

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 23, 2020

Administrator Chris Jensen Health & Rehabilitation Center 2501 Rice Lake Road Duluth, MN 55811

RE: CCN: 245366 Cycle Start Date: July 22, 2020

Dear Administrator:

On August 12, 2020, we notified you a remedy was imposed. On October 20, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 7, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 11, 2020 be discontinued as of October 7, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 12, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Electronically delivered August 12, 2020

Administrator Chris Jensen Health & Rehabilitation Center 2501 Rice Lake Road Duluth, MN 55811

RE: CCN: 245366 Cycle Start Date: July 22, 2020

Dear Administrator:

On July 22, 2020, a survey was completed at your facility by the Minnesota Department of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

#### REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 11, 2020.

• Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 11, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 11, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 11, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Chris Jensen Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 11, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 22, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

### APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

## Tamika.Brown@cms.hhs.gov

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

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

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

#### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:

> Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED		
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			-	. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	`´co∧	E SURVEY		
		245366	B. WING			C / <b>22/2020</b>		
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE				
CHRIS J	ENSEN HEALTH & RI	EHABILITATION CENTER		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
E 000	Initial Comments		E 0(	00				
	was conducted 7/2 facility by the Minne determine complian Preparedness regu facility was IN full c							
		nrolled in ePOC, your juired at the bottom of the first 567 form.						
		f correction is required, it is cility acknowledge receipt of ments.						
F 000	INITIAL COMMEN	TS	F 00	00				
	survey and a COVI Control survey was the Minnesota Dep if your facility was in requirements of 42 Requirements for L	gh 7/22/20, an abbreviated D-19 Focused infection a conducted at your facility by artment of Health to determine n compliance with CFR Part 483, Subpart B, and ong Term Care Facilities. The e facility was NOT in						
	The following comp H5366146C H5366147C H5366148C H5366149C H5366150C	plaints were substantiated:						
	as your allegation of Department's acce	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required						
	director's or provid	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/14/2020		

**Electronically Signed** 

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.

		AND HUMAN SERVICES		FOR	D: 10/22/202 MAPPROVE 0. 0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY		
		245366	B. WING		C 07/22/2020		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER		2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 000	Continued From pa	ge 1	F 000	)			
	<ul> <li>at the bottom of the first page of the CMS-2567</li> <li>form. Your electronic submission of the POC will be used as verification of compliance.</li> <li>Upon receipt of an acceptable electronic POC, a on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.</li> </ul>						
	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)		F 812	2	9/1/20		
	§483.60(i) Food sat The facility must -	fety requirements.					
	approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision de facilities from using gardens, subject to safe growing and fo (iii) This provision de	s food items obtained directly rs, subject to applicable State					
	serve food in accor standards for food a This REQUIREMEN by: Based on observat review, the facility fa sanitary conditions, contamination from	NT is not met as evidenced tion, interview, and document ailed to handle ice under		This plan of correction constitutes this facility⊡s written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the			

Facility ID: 00598

If continuation sheet Page 2 of 23

		AND HUMAN SERVICES				FORM	10/22/2020 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	COM	E SURVEY PLETED	
		245366	B. WING	G		C 07/22/2020		
NAME OF F	PROVIDER OR SUPPLIER							
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 812	Continued From pa	ge 2	F	812				
	resided on the Cedar unit at the facility. Findings include: According to the Minnesota Department of Health (MDH) website https://www.health.state.mn.us/diseases/crab/ind ex.html undated, "Carbapenem-resistant Acinetobacter baumannii (CRAB) is a type of				deficiencies or conclusions contain the Department⊡s inspection repo	rt.		
					Directed Plan of Correction is follow indicated:	wed as		
					Staff education has been complete utilizing MedCom system for trainin tracking of the education. MedCon training materials utilize CDC resou	ng and n		
	especially in soil an human infections of lungs, wounds, and	bacteria commonly found in the environment, especially in soil and water. CRAB can cause human infections of the blood, urinary tract, lungs, wounds, and other body sites. The bacteria are multidrug-resistant, making infections very			R #1 continues to live on the Ceda with Enhanced Barrier Precautions negative affect has occurred relate this deficient practice.	. No		
	R1's diagnoses incl inflammatory reaction	cord dated 7/23/20, indicated luded infection and on, and methicillin resistant eus (a multi-drug resistant			Residents who live on the Cedar up could have been affected by this de practice. No negative outcomes have been determined. Water pass practice has changed to	eficient ave		
	R1's quarterly Minir	num Data Set (MDS) dated			include the use of disposable cups will be replaced after each use.			
	assistance with bec locomotion, and toil identified he had an	/25/20, identified R1 required extensive ssistance with bed mobility, transfers, ocomotion, and toilet use. R1's MDS further lentified he had an indwelling catheter and was equently incontinent of bowel.			Staff have received education rega keeping items away from their pers uniform. Staff education has been completed for sanitation.	son and		
	R1's care plan dated 1/27/16, indicated R1 had a chronic indwelling Foley catheter related to benign prostatic hyperplasia (prostate gland enlargement).				Audits of sanitation of water pass v conducted 4 times weekly for 4 we then monthly for 2 months.	eks,		
	R1's care plan dated 1/8/20, indicated R1 had a history of MRSA in his urine and a "carbapenem resistive organism." Staff were to adhere to enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to				Audits will be taken to QAPI for fur review and recommendations.	nner		

		AND HUMAN SERVICES					FORM	10/22/2020 APPROVED	
	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	<u> </u>	OMB NO. 0938-0391 (X3) DATE SURVEY		
	FCORRECTION	IDENTIFICATION NUMBER:	· /				COMPLETED		
		245366	B. WING					C 22/2020	
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE	E, ZIP CODE	•		
CHRIS JI	CHRIS JENSEN HEALTH & REHABILITATION CENTER				501 RICE LAKE ROAD DULUTH, MN 55811				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN	OF CORRECTION	1	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	Х	(EACH CORRECTIVE A CROSS-REFERENCED T			COMPLETION DATE	
		,			DEFICIE				
E 040		-	1						
F 812	Continued From pa	-	F 8	312					
	infection.	ds is anticipated) to prevent							
	A progress note dat	ted 3/20/20, at 5:03 p.m.							
		was notified R1 had tested							
	positive for CRAB.								
		cord dated 7/23/20, indicated							
	R/'s diagnoses incl	uded Alzheimer's disease.							
		nge MDS dated 6/15/20,							
	required supervision	everely impaired cognition and n eating.							
		a.m., an enhanced barrier							
		s noted to be posted on R1's white plastic three drawer bin							
	was noted, outside	of R1's room, which contained							
	personal protective	equipment (PPE) supplies.							
		a.m., an interview was							
		sing assistant (NA)-F. NA-F arrier precautions were used							
		was diagnosed with CRAB.							
		-							
		9 a.m., R1's call light was rsing assistant (NA)-E walked							
	towards R1's room,	and put on an isolation gown							
	and gloves. NA-E e asked for water.	entered R1's room, and R1							
	askeu iui Walei.								
		9 a.m. NA-E exited R1's room							
		mug which was partially filled eld the large plastic mug							
		iniform shirt by using both of							
	her forearms (hugg	ing motion). NA-E walked							
		nd entered R24 and R36's on who was inside R24 and							
	•	NA-E about the mug. The							

Facility ID: 00598

If continuation sheet Page 4 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/22/2020 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245366	B. WING			C 07/22/2020	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	staff person stated used to fill the mug room and walked to station. NA-E oper nurses' station, whi entered the room a mug. NA-E poured sink. NA-E then op was on a rolling car which was on the s transferred ice from placed the scoop in made direct contac mug. NA-E remove and used it to obtai cooler. NA-E again inside of the mug, a inner surface. NA-I placed the scoop in cooler. NA-E again inside of the mug, a inner surface. NA-I placed the scoop in cooler. NA-E used with water, and rep exited the Staff Onl R1's room. NA-E p white plastic three of room. NA-E was in confirmed the mug requested it to be ro placed on enhance CRAB infection. No where the source o On 7/21/20, at 11:3 NA-E and stated sh NA-F put on gloves entered R1's room	another cup needed to be NA-E exited R24 and R36's wards the Cedar nurses' red a door near the Cedar ch indicated Staff Only. NA-E nd removed the lid from the water from the mug into the ened a white ice cooler which t. NA-E obtained a scoop ide of the cooler, and the cooler to the mug. NA-E side the mug, and the scoop t with the inner surface of the ed the scoop from the mug, n additional ice from the placed the scoop on the and made contact with the E closed the cooler lid and a holder on the side of the the sink faucet to fill the mug laced the plastic lid. NA-E y room and walked towards laced the mug on top of the drawer bin outside of R1's terviewed at that time and belonged to R1, and she rom R1's room when he efilled. NA-E stated R1 was d barrier precautions due to a A-E stated she was unsure f the resident's infection was. 1 a.m. NA-F approached he would bring the mug to R1. and an isolation gown, and	F	312			

