting personal hygiene, and A Hospice Team Care indicated R90 was to services 1 time per will plan included the folloactivities: assisting wiskin care every visit, ostomy care as needed, bath every vinger nail care as neand as needed, foley every 2 hours, sociali patient/family about put for more consistent of the patient of the pati	e Plan dated 3/20/14, inosis included cancer of the most between the most cancer of the m	he are	2 830			

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 7 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		D	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00598	В.	. WING		03/2	27/2014
	ROVIDER OR SUPPLIER	BILITATION CENTER	STREET ADDRES 2501 RICE LAI DULUTH, MN	KE ROAD	TE, ZIP CODE		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE	ILD BE	(X5) COMPLETE DATE
2 830	(LPN)-C stated the h first when planning to the hospice aide wor provide personal care R259 was receiving I On 3/27/14, at 9:14 a stated the hospice numornings and some Thursday. RN-D furth services would be for were primary care primary c	a.m. licensed practical nurspice nurse usually call o visit. LPN-C further standed call ahead of planning e. LPN-C was not sure if hospice aide services/visit. a.m. registered nurse (RNurse visited R259 on Mortimes will return on their stated the hospice aide rextra care and facility stroviders. RN-D stated shouspice aide visiting R25 a.m. RN-D stated she has agency to request a cotting. RN-D stated the not sure R259 had hospice was difficulty finding the visit History Information for 3/20/14, indicated R25 on 3/20/14, on the facility on those date in the facility on those date the hospice aide needs to the ospice aide needs to out.	urse Is ated g to stated g to stated g to stated g to state	2 830			
	and document activit	s, communicate with staf ies. HOD OF CORRECTION: ng (DON) could work with					

Minnesota Department of Health STATE FORM

STATE FORM EE8611 If continuation sheet 8 of 13

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.11.5 1 27.11 0			A. BUILDING: _		"""	
		00598	B. WING		03/2	7/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHRIS JE	NSEN HEALTH & REHAE	BILITATION CENTER 2501 RICE DULUTH, N	LAKE ROAD IN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	coordination of care is facility and all hospice in the facility. The DO educate all appropriation policies/procedures, a monitoring systems to compliance. TIME PERIOD FOR (21) Days	op a system to ensure is maintained between the estaff who provide services on or designee could te staff on the eand could develop or ensure ongoing	2 830			
2 915	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		2 915			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming for 2					

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 9 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00598	B. WING	····	0:	3/27/2014
	ROVIDER OR SUPPLIER	BILITATION CENTER 25	REET ADDRESS, CITY, STATE 01 RICE LAKE ROAD JLUTH, MN 55811	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 915	of 3 residents (R148 activities of daily living Findings include: R148's annual Mining 2/14/14, indicated R diabetes type II, hist accident (CVA, command anxiety. R148 windependent with peup. The care plan dawas independent with set up. On 3/25/14, at 1:48 have long fingernails On 3/26/14, at 9:50 at trim her own nails be the licensed nurse is bath day. R148 state but her nails were not it would be easier to were shorter. On 3/27/14, at 12:06 (RN)-D was interview nurse is responsible resident's bath day. have expected R148 The facility was unall procedure on ADL care	num Data Set (MDS) dated 148 had diagnoses of cry of cerebral vascular monly referred to as a stroke as cognitively intact and warsonal hygiene after staff se ted 2/27/14, directed R148 h personal hygiene after staff she with debris under them. a.m. R148 stated she did not excause she had diabetes an supposed to trim them on a she had a bath on Monda of trimmed. R148 also stated clean under her nails if they p.m. registered nurse wed and stated the team lead for trimming nails on RN-D verified she would it's fingernails to be trimmed. Die to provide a policy and are.	s t t t t t t t t t t t t t t t t t t t			
	cognitive impairment	S indicated R202 had sever and required limited aff for personal hygiene. The /14, directed staff to shave				

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 10 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00598	B. WING		03/27/2014
NAME OF PI	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA	TE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
CHRIS JE	NSEN HEALTH & REHAE	BILITATION CENTER	RICE LAKE ROAD		
0/0/15	SHMMADV ST.	ATEMENT OF DEFICIENCIES	JTH, MN 55811	PROVIDER'S PLAN OF CORRECTION	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 915	Continued From page	e 10	2 915		
	daily.				
	On 3/25/14, at 10:42 a.m. R202 was obser growth of facial hair.	a.m., and 3/26/14 at 7:15 ved with several days			
	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 unabl procedure on ADL car	e to provide a policy and re.			
	The director of nursin develop, review, and/ procedures to ensure with grooming needs improve activities of d The DON or designed appropriate staff on the development of the director of the	all residents are assisted as required to maintain or laily living (ADL) abilities.			
	TIME PERIOD FOR ((21) Days	CORRECTION: Twenty One			
2 965	MN Rule 4658.0600 S -Nutritional Status	Subp. 2 Dietary Service	2 965		
	must ensure that a re	al status. The nursing home sident is offered a diet loric and nutrient needs as			

Minnesota Department of Health

STATE FORM EE8611 If continuation sheet 11 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		DED:	LTIPLE CONSTRUCTION DING:		(X3) DATE SURVEY COMPLETED		
		00598	B. WING			03/27/2014	
	ROVIDER OR SUPPLIER	BILITATION CENTER	STREET ADDRESS, CI 2501 RICE LAKE R DULUTH, MN 5581	DAD			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR		IX (EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA DEFICIENCY)			
2 965	determined by the coassessment. Substi	re 11 comprehensive resident tutes of similar nutritive esidents who refuse food					
	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.		ent ate ss for				
	included dementia, or reflux and depression Set (MDS) assessments as a see that the second se	ng. R83's recorded wei 18/13-139 pounds; 2/26/14-133 pounds; an	Data ated ht ghts				
	nutritional problems loss. The interventio arrange place setting a magic cup at meal was discontinued on On 3/26/14 at 12:30	p.m. R83 was observed 33 stated at times she w	et, and ent				
	The registered dietic	ian (RD), interviewed or , stated awareness of F					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
00598		B. WING		03.	27/2014		
	ROVIDER OR SUPPLIER NSEN HEALTH & REHAE	BILITATION CENTER		RESS, CITY, STA LAKE ROAD IN 55811	TE, ZIP CODE		
(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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 965	weight loss but unaway pounds. RD stated the discontinued when Renutritional supplement and January 2014 incomposed month. There was not intake of magic cup of continued weight loss. The policy titled Weight indicated residents with body weight range, unviewed as unavoidable assessed and interve address weight loss. SUGGESTED METH The director of nursind dietician (RD) could derevise policies and prosystem is in place to compliance to compliance.	are of current weight of e supplement was 83 refused it. Document intake for December 2 licated about six refusate of evidence of document interventions to avoid it. The Loss dated on 1/200 ill not fall below their idealess the weight loss is le. Weight loss was nations care planned to OD OF CORRECTION g (DON) and the register levelop, review, and/or occedures to ensure a decrease the risk of weight loss in a timely made implemented. The Document of the point of the proper intervence of the point of the po	ted 2013, Is per ed 88 eal ight anner ON n the	2 965			

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