DEPARTMENT OF HEALTH

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:

Nursing Home Informal Dispute Process

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 07/22/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 7/20/20, through 7/22/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/20/20, through 7/22/20, an abbreviated survey and a COVID-19 Focused infection Control survey was conducted at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey identified the facility was NOT in compliance. The following complaints were substantiated: H5366146C H5366147C H5366148C H5366149C H5366150C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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

Electronically Signed | 08/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This 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	F 812	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	9/1/20

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F 812	Continued From page 2 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/index.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." 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). R1's quarterly Minimum Data Set (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. R1's care plan dated 1/27/16, indicated R1 had a chronic indwelling Foley catheter related to benign prostatic hyperplasia (prostate gland enlargement). 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	F 812	deficiencies or conclusions contained in the Department□s inspection report. Directed Plan of Correction is followed as indicated: Staff education has been completed utilizing MedCom system for training and tracking of the education. MedCom training materials utilize CDC resources R #1 continues to live on the Cedar unit with Enhanced Barrier Precautions. No negative affect has occurred related to this deficient practice. Residents who live on the Cedar unit could have been affected by this deficient practice. No negative outcomes have been determined. Water pass practice has changed to include the use of disposable cups which will be replaced after each use. Staff have received education regarding keeping items away from their person and uniform. Staff education has been completed for sanitation. Audits of sanitation of water pass will be conducted 4 times weekly for 4 weeks, then monthly for 2 months. Audits will be taken to QAPI for further review and recommendations.	

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F 812	Continued From page 3	F 812		

blood and body fluids is anticipated) to prevent infection.

A progress note dated 3/20/20, at 5:03 p.m. indicated the facility was notified R1 had tested positive for CRAB.

R7's Admission Record dated 7/23/20, indicated R7's diagnoses included Alzheimer's disease.

R7's significant change MDS dated 6/15/20, identified R7 had severely impaired cognition and required supervision eating.

On 7/21/20, at 8:57 a.m., an enhanced barrier precaution sign was noted to be posted on R1's outer room door. A white plastic three drawer bin was noted, outside of R1's room, which contained personal protective equipment (PPE) supplies.

On 7/21/20, at 9:42 a.m., an interview was conducted with nursing assistant (NA)-F. NA-F stated enhanced barrier precautions were used for R1 because he was diagnosed with CRAB.

On 7/21/20, at 11:19 a.m., R1's call light was noted to be on. Nursing assistant (NA)-E walked towards R1's room, and put on an isolation gown and gloves. NA-E 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 with water. NA-E held the large plastic mug against her upper uniform shirt by using both of her forearms (hugging motion). NA-E walked down the hallway and entered R24 and R36's room. A staff person who was inside R24 and R36's room asked NA-E about the mug. The

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F 812	Continued From page 4	F 812		

staff person stated another cup needed to be used to fill the mug. NA-E exited R24 and R36's room and walked towards the Cedar nurses' station. NA-E opened a door near the Cedar nurses' station, which indicated Staff Only. NA-E entered the room and removed the lid from the mug. NA-E poured water from the mug into the sink. NA-E then opened a white ice cooler which was on a rolling cart. NA-E obtained a scoop which was on the side of the cooler, and transferred ice from the cooler to the mug. NA-E placed the scoop inside the mug, and the scoop made direct contact with the inner surface of the mug. NA-E removed the scoop from the mug, and used it to obtain additional ice from the cooler. NA-E again placed the scoop on the inside of the mug, and made contact with the inner surface. NA-E closed the cooler lid and placed the scoop in a holder on the side of the cooler. NA-E used the sink faucet to fill the mug with water, and replaced the plastic lid. NA-E exited the Staff Only room and walked towards R1's room. NA-E placed the mug on top of the white plastic three drawer bin outside of R1's room. NA-E was interviewed at that time and confirmed the mug belonged to R1, and she removed the mug from R1's room when he requested it to be refilled. NA-E stated R1 was placed on enhanced barrier precautions due to a CRAB infection. NA-E stated she was unsure where the source of the resident's infection was.

On 7/21/20, at 11:31 a.m. NA-F approached NA-E and stated she would bring the mug to R1. NA-F put on gloves and an isolation gown, and entered R1's room with the mug.