If continuation sheet Page 5 of 23

TAG       REGULATORY OR LISC IDENTIFYING INFORMATION)       TAG       TAG       CROSS-REPERENCED TO THE APPROPRIATE       DATE         F 812       Continued From page 5 paper wrapper. NA-G entered the Staff Only room near the Cedar nurses' station. NA-G opened the white cooler and used a scoop to transfer ice from the cooler to the cup. NA-G then closed the cooler, placed the scoop in a holder located on, and used the faucet to fill the cup with water. NA-G exited the Staff Only room and walked to the Cedar dining room and approached R7. NA-G removed the straw from the wrapper and placed the straw in the cup. NA-G leaned towards R7, with the cup of water, and NA-G was asked to stop by the surveyor. NA-G confirmed she intended to help R7 drink water. NA-G was told the ice was contaminated from a source removed from R1's room. NA-G stated the cooler and ice needed to be removed right away.       On 7/21/20, at 12:10 p.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated the facility was going to change the way water was brought to residents. LPN-A stated the facility was going to change the way water was brought to residents. LPN-A was observed pushing the white cooler towards the unit elevator on a wheeled cart.       On 7/22/20, at 11:31 a.m. an interview was conducted with the assistant director of nursing (ADON). The ADON stated staff contaminated themselves by removing a mug from R1's room and placing it against their scrubs. The ADON confirmed the ice was contaminated when staff touched the large plastic mug with the scopp and placed it back in the cooler. The ADON stated			AND HUMAN SERVICES				FORM	APPROVED	
245366     Description       NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, ZIP CODE       CHRIS JENSEN HEALTH & REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       CMUID     SUMMARY STATEMENT OF DEFICIENCIES     DULUTH, MN 58811       PREFX     REGULATIONY OR LSCIDENTIFYING INFORMATION)     TO     CASI, C	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		(X3) DATE SURVEY		
245366         B. WING         01/22/2020           NAME OF PROVIDER OR SUPPLER         STREET ADDRESS, CITY, STATE, ZIP CODE         2501 RICE LAKE ROAD DULUTH, IMN 55811           (M) [D]         SUMMARY STATEMENT OF DEFICIENCIES (EQUILATION ON INST IS PRECEDED BY FULL (EQUILATION ON INST IS DEPICIENCIES)         PROVIDERS IN AN OF CORRECTION (EQUILATION ON IS COMPTICIENCIES)         00 (CONSTREET ADDRESS, CITY, STATE, ZIP CODE         CONSTREET (EQUILATION ON IS COMPTICIENCIES)           (M) [D]         SUMMARY STATEMENT OF DEFICIENCIES (EQUILATION ON ISC DEPICIENCIES)         ID (CONSTREET ADDRESS, CITY, STATE, ZIP CODE         CONSTREET (EQUILATION ON ISC DEFICIENCIES)           (M) [D]         SUMMARY STATEMENT OF DEFICIENCIES (EQUILATION ON ISC DEPICIENCIES)         ID (CONSTREET ADDRESS, CITY, STATE, ZIP CODE         CONSTREET (EQUILATION ON ISC DEFICIENCIES)           (P) [P) [P) [P]	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	i			
CHRIS JENSEN HEALTH & REHABILITATION CENTER         2501 RICE LAKE ROAD DULUTH, MN 55811           PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH OERICENCY MUST BE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFX TAG         PROVIDER'S FLAN OF CORRECTION (EACH OERICET'NE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH OERICET'NE ACTION (EACH OERICET'NE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH OERICET'NE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           F 812         Continued From page 5 paper wrapper. NA-G entered the Staff Only room and used the scoop to transfer ice from the cooler to the cup. NA-G then closed the cooler, placed the staff Only room and walked to the Cedar dining room and approached R7. NA-G exited the Staff Only room and walked to the Cedar dining room and approached R7. NA-G removed the straw form the wrapper and placed the straw on the cup. NA-G leaned towards R7, with the cup of water, and NA-G was told the ice was contaminated from a source removed from R1's room. NA-G stated the cooler and ice needed to be removed right away. On 7/21/20, at 12:10 p.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated R1 had CRAB in his urine. LPN-A stated the facility was going to change the way water was brought to residents. LPN-A was observed pushing the white cooler towards the unit elevator on a wheeled cart. On 7/22/20, at 11:31 a.m. an interview was conducted with the assistent director of nursing (ADON). The ADON stated staff contaminated themselves by removing a mug from R1's room and placing it against their scrubs. The ADON confirmed the ice was contaminated when staff touched the large plastic mug with the scoop and placed it back in the cooler. The ADON stated			245366	B. WING					
DULUTH, MN 55811       DULUTH, MN 55811       (M) ID (PACT DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDENT TAG     PROVIDENT (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID (EACH CORRECTIVE ACTION SHOULD BE CORDSR-REFERENCED TO THE APPROPRIATE DEFICIENCY)     O(M) TO DATE       F 812     Continued From page 5 paper wrapper. NA-G entered the Staff Only room near the Coder to the cup. NA-G then closed the cooler, placed the store to transfer ice from the cooler to the cup. NA-G then closed the cooler, placed the Staff Only room and walked to the Cedar dining room and approached R7. NA-G removed the straw from the wrapper and placed the straw in the cup. NA-G leaned towards R7, with the cup of water, and NA-G was saked to top bp Ythe surveyor. NA-G confirmed she intended to be PR 77 drink water. NA-G subted the cooler removed from R1's room. NA-G Stated the cooler and ice needed to be removed right away.     On 7/21/20, at 12:10 p.m, an interview was conducted with licensed practical nurse (LPN-A stated the facility was going to change the way water was brought to residents. LPN-A wate was brought to residents. LPN-A wate was brought to residents. LPN-A wate was conducted with the assistant director of nursing (ADON). The ADON stated staff contaminated themselves by removing a mug from R1's room and placing the wite scrubs. The ADON confirmed the ice was contaminated when staff touched the large plasit mug with the scop and place it back in the cooler. The ADON stated	NAME OF F	NAME OF PROVIDER OR SUPPLIER					-		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 812       Continued From page 5 paper wrapper. NA-G entered the Staff Only room near the Cedar nurses' station. NA-G opened the white cooler and used a scoop to transfer ice from the cooler to the cup. NA-G then closed the cooler, placed the scoop in a holder located on, and used the faucet to fill the cup with water. NA-G exited the Staff Only room and walked to the Cedar dining room and approached R7. NA-G removed the straw from the wrapper and placed the straw in the cup. NA-G leaned towards R7, with the cup of water, and NA-G was asked to stop by the surveyor. NA-G confirmed she intended to help R7 drink water. NA-G was told the ice was contaminated from a source removed from R1's room. NA-G stated the cooler and ice needed to be removed right away.         On 7/21/20, at 12:10 p.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated the facility was going to change the way water was brought to residents. LPN-A stated the facility was going to change the way water was brought to residents. LPN-A was observed pushing the white cooler rowards the unit elevator on a wheeled cart.         On 7/22/20, at 11:31 a.m. an interview was conducted with the assistant director of nursing (ADON). The ADON stated staff contaminated themselves by removing a mug from R1's room and placing it against their scrubs. The ADON confirmed the ice was contaminated when staff touched the large plastic mug with the scoop and placed it back in the cooler. The ADON stated	CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER						
<ul> <li>paper wrapper. NA-G entered the Staff Only room near the Cedar nurses' station. NA-G opened the white cooler and used a scoop to transfer ice from the cooler to the cup. NA-G then closed the cooler, placed the scoop in a holder located on, and used the faucet to fill the cup with water. NA-G exited the Staff Only room and walked to the Cedar dining room and approached R7. NA-G removed the straw from the wrapper and placed the straw in the cup. NA-G leaned towards R7, with the cup of water, and NA-G was asked to stop by the surveyor. NA-G confirmed she intended to help R7 drink water. NA-G was told the ice was contaminated from a source removed from R1's room. NA-G stated the cooler and ice needed to be removed right away.</li> <li>On 7/21/20, at 12:10 p.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated R1 had CRAB in his urine. LPN-A stated the facility was going to change the way water was brought to residents. LPN-A was observed pushing the white cooler towards the unit elevator on a wheeled cart.</li> <li>On 7/22/20, at 11:31 a.m. an interview was conducted with the assistant director of nursing (ADON). The ADON stated staff contaminated from and placed the ice was contaminated free of nursing it against their scrubs. The ADON confirmed the ice was contaminated when staff</li> </ul>	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	) BE	COMPLETION	
many other areas would had been contaminated, as well. On 7/22/20, at 1:57 p.m. an interview was conducted with the director of nursing (DON). The DON stated there was concerns for	F 812	paper wrapper. NA- near the Cedar nurs white cooler and us from the cooler to the cooler, placed the sta and used the fauce NA-G exited the Sta the Cedar dining roo NA-G removed the placed the straw in towards R7, with the asked to stop by the she intended to hell told the ice was cor- removed from R1's and ice needed to b On 7/21/20, at 12:1 conducted with lice LPN-A stated R1 has stated the facility wa water was brought to observed pushing the unit elevator on a w On 7/22/20, at 11:3 conducted with the (ADON). The ADO themselves by remo- and placing it again confirmed the ice w touched the large p placed it back in the many other areas w as well. On 7/22/20, at 1:57 conducted with the	-G entered the Staff Only room ses' station. NA-G opened the red a scoop to transfer ice the cup. NA-G then closed the scoop in a holder located on, t to fill the cup with water. aff Only room and walked to om and approached R7. straw from the wrapper and the cup. NA-G leaned e cup of water, and NA-G was e surveyor. NA-G confirmed p R7 drink water. NA-G was taminated from a source room. NA-G stated the cooler be removed right away. 0 p.m. an interview was nsed practical nurse (LPN)-A. ad CRAB in his urine. LPN-A as going to change the way to residents. LPN-A was the white cooler towards the theeled cart. 1 a.m. an interview was assistant director of nursing N stated staff contaminated oving a mug from R1's room st their scrubs. The ADON vas contaminated when staff lastic mug with the scoop and e cooler. The ADON stated yould had been contaminated, p.m. an interview was director of nursing (DON).	F 8	12				

Facility ID: 00598

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		AND HUMAN SERVICES			FORM	: 10/22/2020 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245366	B. WING		C 07/22/2020		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 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 PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	dedicated equipme and staff contamina mug from his room The facility policy P Initiation of Isolation directed, "No speci- dishes, cups, glass A facility policy for s requested, but not R1's laboratory CR not provided. Infection Prevention CFR(s): 483.80(a)( §483.80 Infection C The facility must es infection prevention designed to provide comfortable environ development and tr diseases and infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investiga and communicable staff, volunteers, via providing services to arrangement based	<ul> <li>ant, potential for transmission, ation when staff removed R1's</li> <li>Procedure for Isolation:</li> <li>In Precautions undated, al precautions are needed for es, or eating utensils.</li> <li>storing/handling ice was provided.</li> <li>AB result was requested, but</li> <li>In &amp; Control 1)(2)(4)(e)(f)</li> <li>Control stablish and maintain an and control program a safe, sanitary and ment and to help prevent the ransmission of communicable tions.</li> <li>In prevention and control</li> <li>Stablish an infection prevention m (IPCP) that must include, at</li> </ul>	F 81			9/1/20	

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´		CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245366	B. WING _			C 07/22/2020		
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	-	
CHRIS JI	CHRIS JENSEN HEALTH & REHABILITATION CENTER				01 RICE LAKE ROAD ULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 880	procedures for the p but are not limited t (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pro- (iv)When and how i resident; including the (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplo- disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in of §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens.	tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact.	F 88	30				
	transport linens so a infection.	as to prevent the spread of						

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		AND HUMAN SERVICES			F	ORM A	10/22/2020 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		.E CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED		
		245366	B. WING	;		C 07/22/2020		
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	0172	2/2020	
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 880	Continued From pa	ge 8	F	880				
	IPCP and update the This REQUIREMENT by: Based on observation review, the facility for bathroom was constant a resident who was Carbapenem-resist (CRAB) infection for reviewed for transminad addition, the facility housekeeping serve Cedar nursing unit of multi-drug resistant addition, the facility appropriate transmination of 1 residents (R1), resistant staphylocol infection. In addition appropriately wear (PPE) when in closs R9) who wer placed precautions (use of situations in which of fluids is anticipated potential to affect and the Cedar nursing ut Findings include: According to the Mit (MDH) website https://www.health.sex.html undated, "C	duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to ensure a shared sistently cleaned when used by identified to have a ant Acinetobacter baumannii r 3 of 4 residents (R2, R3, R4) hission based precautions. In failed to ensure routine ices were provided on the to prevent the potential spread ant organisms (MDROs). In failed to implement ission based precautions for 1 who had a methicillin boccus aureus (MRSA) in, the facility failed to personal protective equipment e contact with 2 residents (R8, d on enhanced barrier i gowns and gloves beyond exposure to blood and body ). These practices had the II 37 residents who resided on			R2 no longer resides in the facility. No negative affect has occurred related to this deficient practice. Residents #3, # #8 ,and #9 did not sustain any negative affect related to this deficient practice. Residents sharing a bathroom with a resident infected with Carbepenem resistant Acinetobacter baumannii (CF could be affected by this deficient practice. Residents residing on the Co unit have the potential to be affected by this deficient practice. Resident #1 has been moved to a prive room with a private bathroom. Resident #10 has discharges plans, however, he does not utilize the bathroom at this time. Resident #9 MRSA is colonized and me longer in isolation related to the MRSA remains in enhanced precautions related to risk of the CRAB infection. Staff have been educated regarding proper use of PPE as well as sanitation via MEDCOM. Housekeeping staff is assigned to the Cedar unit and have received education regarding PPE use and proper sanitation	o #4, ve RAB) cedar by vate vate no A but ated		

Facility ID: 00598

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245366	B. WING _			C 22/2020	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(X5) COMPLETIO DATE	
F 880	especially in soil an human infections o lungs, wounds, and are multidrug-resist difficult to treat." Fu infected with CRAE other patients via th healthcare workers medical equipment care environment. prevention and com preventing CRAB th facilities." R2's Medical Diagn indicated R2's diag obstruction, trauma bypass. R2's quarterly Minin 5/22/20, identified F cognition. R2's ME extensive assistant supervision with loc (surgical opening in to leave the body), bladder. R2's care plan date bowel and bladder and urinary retention offering toileting up bedtime, and as ne indicated R2 indepen non-compliant with attached to ostomy ask for assistance also identified he w	age 9 ad water. CRAB can cause f the blood, urinary tract, d other body sites. The bacteria tant, making infections very urther, "Patients colonized or 8 can spread the bacteria to be contaminated hands of 5, through contaminated , or a contaminated health Implementing infection trol measures is critical to ransmission in health care hosis list dated 7/23/20, noses included intestinal atic brain injury, and intestinal mum Data Set (MDS) dated R2 had moderately impaired DS further identified he required ce toileting, and he needed comotion. R2 had an ostomy not the abdomen to allow stool and was always continent of ed 6/30/20, indicated R2 had a deficit related to an ostomy, on. Interventions included on arising, between meals, at eeded. The care plan further endently used a urinal, was his ileostomy bag (pouch to collect stool), and "will not from staff." R2's care plan ras placed on enhanced a CRAB infection at his	F 88	Audits of proper PPE use and sar will be conducted 4 times weekly weeks, then monthly for 2 months Audits will be taken to QAPI for fur review and recommendations.	for 4 s.		

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	10/22/2020 APPROVED	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		MB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				COMPLETED		
		245366	B. WING				( 07/2	C 22/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
CHRIS J	CHRIS JENSEN HEALTH & REHABILITATION CENTER				501 RICE LAKE ROAD DULUTH, MN 55811				
(X4) ID		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION	
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)			DATE	
F 880	Continued From pa	ge 10	F٤	380					
	ostomy site.								
		ed 4/6/20, at 4:26 p.m. notified R2 he tested positive							
	R3's diagnoses incl	cord dated 7/23/20, identified uded hemiplegia (paralysis of y), and muscle weakness.							
	BIMS score was 12 impaired cognition. he required extensi	dated 4/7/20, identified R3's which indicated moderately R3's MDS further identified ve assistance toileting, was nt of bladder, and was nent of bowel.							
	deficit with his bowe	d 9/8/17, indicated R3 had a al and bladder. Interventions arising, between meals, at eded.							
		cord dated 7/23/20, indicated uded muscle weakness and et.							
	had severely impair further identified he	dated 7/15/20, identified R4 ed cognition. R4's MDS required supervision toileting, of bowel and bladder.							
	precaution signage R2's door. A white outside of R2's roor contained PPE sup shared with R3 and	a.m. enhanced barrier was observed to be fixated to plastic three drawer bin was n. The white plastic bin plies. R2's bathroom was R4's room. R2 was observed upty urinal was hanging on							

		AND HUMAN SERVICES				F	ORM	10/22/2020 APPROVED	
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		MB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	` ´			(,	COMPLETED		
						С			
		245366	B. WING				07/2	22/2020	
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD					
CHRIS JI	ENSEN HEALTH & RE	EHABILITATION CENTER			DULUTH, MN 55811				
(X4) ID			ID	.,	PROVIDER'S PLAN OF CORRECT			(X5) COMPLETION	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR		E	DATE	
					DEFICIENCY)				
F 880	Continued From pa	ae 11	F 8	000					
1 000	Continued From pa	gen	ГС	000					
		a.m. R2 was observed to							
		elchair to the adjoining his room. R2 carried a urinal							
		amount of urine in it. At 9:09							
	a.m. the toilet in R2	's bathroom was overheard to							
		a.m., R2 exited the bathroom							
	hand.	ith an empty urinal in his							
		a.m. an interview was sing assistant (NA)-F. NA-F							
		and R4 shared a bathroom.							
	NA-F stated R2 did	things by himself, and staff							
		a day" not to independently							
		NA-F stated R2 doesn't sit on ed his ostomy pouch into a							
	graduate, and would	d leave it in the bathroom.							
		opped R2's bathroom several							
		use he "does not listen." NA-F assistance to use the							
		wiped the toilet with bleach							
	prior to R3 using it.								
		l the adjoining bathroom, and NA-F confirmed a risk for							
		n existed as R2 and R4 both							
		the shared bathroom							
	independently and v	without staff knowledge.							
	On 7/22/20, at 10:1	7 a.m. an interview was							
	conducted with NA-	H. NA-H confirmed R3 and							
		om with R2. NA-H stated							
		n was at his ostomy site, and urine was infected. NA-H							
	stated R2 liked to e	mpty his ostomy pouch in the							
		, and dumped his urine in the							
		n the bathroom sink. NA-H							
		ith his ostomy site, and had							

Facility ID: 00598

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		AND HUMAN SERVICES				FORM	10/22/2020 APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED	
		245366	B. WING				C 22/2020
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
CHRIS JI	ENSEN HEALTH & RE	EHABILITATION CENTER			501 RICE LAKE ROAD		
					OULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	Continued From pa	ige 12	F 8	80			
	red spots to the are	ea. NA-H confirmed R4					
		A-H stated R4's cognition was ut "a lot of times he is not					
		H stated there was risk for					
		n from "time-to-time" as R2					
		pendently use the adjoining tated R4 would notify staff if					
		ess" in the bathroom.					
On 7/22/20, at 10:48 a.m. an interview was conducted with licensed practical nurse (LPN)-A.							
	with R2. LPN-A sta	3 and R4 shared a bathroom ated R2 had a CRAB infection					
		and was unsure if the infection PN-A confirmed R2 emptied					
	his ostomy pouch ir	ndependently. LPN-A stated					
		nd used the bathroom N-A stated she was unsure if					
	nursing staff cleane	ed the bathrooms. LPN-A					
		is risk for cross contamination n they used the bathroom					
	shared with R2.	i iley used ile balliooni					
	0= 7/04/00 =+ 40.5	Constant Defense all and a second					
		5 p.m. R4 was observed vheelchair from his room,					
	towards the Cedar						
		1 a.m. an interview was					
		assistant director of nursing N confirmed R2 played with					
		The ADON stated R2 was					
		, but he continued. The ADON					
	adjoining bathroom	know if R3 or R4 used the shared with R2.					
	On 7/22/20. at 1:57	′ p.m. an interview was					
	conducted with the	director of nursing (DON).					
		ne believed commodes were dents who had a CRAB					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		DENTITION TONIBER.	A. BUILDII	NG _			C
		245366	B. WING			07/:	22/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	infection and shared non-infected reside cross contamination a CRAB infection us residents who were stated she was una who had a CRAB in those who were not she did not work at was given recomme outbreak at the faci beds existed at the survey. On 7/22/20, at 2:32 conducted with the administrator. The infections were ider , 2020. The admini resident who had si infection while hosp stated it was unable residents were infec stated recommenda private rooms to resi infection. The exect recommendations a commode to reside infection and shared who did not. The exect shared bathroom w after a commode w R1's Admission Rec R1's diagnoses incl inflammatory reaction	d a bathroom with ents. The DON stated a risk for n existed if residents who had sed a shared a bathroom, with a not infected. The DON able to speak to why residents infection shared bathrooms with t infected. The DON stated the facility when the facility endations related to the CRAB ility. The DON stated open facility at the time of the P.m. an interview was executive director and administrator stated CRAB ntified at the facility in February istrator stated they believed a ince died, acquired the bitalized. The administrator e to be determined how other cted. The executive director ations included providing sidents who had a CRAB cutive director stated also included providing a ents who had the CRAB d a bathroom with a resident executive director stated a /as supposed to be cleaned /as supposed to be cleaned /as emptied.	F 8	80			

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
			A. BUILDI	ING	i	с	
		245366	B. WING			07/2	22/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	R1's quarterly MDS required extensive a transfers, locomotic further identified he and was frequently R1's care plan date history of MRSA in I resistive organism ( to enhanced barrier and gloves beyond to blood and body fl infection. R10's Admission Re R10's Admission Re R10's diagnoses in communication defi of legs and lower bo R10's quarterly MD required extensive a always incontinent of incontinent of bowe Facility infection sur dated 7/20, indicate infected with CRAB On 7/21/20, at 12:1 (LPN)-A was inform room, located on th contaminated. LPN not assigned to the 7/21/20. On 7/22/20, at 9:37 conducted with NA- staff was "picky" an	<ul> <li>dated 5/25/20, identified R1</li> <li>assistance with bed mobility, on, and toilet use. R1's MDS</li> <li>had an indwelling catheter, incontinent of bowel.</li> <li>ad 1/8/20, indicated R1 had a his urine, and a carbapenem (CRAB). Staff were to adhere r precautions (use of gowns situations in which exposure luids is anticipated) to prevent</li> <li>ecord dated 7/23/20, indicated cluded cognitive icit, and paraplegia (paralysis ody).</li> <li>S dated 7/3/20, identified he assistance toileting, was of bladder, and frequently el.</li> <li>rveillance documentation ed R1, R2, and R10 were</li> </ul>	F 8	80			