On 7/21/20, at 12:08 p.m. NA-G was observed carrying an empty cup and straw which was in a

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F 812	Continued From page 5	F 812		

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 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 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 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

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F 812	Continued From page 6 dedicated equipment, potential for transmission, and staff contamination when staff removed R1's mug from his room. The facility policy Procedure for Isolation: Initiation of Isolation Precautions undated, directed, "No special precautions are needed for dishes, cups, glasses, or eating utensils. A facility policy for storing/handling ice was requested, but not provided. R1's laboratory CRAB result was requested, but not provided.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		9/1/20

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F 880	Continued From page 7 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 8 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document 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 addition, the facility failed to ensure routine housekeeping services were provided on the Cedar nursing unit to prevent the potential spread of multi-drug resistant organisms (MDROs). In addition, the facility failed to implement appropriate transmission based precautions for 1 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, R9) who wer placed on enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to blood and body fluids is anticipated). These practices had the potential to affect all 37 residents who resided on the Cedar nursing unit at the facility. Findings include: According to the Minnesota Department of Health (MDH) website https://www.health.state.mn.us/diseases/crab/index.html undated, "Carbapenem-resistant Acinetobacter baumannii (CRAB) is a type of bacteria commonly found in the environment,	F 880	R2 no longer resides in the facility. No negative affect has occurred related to this deficient practice. Residents #3, #4, #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 (CRAB) could be affected by this deficient practice. Residents residing on the Cedar unit have the potential to be affected by this deficient practice. Resident #1 has been moved to a private 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 no longer in isolation related to the MRSA but 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.	

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F 880	Continued From page 9 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." R2's Medical Diagnosis list dated 7/23/20, indicated R2's diagnoses included intestinal obstruction, traumatic brain injury, and intestinal bypass. R2's quarterly Minimum Data Set (MDS) dated 5/22/20, identified R2 had moderately impaired cognition. R2's MDS further identified he required extensive assistance toileting, and he needed supervision with locomotion. R2 had an ostomy (surgical opening into the abdomen to allow stool to leave the body), and was always continent of bladder. R2's care plan dated 6/30/20, indicated R2 had a bowel and bladder deficit related to an ostomy, and urinary retention. Interventions included offering toileting upon arising, between meals, at bedtime, and as needed. The care plan further indicated R2 independently used a urinal, was non-compliant with his ileostomy bag (pouch attached to ostomy to collect stool), and "will not ask for assistance from staff." R2's care plan also identified he was placed on enhanced precautions due to a CRAB infection at his	F 880	Audits of proper PPE use and sanitation will be conducted 4 times weekly for 4 weeks, then monthly for 2 months. Audits will be taken to QAPI for further review and recommendations.	

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ostomy site.

A progress note dated 4/6/20, at 4:26 p.m. indicated the facility notified R2 he tested positive for CRAB.

R3's Admission Record dated 7/23/20, identified R3's diagnoses included hemiplegia (paralysis of one side of the body), and muscle weakness.

R3's quarterly MDS dated 4/7/20, identified R3's BIMS score was 12 which indicated moderately impaired cognition. R3's MDS further identified he required extensive assistance toileting, was frequently incontinent of bladder, and was occasionally incontinent of bowel.

R3's care plan dated 9/8/17, indicated R3 had a deficit with his bowel and bladder. Interventions included toilet upon arising, between meals, at bedtime, and as needed.

R4's Admission Record dated 7/23/20, indicated R4's diagnoses included muscle weakness and unsteadiness on feet.

R4's quarterly MDS dated 7/15/20, identified R4 had severely impaired cognition. R4's MDS further identified he required supervision toileting, and was continent of bowel and bladder.

On 7/21/20, at 9:05 a.m. enhanced barrier precaution signage was observed to be fixated to R2's door. A white plastic three drawer bin was outside of R2's room. The white plastic bin contained PPE supplies. R2's bathroom was shared with R3 and R4's room. R2 was observed lying in bed. An empty urinal was hanging on R2's bed rail.

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On 7/22/20, at 9:06 a.m. R2 was observed to self-propel his wheelchair to the adjoining bathroom located in his room. R2 carried a urinal which had a small amount of urine in it. At 9:09 a.m. the toilet in R2's bathroom was overheard to be flushed. At 9:12 a.m., R2 exited the bathroom in his wheelchair, with an empty urinal in his hand.

On 7/22/20, at 9:37 a.m. an interview was conducted with nursing assistant (NA)-F. NA-F confirmed R2, R3, and R4 shared a bathroom. NA-F stated R2 did things by himself, and staff told him "100 times a day" not to independently empty his ostomy. NA-F stated R2 doesn't sit on the toilet, but emptied his ostomy pouch into a graduate, and would leave it in the bathroom. NA-F stated she mopped R2's bathroom several times per day because he "does not listen." NA-F stated R3 required assistance to use the bathroom, and she wiped the toilet with bleach prior to R3 using it. NA-F stated R4 independently used the adjoining bathroom, and was very confused. NA-F confirmed a risk for cross contamination existed as R2 and R4 both were known to use the shared bathroom independently and without staff knowledge.