If continuation sheet Page 15 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245366	B. WING			C 07/22/2020	
NAME OF F	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CHRIS JI	ENSEN HEALTH & RE	HABILITATION CENTER			2501 RICE LAKE ROAD		
				0	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	did not want to com stated some house resident rooms to s NA-F stated some h confused, and she trained. On 7/22/20, at 10:1 conducted with NA- housekeeping staff were supposed to o she emptied garbag housekeeping staff all the time. On 7/22/20, at 10:3 conducted with hou she did not know if assigned to the Ceo primary Cedar hous everyone cleaned re some staff only clea stated she was train when cleaning a roo CRAB. On 7/22/20, at 10:4 conducted with LPN who had a CRAB in Cedar unit with the would be provided. staff being assigned "hit-and-miss" wher was not scheduled. On 7/22/20, at 11:3 conducted with the was not aware of an	<ul> <li>a to the Cedar unit. NA-F</li> <li>keeping staff did not go in</li> <li>weep, mop, or clean toilets.</li> <li>housekeeping staff looked</li> <li>believed they were not well</li> <li>7 a.m. an interview was</li> <li>H. NA-H stated</li> <li>went into resident rooms, and</li> <li>clean bathrooms. NA-H stated</li> <li>ges on the unit because</li> <li>was unable to be everywhere</li> <li>3 a.m. an interview was</li> <li>sekeeper (H)-A. H-A stated</li> <li>a housekeeper was always</li> <li>dar unit. H-A stated the</li> <li>sekeeper was on vacation, and</li> <li>ooms differently. H-A stated</li> <li>aned bathrooms. HSK-A</li> <li>hed to "just protect myself"</li> <li>om with a resident who had</li> <li>8 a.m. an interview was</li> <li>N-A. LPN-A stated residents</li> <li>affection were moved to the</li> <li>promise daily housekeeping</li> <li>LPN-A stated housekeeping</li> <li>d to the Cedar unit was</li> <li>he primary housekeeper</li> </ul>	F 8	380			
	was not scheduled. On 7/22/20, at 11:3 conducted with the was not aware of an	1 a.m. an interview was ADON. The ADON stated she					

Facility ID: 00598

If continuation sheet Page 16 of 23

CENTERS FOR MEDICARE & MEDICALD SERVICES     OMB NO. 0938-032       STATEMENT OF DEFICIENCIES     [X1] PROVIDER UPPLIER       AND FLAN OF CORRECTION     [X1] PROVIDER OR SUPPLIER       INAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE. 2P CODE       CHRIS JENSEN HEALTH & REHABILITATION CENTER     D       [X4] ID     SUMMARY STATEMENT OF DEFICIENCIES       [Y4] ID     SUMMARY STATEMENT OF DEFICIENCIES       [Y5] 800     Continued From page 16 <t< th=""><th></th><th></th><th>AND HUMAN SERVICES</th><th></th><th></th><th></th><th>FORM</th><th>APPROVED</th></t<>			AND HUMAN SERVICES				FORM	APPROVED	
Image: Continued From page 16     F 880       expressed concern about housekeeping availability.     F 880       Contructed from page 16     F 880       expressed concern about housekeeping availability.     F 880       Contructed from page 16     F 880       expressed concern about housekeeping availability.     F 880       Contructed with the environmental services director. ESD-A stated a staff person was assigned to the Cedar unit. But not coder was assigned to the Cedar unit. But not coder with services not be coder unit. But not coder with services not be coder unit. But not be cedar unit. But not coder was assigned to Cedar unit. ESD-A stated "this devastated when a tousekeeping and "do what they can" on the Cedar unit. ESD-A stated mult. ESD-A stated mult. ESD-A stated mult. ESD-A stated mult. ESD-A stated housekeeping and "do what they can" on the Cedar unit. ESD-A stated housekeeping and "do what they can" on the Cedar unit. ESD-A stated mult. ESD-A stated mult. ESD-A stated mult. ESD-A stated mult be to hinfections that were on else.     Con 7/22/20, at 1:57 p.m. an interview was conducted with the DON. The DON stated she had torouble with a conversations with ESD-A so show to the Cedar unit. ESD-A stated mult. ESD-A stated mult. ESD-A stated mult. ESD-A stated mult. ESD-A so show the Cedar unit. ESD-A so show the Cedar unit. ESD-A so show the fourther was conducted with the DON. The DON stated she had torouble to baskeepers had concerns thousekeeping was not stated she was torout housekeepers had concerns thousekeeping was not show that the SD-A so show the fourther was show to the Cedar unit. ESD-A stated this devastated when there was show to the cedar unit. ESD-A so show the cedar unit. ESD-A so show the the Cedar unit. The DON stated she would have liked to have had conversitoms with ESD	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
245366         B. WING         07/22/2020           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2501 RICE LAKE ROAD         2501 RICE LAKE ROAD         DULUTH, MN 55811         STREET ADDRESS, CITY, STATE, ZIP CODE         2501 RICE LAKE ROAD         DULUTH, MN 55811         STREET ADDRESS, CITY, STATE, ZIP CODE         2501 RICE LAKE ROAD         DULUTH, MN 55811         PROVIDERS PLAN OF CORRECTION         (%) [D]	AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING				
CHRIS JENSEN HEALTH & REHABILITATION CENTER     2501 RICE LAKE ROAD DULUTH, MN 55811       (24) ID TRA     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)     IP PREV     PROVIDENS PLAN OF CORRECTION (EACH OWNERT ACTION PHOLID BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY)     Continued From page 16 expressed concern about housekeeping availability.     F 880     F 880       On 7/22/20, at 12:52 p.m. an interview was conducted with the environmental services director (ESD)-A. ESD-A stated a staff person was assigned to the Cedar unit, but was on vacation. ESD-A stated public areas and bathrooms were cleaned. ESD-A stated she had trouble with a housekeeper was not scheduled on Cedar unit. other housekeeping staff were expected to clean their primary wing and "do what they can" on the Cedar unit. ESD-A stated neisidents, families, and other staff did not have complaints. ESD-A stated fulls cedar unit, she assigned someone else.       On 7/22/20, at 1:57 p.m. an interview was conducted with the DON. The DON stated she had on concerns cleaning the Cedar unit. ESD-A stated full to be had concerns if housekeeping was not on the Cedar unit. The DON stated she had concerns if housekeeping was not on the Cedar unit. The DON stated she had had no concerns cleaning the Cedar unit, she assigned someone else.       On 7/22/20, at 1:57 p.m. an interview was conducted with the DON. The DON stated she had concerns if housekeeping was not on the Cedar unit. The DON stated she would have liked to have head conversations with ESD-A stated when staff declined to be assigned to the Cedar unit. The DON stated she would have liked to have head conversations with ESD-A stated she would have liked to have head conversations with ESD-A stated housekeeping was not on the Cedar unit. The DON stated s			245366	B. WING					
DULUTH, MN 55811       DULUTH, MN 55811       PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)     PUE PREFX TAG     PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PUE PREFX TAG     PREFX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PUE PREFX TAG     PREFX (EACH CORRECTION CONFERENCE ACTION MOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     CONFULTION DATE       F 880     Continued From page 16 expressed concern about housekeeping availability.     F 880     F 880     F 880       On 7/22/20, at 12:52 p.m. an interview was conducted with the environmental services director (ESD)-A. ESD-A stated she had trouble with a housekeeper who worked on the Cedar unit, as they hurt their wrist, were on light duty, and later quit. ESD-A stated this devastated us a lot." ESD-A stated housekeeping staff were expected to clean their primary wing and "do what they can" on the Cedar unit. ESD-A stated residents, families, and other staff did not have complaints. ESD-A stated when staff declined to be assigned to the Cedar unit, she assigned someone else.       On 7/22/20, at 1:57 p.m. an interview was conducted with the DON. The DON stated she had concerns cleaning the Cedar unit due to infections that were on the hurt. ESD-A stated residents to basigned to the Cedar unit, she assigned someone else.       On 7/22/20, at 1:57 p.m. an interview was conducted with the DON. The DON stated she had concerns if housekeeping was not on the Cedar unit. The DON stated she had concerns if housekeeping was not on the Cedar unit. The DON stated she idd not know if additional cleaning was being completed on the <td>NAME OF F</td> <td>ROVIDER OR SUPPLIER</td> <td></td> <td></td> <td></td> <td>, , ,</td> <td></td> <td></td>	NAME OF F	ROVIDER OR SUPPLIER				, , ,			
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         F 880       Continued From page 16 expressed concern about housekeeping availability.       F 880       F 880         On 7/22/20, at 12:52 p.m. an interview was conducted with the environmental services director (ESD)-A. ESD-A stated a staff person was assigned to the Cedar unit, but was on vacation. ESD-A stated public areas and bathrooms were cleaned. ESD-A stated she had trouble with a housekeeper who worked on the Cedar unit, as they hurt their wrist, were on light duty, and later quit. ESD-A stated she had trouble do Cedar unit, other housekeeping staff were expected to clean their primary wing and "do what they can" on the Cedar unit. ESD-A stated residents, families, and other staff did not have complaints. ESD-A stated housekeepers had no concerns cleaning the Cedar unit due to infections that were on the unit. ESD-A stated when staff declined to be assigned to the Cedar unit, she assigned someone else.       On 7/22/20, at 1:57 p.m. an interview was conducted with the DON. The DON stated she had concerns if housekeeping was not on the Cedar unit. The DON stated she would have liked to have had conversions with ESD-A so she knew when there was short staffing on the Cedar unit. The DON stated she did not know if additional cleaning was being completed on the	CHRIS JE	ENSEN HEALTH & RE	HABILITATION CENTER						
expressed concern about housekeeping availability. On 7/22/20, at 12:52 p.m. an interview was conducted with the environmental services director (ESD)-A. ESD-A stated a staff person was assigned to the Cedar unit, but was on vacation. ESD-A stated public areas and bathrooms were cleaned. ESD-A stated she had trouble with a housekeeper who worked on the Cedar unit, as they hurt their wrist, were on light duty, and later quit. ESD-A stated "this devastated us a lot." ESD-A stated when a housekeeper was not scheduled on Cedar unit, other housekeeping staff were expected to clean their primary wing and "do what they can" on the Cedar unit. ESD-A stated residents, families, and other staff did not have complaints. ESD-A stated housekeepers had no concerns cleaning the Cedar unit due to infections that were on the unit. ESD-A stated when staff declined to be assigned to the Cedar unit, she assigned someone else. On 7/22/20, at 1:57 p.m. an interview was conducted with the DON. The DON stated she had concerns if housekeeping was not on the Cedar unit. The DON stated she would have liked to have had conversations with ESD-A so she knew when there was short staffing on the Cedar unit. The DON stated she did not know if additional cleaning was being completed on the	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION	
On 7/22/20, at 2:32 p.m. an interview was conducted with the executive director and administrator. The executive director stated a housekeeper assigned to the Cedar unit was on leave and was no longer employed at the facility.		expressed concern availability. On 7/22/20, at 12:5 conducted with the director (ESD)-A. E was assigned to the vacation. ESD-A st bathrooms were cle trouble with a house Cedar unit, as they duty, and later quit. us a lot." ESD-A st not scheduled on C staff were expected and "do what they c stated residents, fai have complaints. Es had no concerns cle infections that were when staff declined unit, she assigned s On 7/22/20, at 1:57 conducted with the had concerns if hou Cedar unit. The DC liked to have had co she knew when the Cedar unit. The DC additional cleaning Cedar unit.	about housekeeping 2 p.m. an interview was environmental services ESD-A stated a staff person a Cedar unit, but was on ated public areas and eaned. ESD-A stated she had ekeeper who worked on the hurt their wrist, were on light ESD-A stated "this devastated ated when a housekeeper was edar unit, other housekeeping to clean their primary wing can" on the Cedar unit. ESD-A milies, and other staff did not SD-A stated housekeepers eaning the Cedar unit due to on the unit. ESD-A stated to be assigned to the Cedar someone else. p.m. an interview was DON. The DON stated she usekeeping was not on the DN stated she would have onversations with ESD-A so re was short staffing on the DN stated she did not know if was being completed on the p.m. an interview was executive director and executive director stated a ned to the Cedar unit was on	F8	80	DEFICIENCY)			

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		AND HUMAN SERVICES					FORM	10/22/2020 APPROVED
	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	0	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				COMPLETED	
		245366	B. WING				( 07/2	C 22/2020
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE	•	
CHRIS	ENSEN HEALTH & RE	HABILITATION CENTER			501 RICE LAKE ROAD			
		TEMENT OF DEFICIENCIES	10	U	DULUTH, MN 55811 PROVIDER'S PLAN OF		1	
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI		(EACH CORRECTIVE AC	TION SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO DEFICIEN		KIATE	BATE
<b>-</b> 000								
F 880	•••••••	-	F 8	80				
	a lot when open shi	its were identified.						
		fection Prevention and						
		ated 11/16, directed, "A hat prevents, identified,						
	reports, investigate	s, and controls infections and						
		ase for all residents, staff, and other individuals						
	providing services u	under a contractual						
	arrangement and for standards."	bllowing accepted national						
	R8's Face Sheet pr diagnoses included	inted 7/23/20, indicated R8's pneumonia.						
	had impaired cogni staff for ambulation	dated 6/8/20, indicated R8 tion, and was dependent on , and required minimal with all activities of daily living						
		dated 7/17/20, indicated R8 ospital, and was to remain on						
		ne for 14 days, until 7/31/20.						
	to have a clear bin included PPE, signa precaution,s and a	a.m. R8's room was observed outside of the room which age for enhanced barrier red stop sign directing a 14 to be in effect until 7/31/20.						
	observation NA-A w room with her face shield resting on he standing next to R8 NA-A proceeded to exit room. NA-A wa	a.m. during continuous vas observed entering R8's mask in place, and her eye er chest. NA-A was observed 's wheelchair, and talking. clean off R8's tray table and as observed using alcohol BHR) after placing R8's food						

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	10/22/2020 APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	;		COMPLETED	
		245366	B. WING					C 22/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD	BE	(X5) COMPLETION DATE
F 880	tray on the cart. NA her chest throughou On 7/21/20, at 9:42 entered R8's room, next to R8 without the observation, NA-AA room with her face shield still resting of standing next to R8 proceeded go to R8 of latex gloves and then used ABHR ar face shield remained observation. On 7/22/20, at 11:3 (RN)-A stated staff shields while provid admission were qua staff had been instr direct contact which shield/protection, an stated it was import precautions in orde to staff and other ref On 7/22/20, at 1:56 were to wear the ap cares for residents. be wearing at a mir shield protection wit times. The DON in PPE could increase spreading COVID-1	A-A's face shield remained on ut the observation. a.m. NA-A verified she had and had been standing right he face shield in place. a.m. during continuous was observed entering R8's mask in place, and her eye n her chest. NA-A was 's wheelchair. NA-A 3's bathroom, gathered a pair handed them to R8. NA-A d exited R8's room. NA-A's ed on her chest throughout the 1 a.m. registered nurse were to be wearing eye ling cares. RN-A stated all new arantined for 14 days, and ucted to don full PPE when in n included gown, eye nd face mask. RN-A further the face for the follow contact r to prevent spread of infection	Fε	380				

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245366	B. WING			C 07/22/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		2	2501 RICE LAKE ROAD		
				0	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	<ul> <li>while in the facility t non-COVID-19 resi</li> <li>R9's Face Sheet pr diagnoses included sepsis.</li> <li>R9's quarterly Minir 6/8/20, indicated R<sup>2</sup> cognition, and requi activities of daily liv</li> <li>R9's care plan initia a bowel and bladde catheter, and requi and catheter care.</li> <li>R9's physician order facility to implement place R8 in isolation screening was obtained discontinue contact positive, continue contact positive, contin</li></ul>	wearing full PPE for all cares o include eye protection for dents. inted 7/23/20, indicated R10's history of pneumonia and num Data Set (MDS) dated 10 had severe impaired ired assistance with all	F 8	\$80			
	stated NA-A had to	d her she needed to go get a equired catheter care. NA-E					

Facility ID: 00598

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPENDIX CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09			
	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	COMPLETED		
245366         B. WING         07/22/2           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE	2020		
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         2501 RICE LAKE ROAD			
CHRIS JENSEN HEALTH & REHABILITATION CENTER DULUTH, MN 55811			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)		
PRÉFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX CROSS-REFERENCED TO THE APPROPRIATECOCOTAGCROSS-REFERENCED TO THE APPROPRIATE	DMPLETION DATE		
DEFICIENCY)			
F 880 Continued From page 20 F 880			
stated isolation precaution was not indicated for			
R9 on the daily care sheets, nor was there signage to notify staff of the precautions. NA-E			
further stated she had no idea isolation			
precautions were required for R9.			
At 10:37 a.m. NA-D was observed entering R9's room wearing only her face mask and eye			
shield/protection. NA-D immediately exited the			
room, and stated NA-A and NA-E told her she			
should have had complete PPE in place when			
providing cares for R9. NA-D stated there would			
have been no way of knowing she was required to wear an isolation gown prior to entering R9's			
room, since there had not been a sign in place,			
nor was a PPE bin outside R9's door.			
On 7/21/20, at 10:46 a.m. LPN-A stated the			
facility implemented information sheets and signs			
on resident's doors, PPE bins, and			
communication group sheets to let staff know			
when enhanced precautions or contact precautions were required for specific residents.			
LPN-A stated she had received a call from			
hospice on 7/20/20, around 2:30 p.m. stating R9			
required contact and enhanced precautions,			
related to his diagnosis of MRSA in his urine.			
LPN-A verified R9's room lacked both signage and a PPE bin, both of which would have			
indicated to staff contact precautions or enhanced			
barrier precautions were required prior to entering			
R9's room. LPN-A stated staff would not have			
known he required additional precautions.			
On 7/21/20, at 3:59 p.m. the outside hospice			
agency staff was interviewed and verified a			
hospice nurse had called the facility on 7/20/20,			
with concerns that R9 was not on full precautions as ordered. The hospice supervisor also stated			

Facility ID: 00598

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		AND HUMAN SERVICES				FORM	10/22/2020 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMPLETED	
		245366	B. WING				C 22/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS JI	ENSEN HEALTH & RE	HABILITATION CENTER			501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 880	Continued From pa	ne 21	F 8	80			
	•	precautions prior to his		00			
		om the Spruce Unit to the					
		1 a.m. registered nurse					
		were made made aware of the re isolation or precautions					
residents that require isolation or precautions through the use of signage on doors, PPE bins		signage on doors, PPE bins					
		ooms, and group care sheets. roviding cares for R9 due to					
	his diagnosis of MR	SA, should have been					
		on precaution measures to ansmission of infection. RN-A					
	stated R9 was trans	sferred from Spruce unit to					
		20, and contact precautions we when he transferred. RN-A					
		be the risk of and spread of					
		signage, no PPE bin, and on group sheets. RN-A stated					
		licensed nurse should have to ensure accuracy when					
		fer occurred on 7/14/20.					
	On 7/22/20, at 1:56	p.m. during interview the					
		quired full precautions related SA in urine. The DON stated					
	failure to implement	t precautions when R9					
		r unit on 7/14/20, increased g infection. The DON stated					
	due to lack of signa	ge, no PPE bin, nor was this					
		s, staff would not have known ons. The DON stated failure to					
	implement precauti	ons had the potential for					
	spreading MRSA to	residents.					
		olation Precautions undated,					
	infections within the	to prevent the transmission of a facility through the use of					
	Isolation Precaution	ns. In addition to Standard					

If continuation sheet Page 22 of 23

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245366	B. WING		C 07/22/2020	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS JENSEN HEALTH & RE	EHABILITATION CENTER		2501 RICE LAKE ROAD		
			DULUTH, MN 55811		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
residents known or microorganisms tha direct or indirect co	age 22 Contact Precautions for 's uspected to be infected with at can be easily transmitted by ontact, such as handling aces or resident-care items.	F 8			

Facility ID: 00598



Protecting, Maintaining and Improving the Health of All Minnesotans

#### DIRECTED PLAN OF CORRECTION

# A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

#### PERSONAL PROTECTIVE EQUIPMENT (PPE)

• 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.

#### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE for TBD and during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

#### TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

• The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection

Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.

• Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

#### CDC RESOURCES:

Infection Control Guidance: <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</u> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Page 2

Settings (2007): <u>https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</u> CDC: Personal Protective Equipment: <u>https://www.cdc.gov/niosh/ppe/</u> Healthcare Infection Prevention and Control FAQs for COVID-19: <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cd</u> <u>c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html</u>

## MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

<u>https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html</u> MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

<u>https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html</u> Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

## MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

## ENVIRONMENT

• 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.

#### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention

or corrective action plan to prevent recurrence.

• The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

## TRAINING/EDUCATION:

• The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training. Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic\_in\_HCF\_03.pdf
- MDH COVID-19 Toolkit. <u>https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf</u>
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

## CDC RESOURCES:

Infection Control Guidance: <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</u> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <u>https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</u>

CDC: Personal Protective Equipment: <u>https://www.cdc.gov/niosh/ppe/</u>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

# MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): <u>https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf</u>

Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

#### <u>https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html</u> Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

#### MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

#### COHORTING RESIDENTS/TRANSMISSION BASED PRECAUTION "ISOLATION"

- 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.

#### POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

- Grouping of residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

When a resident is placed on transmission-based precautions, the staff should implement the following:

- Clearly identify the type of precautions and the appropriate PPE to be used.
- Place signage in a conspicuous place outside the resident's room (e.g., the door or on the wall next to the door) identifying the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complies with residents' rights to confidentiality and privacy.
- Make PPE readily available near the entrance to the resident's room.
- Don appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on

- Use disposable or dedicated noncritical resident-care equipment (e.g., blood pressure cuff, bedside commode). If noncritical equipment is shared between residents, it will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use.
- Clean and disinfect objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms).

# TRAINING/EDUCATION:

- Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.
- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. <u>https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</u>
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. <u>https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf</u>
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. <u>https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf</u>

## CDC RESOURCES:

Infection Control Guidance: <u>https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html</u> CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <u>https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html</u>

CDC: Personal Protective Equipment: <u>https://www.cdc.gov/niosh/ppe/</u>

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\_AA\_refVal=https%3A%2F%2Fwww.cd c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care

Settings (PDF): <u>https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf</u>

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Interim Guidance on Alternative Facemasks (PDF):

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Droplet Precautions:

<u>https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html</u> Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

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#### MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.

• Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforR CA.pdf

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required
	for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Attach all items into ePOC.

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 12, 2020

Administrator Chris Jensen Health & Rehabilitation Center 2501 Rice Lake Road Duluth, MN 55811

Re: State Nursing Home Licensing Orders Event ID: TFUX11

Dear Administrator:

The above facility was surveyed on July 20, 2020 through July 22, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Chris Jensen Health & Rehabilitation Center August 12, 2020 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth					AT TROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00598		B. WING		07/2	C 22/2020
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2 000	Initial Comments			2 000			
	****ATTEI	NTION*****					
	NH LICENSING	CORRECTION OR	DER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wit corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	ction order has bee y. If, upon reinspec- iency or deficiencie ected, a fine for eac- be assessed in acc- înes promulgated b artment of Health. The ther a violation ha compliance with all rule provided at tha ile number indicate ns several items, fa the items will be co- Lack of compliance ny item of multi-par ment of a fine even	n issued ction, it is s cited h violation ordance by rule of as been e tag d below. ilure to nsidered ce upon t rule will i f the item				
	You may request a that may result from orders provided tha the Department with notice of assessme	n non-compliance w t a written request i hin 15 days of recei	vith these is made to ipt of a				
	INITIAL COMMENT On 7/20/20, through survey was comple complaint investiga to be not in complia Requirements for L	n 7/22/20, an abbre ted at your facility to tions. Your facility w unce with 42 CFR P	o conduct /as found art 483,				
	The following comp	laints were found to	o be				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 08/14/20

Electronically Signed

STATE FORM

TFUX11

If continuation sheet 1 of 21

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED
		00598	B. WING		07/22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
CHRIS J	ENSEN HEALTH & RE	ΗΔΒΙΙ ΙΤΔΤΙΟΝ C	E LAKE RO , MN 55811	AD	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
2 000	Continued From pa	ge 1	2 000		
	substantiated with o H5366146C H5366147C H5366148C H5366149C H5366150C	correction orders issued:			
21015	MN Rule 4658.0610 Requirements- Sai	) Subp. 7 Dietary Staff hitary conditi	21015		9/1/20
	Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to handle ice under sanitary conditions, to prevent cross contamination from infectious sources. This practice had the potential to affect all 37 who resided on the Cedar unit at the facility.			Acknowledge receipt	
	Findings include:				
	(MDH) website https://www.health.s ex.html undated, "C Acinetobacter baun bacteria commonly especially in soil an human infections of lungs, wounds, and	nnesota Department of Health state.mn.us/diseases/crab/ind Carbapenem-resistant nannii (CRAB) is a type of found in the environment, d water. CRAB can cause f the blood, urinary tract, other body sites. The bacteria ant, making infections very			

If continuation sheet 2 of 21

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00598	B. WING			C 22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21015	Continued From pa	ge 2	21015			
	R1's Admission Record dated 7/23/20, indicated R1's diagnoses included infection and inflammatory reaction, and methicillin resistant staphylococcus aureus (a multi-drug resistant organism).					
	5/25/20, identified F assistance with bec locomotion, and toil	num Data Set (MDS) dated R1 required extensive I mobility, transfers, let use. R1's MDS further indwelling catheter and was ent of bowel.				
	chronic indwelling F	ed 1/27/16, indicated R1 had a Foley catheter related to perplasia (prostate gland				
	history of MRSA in resistive organism.' enhanced barrier p gloves beyond situa	ed 1/8/20, indicated R1 had a his urine and a "carbapenem " Staff were to adhere to recautions (use of gowns and ations in which exposure to ds is anticipated) to prevent				
		ted 3/20/20, at 5:03 p.m. / was notified R1 had tested				
		cord dated 7/23/20, indicated luded Alzheimer's disease.				
		nge MDS dated 6/15/20, everely impaired cognition and n eating.				
	precaution sign was	a.m., an enhanced barrier s noted to be posted on R1's white plastic three drawer bin				

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
						С
		00598	B. WING			22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	ENSEN HEALTH & RE	ELABLITATION C 2501 RICE	E LAKE ROAI	D		
		DULUTH,	MN 55811			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
				DEFICIENC	Y)	
21015	Continued From pa	ige 3	21015			
	was noted outside	of P1's room, which contained				
	was noted, outside of R1's room, which contained personal protective equipment (PPE) supplies.					
		equipment (i i L) supplies.				
	On 7/21/20, at 9:42	a.m., an interview was				
	conducted with nursing assistant (NA)-F. NA-F					
		arrier precautions were used				
	for R1 because he	was diagnosed with CRAB.				
	On $7/21/20$ at $11.1$	9 a.m., R1's call light was				
		rsing assistant (NA)-E walked				
		, and put on an isolation gown				
		entered R1's room, and R1				
	asked for water.					
	On 7/21/20, at 11:29 a.m. NA-E exited R1's room with a large plastic mug which was partially filled					
		eld the large plastic mug				
		iniform shirt by using both of				
		ing motion). NA-E walked				
		nd entered R24 and R36's				
		on who was inside R24 and				
		NA-E about the mug. The				
		another cup needed to be				
		NA-E exited R24 and R36's				
		owards the Cedar nurses'				
		ned a door near the Cedar				
		ch indicated Staff Only. NA-E nd removed the lid from the				
		I water from the mug into the				
	<b>.</b> .	bened a white ice cooler which				
		rt. NA-E obtained a scoop				
		ide of the cooler, and				
		n the cooler to the mug. NA-E				
		iside the mug, and the scoop				
		t with the inner surface of the				
		ed the scoop from the mug,				
		n additional ice from the				
		n placed the scoop on the and made contact with the				
		E closed the cooler lid and				
nacata D	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00598	B. WING			22/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
HRIS J	ENSEN HEALTH & RE	HARII ITATION C	E LAKE ROAD	)		
		DULUTH	, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	ge 4	21015			
	cooler. NA-E used with water, and replexited the Staff Onl R1's room. NA-E p white plastic three of room. NA-E was in confirmed the mug removed the mug fir requested it to be replaced on enhance CRAB infection. Na where the source of On 7/21/20, at 11:3 NA-E and stated sh NA-F put on gloves entered R1's room On 7/21/20, at 12:0 carrying an empty of paper wrapper. NA- near the Cedar nurs white cooler and us from the cooler to the cooler, placed the st and used the fauce NA-G exited the Stat the Cedar dining ro NA-G removed the placed the straw in towards R7, with th asked to stop by the she intended to hell told the ice was cor removed from R1's	a holder on the side of the the sink faucet to fill the mug laced the plastic lid. NA-E y room and walked towards blaced the mug on top of the drawer bin outside of R1's neterviewed at that time and belonged to R1, and she rom R1's room when he efilled. NA-E stated R1 was d barrier precautions due to a A-E stated she was unsure f the resident's infection was. 1 a.m. NA-F approached he would bring the mug to R1. and an isolation gown, and with the mug. 8 p.m. NA-G was observed cup and straw which was in a -G entered the Staff Only room ses' station. NA-G opened the sed a scoop to transfer ice he cup. NA-G then closed the scoop in a holder located on, t to fill the cup with water. aff Only room and walked to om and approached R7. straw from the wrapper and the cup. NA-G leaned e cup of water, and NA-G was e surveyor. NA-G confirmed p R7 drink water. NA-G was ntaminated from a source room. NA-G stated the cooler peremoved right away.				
	On 7/21/20, at 12:1	0 p.m. an interview was nsed practical nurse (LPN)-A.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	- (X3) DATE SURVEY COMPLETED C 07/22/2020	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00598	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S		•	
		2501 RIC				
HRIS JI	ENSEN HEALTH & R	EHABILITATION C DULUTH	, MN 55811			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLE
				DEFICIENC	CY)	
21015	Continued From pa	age 5	21015			
	LPN-A stated R1 h	ad CRAB in his urine. LPN-A				
		as going to change the way				
		to residents. LPN-A was the white cooler towards the				
	unit elevator on a v					
		31 a.m. an interview was				
		assistant director of nursing N stated staff contaminated				
		loving a mug from R1's room				
		nst their scrubs. The ADON				
		vas contaminated when staff				
		plastic mug with the scoop and				
		e cooler. The ADON stated would had been contaminated,				
	as well.					
		7				
		7 p.m. an interview was director of nursing (DON).				
		ere was concerns for				
		ent, potential for transmission,				
		ation when staff removed R1's				
	mug from his room	).				
	The facility policy F	Procedure for Isolation:				
	Initiation of Isolatio	n Precautions undated,				
		ial precautions are needed for				
	dishes, cups, glass	ses, or eating utensils.				
	A facility policy for	storing/handling ice was				
	requested, but not					
	R1's Jahoratory CE	AB result was requested, but				
	not provided.	no result was requested, but				
	SUGGESTED MF	THOD OF CORRECTION:				
		rsing, or designee, could				
	review policies, tra	in staff, and monitor to assure				
		ocedures are followed at all				
	times. epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED	
		00598	B. WING		07/22/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
HRIS JE	ENSEN HEALTH & RE	HARILITATION C	E LAKE ROA , MN 55811	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
21015	Continued From pa	ge 6	21015			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	) Subp. 1 Infection Control;	21375		9/1/20	
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.				
	This MN Requireme	This MN Requirement is not met as evidenced by:				
	Based on observation, interview, and document review, the facility failed to ensure a shared bathroom was consistently cleaned when used by a resident who was identified to have a Carbapenem-resistant Acinetobacter baumannii (CRAB) infection for 3 of 4 residents (R2, R3, R4) reviewed for transmission based precautions. In			Acknowledge receipt		
	housekeeping servi Cedar nursing unit of multi-drug resista addition, the facility appropriate transmi	failed to ensure routine ices were provided on the to prevent the potential spread ant organisms (MDROs). In failed to implement ission based precautions for 1 who had a methicillin				
	of 1 residents (R1), who had a methicillin resistant staphylococcus aureus (MRSA) infection. In addition, the facility failed to appropriately wear personal protective equipment (PPE) when in close contact with 2 residents (R8,					
	precautions (use of situations in which of fluids is anticipated	d on enhanced barrier gowns and gloves beyond exposure to blood and body ). These practices had the				
	potential to affect a the Cedar nursing נ	ll 37 residents who resided on unit at the facility.				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	or contraction	IDENTIFICATION NOWIDEN.	A. BUILDING:			
		00598	B. WING			C 22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	ΕΗΔΒΙΙ ΙΤΔΤΙΟΝ C	E LAKE ROAI	D		
		DULUTH	, MN 55811		DECTION	()(5)
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 7	21375			
	Findings include:					
	According to the Minnesota Department of Health (MDH) website https://www.health.state.mn.us/diseases/crab/ind ex.html undated, "Carbapenem-resistant Acinetobacter baumannii (CRAB) is a type of bacteria commonly found in the environment, especially in soil and water. CRAB can cause human infections of the blood, urinary tract, lungs, wounds, and other body sites. The bacteria are multidrug-resistant, making infections very difficult to treat." Further, "Patients colonized or infected with CRAB can spread the bacteria to other patients via the contaminated hands of healthcare workers, through contaminated medical equipment, or a contaminated health care environment. Implementing infection prevention and control measures is critical to preventing CRAB transmission in health care facilities."					
	indicated R2's diag	nosis list dated 7/23/20, noses included intestinal atic brain injury, and intestinal				
	5/22/20, identified I cognition. R2's ME extensive assistant supervision with loc (surgical opening ir	mum Data Set (MDS) dated R2 had moderately impaired DS further identified he required to toileting, and he needed comotion. R2 had an ostomy nto the abdomen to allow stool and was always continent of				
	bowel and bladder	ed 6/30/20, indicated R2 had a deficit related to an ostomy, on. Interventions included				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00598	B. WING		C 07/22/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HRIS J	ENSEN HEALTH & RE	FHABILITATION C	CE LAKE ROAD I, MN 55811	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	ge 8	21375			
	bedtime, and as ne indicated R2 independent non-compliant with attached to ostomy ask for assistance to also identified he w	on arising, between meals, at eded. The care plan further endently used a urinal, was his ileostomy bag (pouch to collect stool), and "will not from staff." R2's care plan as placed on enhanced a CRAB infection at his				
		ted 4/6/20, at 4:26 p.m. / notified R2 he tested positive	•			
	R3's diagnoses incl	cord dated 7/23/20, identified luded hemiplegia (paralysis of y), and muscle weakness.				
	BIMS score was 12 impaired cognition. he required extensi	dated 4/7/20, identified R3's which indicated moderately R3's MDS further identified ve assistance toileting, was ent of bladder, and was inent of bowel.				
	deficit with his bowe	ed 9/8/17, indicated R3 had a el and bladder. Interventions arising, between meals, at eded.				
		cord dated 7/23/20, indicated luded muscle weakness and et.				
	had severely impair further identified he	6 dated 7/15/20, identified R4 red cognition. R4's MDS e required supervision toileting of bowel and bladder.	,			
	On 7/21/20. at 9:05	a.m. enhanced barrier				

	ta Department of He	(X1) provider/supplier/clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		C 07/22/2020	
		00598	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
CHRIS JE	ENSEN HEALTH & RE	FHABILITATION C	CE LAKE ROAI I, MN 55811			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21375	Continued From pa	ige 9	21375		·	
		0				
	precaution signage was observed to be fixated to R2's door. A white plastic three drawer bin was					
		m. The white plastic bin				
		plies. R2's bathroom was				
		, R4's room. R2 was observed				
	lying in bed. An em	npty urinal was hanging on				
	R2's bed rail.					
	0= 7/00/00 =+ 0.00					
		a.m. R2 was observed to elchair to the adjoining				
		n his room. R2 carried a urina				
		amount of urine in it. At 9:09				
		's bathroom was overheard to				
		a.m., R2 exited the bathroom				
		<i>i</i> th an empty urinal in his				
	hand.					
	On 7/22/20 at 0.37	a.m. an interview was				
		sing assistant (NA)-F. NA-F				
		and R4 shared a bathroom.				
		things by himself, and staff				
		a day" not to independently				
		NA-F stated R2 doesn't sit on				
		ed his ostomy pouch into a				
		d leave it in the bathroom.				
		opped R2's bathroom several				
		use he "does not listen." NA-l assistance to use the				
		wiped the toilet with bleach				
	prior to R3 using it.					
		I the adjoining bathroom, and				
		NA-F confirmed a risk for				
		n existed as R2 and R4 both				
		the shared bathroom				
	independently and	without staff knowledge.				
	On 7/22/20 at 10.1	7 a.m. an interview was				
		-H. NA-H confirmed R3 and				
		om with R2. NA-H stated				
		n was at his ostomy site, and				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00598	B. WING		C 07/22/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	FHARILITATION C	E LAKE ROAD MN 55811	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21375	also believed R2's stated R2 liked to e adjoining bathroom toilet independently his coffee cup out i stated R2 played w red spots to the are toileted himself. N/ good sometimes, b really with it." NA-H cross contaminatio and R4 would indep bathroom. NA-H st there "was a big me On 7/22/20, at 10:4 conducted with lice LPN-A confirmed R with R2. LPN-A stat his ostomy site a was in his urine. LI his ostomy pouch in R4 was confused a independently. LPI nursing staff cleane confirmed there was	age 10 urine was infected. NA-H empty his ostomy pouch in the a, and dumped his urine in the b, and dumped his urine in the b. NA-H stated R2 also rinsed in the bathroom sink. NA-H ith his ostomy site, and had ea. NA-H confirmed R4 A-H stated R4's cognition was out "a lot of times he is not H stated there was risk for in from "time-to-time" as R2 pendently use the adjoining tated R4 would notify staff if ess" in the bathroom. 88 a.m. an interview was insed practical nurse (LPN)-A. 83 and R4 shared a bathroom ated R2 had a CRAB infection ind was unsure if the infection PN-A confirmed R2 emptied independently. LPN-A stated and used the bathroom N-A stated she was unsure if ed the bathrooms. LPN-A is risk for cross contamination in they used the bathroom	21375			
		5 p.m. R4 was observed vheelchair from his room, unit elevator.				
	conducted with the (ADON). The ADO his ostomy pouch. provided education	1 a.m. an interview was assistant director of nursing N confirmed R2 played with The ADON stated R2 was , but he continued. The ADON know if R3 or R4 used the shared with R2.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	ENSEN HEALTH & RE	-HABILITATION C	E LAKE ROAE , MN 55811	0			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
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21375	Continued From pa	ige 11	21375				
	conducted with the The DON stated sh being used for resid infection and share non-infected reside cross contaminatio a CRAB infection u residents who were stated she was una who had a CRAB in those who were no she did not work at was given recomm outbreak at the fact beds existed at the survey. On 7/22/20, at 2:32 conducted with the administrator. The infections were idea , 2020. The admin resident who had s infection while hosp stated it was unable residents were infe stated recommend private rooms to re- infection. The exect recommendations a commode to reside infection and share who did not. The exect who did not. The exect state who had share	p.m. an interview was director of nursing (DON). The believed commodes were dents who had a CRAB d a bathroom with tents. The DON stated a risk for n existed if residents who had sed a shared a bathroom, with a not infected. The DON able to speak to why residents offection shared bathrooms with t infected. The DON stated the facility when the facility endations related to the CRAE lity. The DON stated open facility at the time of the the facility at the time of the the facility in February istrator stated they believed a ince died, acquired the bitalized. The administrator to be determined how other cted. The executive director ations included providing sidents who had a CRAB cutive director stated also included providing a ents who had the CRAB d a bathroom with a resident xecutive director stated a ras supposed to be cleaned					
	after a commode w R1's Admission Re R1's diagnoses inc epartment of Health	cord dated 7/23/20, indicated					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00598	B. WING			C 22/2020
	PROVIDER OR SUPPLIER		 DDRESS, CITY, S <sup>-</sup>		0112212020	
		2501 RIC	CE LAKE ROAI			
	ENSEN HEALTH & RI	DULUTH	I, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ige 12	21375			
	inflammatory reaction, and methicillin resistant staphylococcus aureus (MRSA, a multi-drug resistant organism).					
	R1's quarterly MDS dated 5/25/20, identified R1 required extensive assistance with bed mobility, transfers, locomotion, and toilet use. R1's MDS further identified he had an indwelling catheter, and was frequently incontinent of bowel.					
	history of MRSA in resistive organism to enhanced barrie and gloves beyond	ed 1/8/20, indicated R1 had a his urine, and a carbapenem (CRAB). Staff were to adhere r precautions (use of gowns situations in which exposure fluids is anticipated) to prevent				
	R10's diagnoses in	icit, and paraplegia (paralysis				
	required extensive	S dated 7/3/20, identified he assistance toileting, was of bladder, and frequently				
		rveillance documentation ed R1, R2, and R10 were 3.				
	(LPN)-A was inform room, located on th contaminated. LPN	0 p.m. licensed practical nurse ned a sink in the Staff Only ne Cedar nursing unit, was N-A stated a housekeeper was Cedar unit on 7/20/20, or				
	On 7/22/20, at 9:37 epartment of Health	' a.m. an interview was				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00598	B. WING			22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	FHARILITATION C	E LAKE ROAE , 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21375	•	-	21375			
	conducted with NA-F. NA-F stated housekeeping staff was "picky" and chose what floor they wanted to clean. NA-F stated housekeeping staff did not want to come to the Cedar unit. NA-F stated some housekeeping staff did not go in resident rooms to sweep, mop, or clean toilets. NA-F stated some housekeeping staff looked confused, and she believed they were not well trained.					
	conducted with NA housekeeping staff were supposed to o she emptied garba	7 a.m. an interview was -H. NA-H stated went into resident rooms, and clean bathrooms. NA-H stated ges on the unit because was unable to be everywhere				
	conducted with hou she did not know if assigned to the Ce primary Cedar hous everyone cleaned r some staff only clea stated she was trai	3 a.m. an interview was isekeeper (H)-A. H-A stated a housekeeper was always dar unit. H-A stated the sekeeper was on vacation, and ooms differently. H-A stated aned bathrooms. HSK-A ned to "just protect myself" om with a resident who had	1			
	conducted with LPI who had a CRAB ir Cedar unit with the would be provided. staff being assigned	8 a.m. an interview was N-A. LPN-A stated residents infection were moved to the promise daily housekeeping LPN-A stated housekeeping d to the Cedar unit was in the primary housekeeper				
		1 a.m. an interview was ADON. The ADON stated she				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00598	B. WING			C 22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ENSEN HEALTH & RE	FHABILITATION C	CE LAKE ROAI I, MN 55811	ס		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 14	21375			
	was not aware of any housekeeping issues on the Cedar unit. The ADON stated no staff had expressed concern about housekeeping availability. On 7/22/20, at 12:52 p.m. an interview was conducted with the environmental services director (ESD)-A. ESD-A stated a staff person was assigned to the Cedar unit, but was on vacation. ESD-A stated public areas and bathrooms were cleaned. ESD-A stated she had trouble with a housekeeper who worked on the Cedar unit, as they hurt their wrist, were on light duty, and later quit. ESD-A stated "this devastated us a lot." ESD-A stated when a housekeeper was not scheduled on Cedar unit, other housekeeping staff were expected to clean their primary wing and "do what they can" on the Cedar unit. ESD-A stated residents, families, and other staff did not have complaints. ESD-A stated housekeepers had no concerns cleaning the Cedar unit due to infections that were on the unit. ESD-A stated when staff declined to be assigned to the Cedar unit, she assigned someone else.					
			6			
	conducted with the had concerns if hou Cedar unit. The DO liked to have had co she knew when the Cedar unit. The DO	7 p.m. an interview was DON. The DON stated she usekeeping was not on the ON stated she would have onversations with ESD-A so ere was short staffing on the ON stated she did not know if was being completed on the				
	conducted with the administrator. The housekeeper assig	P.m. an interview was executive director and executive director stated a ned to the Cedar unit was on onger employed at the facility.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00598	B. WING			C <b>22/2020</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HABILITATION C	E LAKE ROAD , MN 55811	0		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETI DATE
21375	Continued From pa	ge 15	21375			
	The administrator stated ESD-A worked the floor a lot when open shifts were identified.					
	The facility policy Infection Prevention and Control (General) dated 11/16, directed, "A system is in place that prevents, identified, reports, investigates, and controls infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement and following accepted national standards."					
	R8's Face Sheet printed 7/23/20, indicated R8's diagnoses included pneumonia.					
	had impaired cogni staff for ambulation	dated 6/8/20, indicated R8 tion, and was dependent on , and required minimal with all activities of daily living				
	returned from the h	dated 7/17/20, indicated R8 ospital, and was to remain on ne for 14 days, until 7/31/20.				
	to have a clear bin included PPE, sign precaution,s and a	a.m. R8's room was observed outside of the room which age for enhanced barrier red stop sign directing a 14 to be in effect until 7/31/20.	ł			
	observation NA-A w room with her face shield resting on he standing next to R8 NA-A proceeded to exit room. NA-A wa	a.m. during continuous vas observed entering R8's mask in place, and her eye er chest. NA-A was observed l's wheelchair, and talking. clean off R8's tray table and as observed using alcohol BHR) after placing R8's food				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HRIS J	ENSEN HEALTH & R	FHARILITATION C	E LAKE ROAI , 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From page 16 tray on the cart. NA-A's face shield remained on her chest throughout the observation. On 7/21/20, at 9:42 a.m. NA-A verified she had entered R8's room, and had been standing right next to R8 without the face shield in place. On 7/21/20, at 9:46 a.m. during continuous observation, NA-A was observed entering R8's room with her face mask in place, and her eye shield still resting on her chest. NA-A was standing next to R8's wheelchair. NA-A proceeded go to R8's bathroom, gathered a pair of latex gloves and handed them to R8. NA-A then used ABHR and exited R8's room. NA-A's face shield remained on her chest throughout the observation.		21375			
	(RN)-A stated staff shields while provid admission were qu staff had been inst direct contact whic shield/protection, a stated it was impor	31 a.m. registered nurse were to be wearing eye ding cares. RN-A stated all new arantined for 14 days, and ructed to don full PPE when in h included gown, eye and face mask. RN-A further tant for staff to follow contact er to prevent spread of infectior esidents.				
	were to wear the a cares for residents be wearing at a mi shield protection w times. The DON in PPE could increase	6 p.m. the DON stated staff ppropriate PPE while providing . The DON stated staff were to nimum a face mask and eye hile providing cares at all ndicated failure to don proper e the risk of contracting or 19 and other related infections.	)			
		solation Precautions undated, wearing full PPE for all cares				

If continuation sheet 17 of 21

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00598	B. WING			22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ENSEN HEALTH & RI	FHARILITATION C	CE LAKE ROAI I, MN 55811	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 17	21375			
	while in the facility in non-COVID-19 resi	to include eye protection for idents.				
		rinted 7/23/20, indicated R10's I history of pneumonia and				
	R9's quarterly Minimum Data Set (MDS) dated 6/8/20, indicated R10 had severe impaired cognition, and required assistance with all activities of daily living (ADLs).					
	a bowel and bladde	ated 8/29/19, indicated R9 had er deficit related to indwelling red total assistance toileting				
	facility to implemen place R8 in isolatio screening was obta discontinue contact	ers initiated 7/3/20, directed the it contact precautions, and n until results of MRSA ained. If negative, may t precautions and isolation. If contact precautions/Isolation.	e			
		dated 7/14/20, indicated R9 ed from Spruce unit to Cedar				
	observation NA-A v which included an i room. NA-A closed then entered R9's r and eye shield/prot	28 a.m. during continuous vas observed donning PPE solation gown from another I the door behind her. NA-E room wearing her face mask ection. NA-E immediately				
	get an isolation gov stated NA-A had to gown on since R9 r	d walked across the hallway to vn from another room. NA-E ld her she needed to go get a required catheter care. NA-E caution was not indicated for e sheets, nor was there				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00598	B. WING			C 22/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	ENSEN HEALTH & RE	-HABILITATION C	E LAKE ROAD , MN 55811	)		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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21375	Continued From pa	ge 18	21375			
	signage to notify staff of the precautions. NA-E further stated she had no idea isolation precautions were required for R9.					
	At 10:37 a.m. NA-D was observed entering R9's room wearing only her face mask and eye shield/protection. NA-D immediately exited the room, and stated NA-A and NA-E told her she should have had complete PPE in place when providing cares for R9. NA-D stated there would have been no way of knowing she was required to wear an isolation gown prior to entering R9's room, since there had not been a sign in place, nor was a PPE bin outside R9's door.					
	facility implemented on resident's doors communication gro when enhanced pre precautions were re LPN-A stated she h hospice on 7/20/20 required contact an related to his diagn LPN-A verified R9's and a PPE bin, both indicated to staff co barrier precautions R9's room. LPN-A	6 a.m. LPN-A stated the d information sheets and signs , PPE bins, and up sheets to let staff know ecautions or contact equired for specific residents. ad received a call from , around 2:30 p.m. stating R9 id enhanced precautions, osis of MRSA in his urine. a room lacked both signage n of which would have ontact precautions or enhanced were required prior to entering stated staff would not have additional precautions.	4			
	On 7/21/20, at 3:59 agency staff was in hospice nurse had with concerns that l as ordered. The ho R9 had been on ful	p.m. the outside hospice terviewed and verified a called the facility on 7/20/20, R9 was not on full precautions ospice supervisor also stated I precautions prior to his om the Spruce Unit to the				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00598	B. WING			C <b>22/2020</b>
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		ELABLITATION C 2501 RIC		)		
	ENSEN HEALTH & RE	DULUTH	, MN 55811			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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21375	Continued From pa	ae 19	21375			
	••••••••••	3				
	On 7/22/20 at 11.3	1 a.m. registered nurse				
		were made made aware of the	2			
		re isolation or precautions				
		signage on doors, PPE bins				
		ooms, and group care sheets.				
		roviding cares for R9 due to				
		RSA, should have been				
		on precaution measures to				
		ansmission of infection. RN-A				
		sferred from Spruce unit to 20, and contact precautions				
		e when he transferred. RN-A				
		be the risk of and spread of				
		k signage, no PPE bin, and				
	lack of information on group sheets. RN-A stated					
	an RN manager or licensed nurse should have verified R9's orders to ensure accuracy when					
	R9's in-house trans	fer occurred on 7/14/20.				
		p.m. during interview the				
	DON verified R9 required full precautions related					
		SA in urine. The DON stated				
		t precautions when R9				
		ar unit on 7/14/20, increased				
		g infection. The DON stated age, no PPE bin, nor was this				
		s, staff would not have known				
		ons. The DON stated failure to				
		ons had the potential for				
	spreading MRSA to	residents.				
	The facility relieves	volation Propositions undeted				
		olation Precautions undated, to prevent the transmission of				
		e facility through the use of				
		ns. In addition to Standard				
		ontact Precautions for				
		suspected to be infected with				
		at can be easily transmitted by				
		ntact, such as handling				

TATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
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AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HRIS J	ENSEN HEALTH & RE	-HABILITATION C	E LAKE ROAD , MN 55811	)		
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21375	•	ige 20 aces or resident-care items.	21375			
	Director of Nursing systems to ensure residents, and non- from infectious sou of Nursing, or desig appropriate staff or appropriate transm Director of Nursing Environmental Serv policies to ensure end consistently perforr known multi-drug re Director of Nursing Environmental Serv appropriate staff or The Director of Nur develop monitoring compliance.	vices Director could develop environmental cleaning is ned on nursing units with esistant organisms. The				