On 7/22/20, at 10:17 a.m. an interview was conducted with NA-H. NA-H confirmed R3 and R4 shared a bathroom with R2. NA-H stated R2's CRAB infection was at his ostomy site, and also believed R2's urine was infected. NA-H stated R2 liked to empty his ostomy pouch in the adjoining bathroom, and dumped his urine in the toilet independently. NA-H stated R2 also rinsed his coffee cup out in the bathroom sink. NA-H stated R2 played with his ostomy site, and had

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red spots to the area. NA-H confirmed R4 toileted himself. NA-H stated R4's cognition was good sometimes, but "a lot of times he is not really with it." NA-H stated there was risk for cross contamination from "time-to-time" as R2 and R4 would independently use the adjoining bathroom. NA-H stated R4 would notify staff if there "was a big mess" in the bathroom.

On 7/22/20, at 10:48 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A confirmed R3 and R4 shared a bathroom with R2. LPN-A stated R2 had a CRAB infection at his ostomy site and was unsure if the infection was in his urine. LPN-A confirmed R2 emptied his ostomy pouch independently. LPN-A stated R4 was confused and used the bathroom independently. LPN-A stated she was unsure if nursing staff cleaned the bathrooms. LPN-A confirmed there was risk for cross contamination for R3 and R4 when they used the bathroom shared with R2.

On 7/24/20, at 10:55 p.m. R4 was observed self-propelling his wheelchair from his room, towards the Cedar unit elevator.

On 7/22/20, at 11:31 a.m. an interview was conducted with the assistant director of nursing (ADON). The ADON confirmed R2 played with his ostomy pouch. The ADON stated R2 was provided education, but he continued. The ADON stated she did not know if R3 or R4 used the adjoining bathroom shared with R2.

On 7/22/20, at 1:57 p.m. an interview was conducted with the director of nursing (DON). The DON stated she believed commodes were being used for residents who had a CRAB

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infection and shared a bathroom with non-infected residents. The DON stated a risk for cross contamination existed if residents who had a CRAB infection used a shared a bathroom, with residents who were not infected. The DON stated she was unable to speak to why residents who had a CRAB infection shared bathrooms with those who were not infected. The DON stated she did not work at the facility when the facility was given recommendations related to the CRAB outbreak at the facility. The DON stated open beds existed at the facility at the time of the survey.

On 7/22/20, at 2:32 p.m. an interview was conducted with the executive director and administrator. The administrator stated CRAB infections were identified at the facility in February , 2020. The administrator stated they believed a resident who had since died, acquired the infection while hospitalized. The administrator stated it was unable to be determined how other residents were infected. The executive director stated recommendations included providing private rooms to residents who had a CRAB infection. The executive director stated recommendations also included providing a commode to residents who had the CRAB infection and shared a bathroom with a resident who did not. The executive director stated a shared bathroom was supposed to be cleaned after a commode was emptied.

R1's Admission Record dated 7/23/20, indicated R1's diagnoses included infection and inflammatory reaction, and methicillin resistant staphylococcus aureus (MRSA, a multi-drug resistant organism).

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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.

R1's care plan dated 1/8/20, indicated R1 had a history of MRSA in his urine, and a carbapenem resistive organism (CRAB). Staff were to adhere to enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to blood and body fluids is anticipated) to prevent infection.

R10's Admission Record dated 7/23/20, indicated R10's diagnoses included cognitive communication deficit, and paraplegia (paralysis of legs and lower body).

R10's quarterly MDS dated 7/3/20, identified he required extensive assistance toileting, was always incontinent of bladder, and frequently incontinent of bowel.

Facility infection surveillance documentation dated 7/20, indicated R1, R2, and R10 were infected with CRAB.

On 7/21/20, at 12:10 p.m. licensed practical nurse (LPN)-A was informed a sink in the Staff Only room, located on the Cedar nursing unit, was contaminated. LPN-A stated a housekeeper was not assigned to the Cedar unit on 7/20/20, or 7/21/20.

On 7/22/20, at 9:37 a.m. an interview was conducted with NA-F. NA-F stated housekeeping staff was "picky" and chose what floor they wanted to clean. NA-F stated housekeeping staff

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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.

On 7/22/20, at 10:17 a.m. an interview was conducted with NA-H. NA-H stated housekeeping staff went into resident rooms, and were supposed to clean bathrooms. NA-H stated she emptied garbages on the unit because housekeeping staff was unable to be everywhere all the time.

On 7/22/20, at 10:33 a.m. an interview was conducted with housekeeper (H)-A. H-A stated she did not know if a housekeeper was always assigned to the Cedar unit. H-A stated the primary Cedar housekeeper was on vacation, and everyone cleaned rooms differently. H-A stated some staff only cleaned bathrooms. HSK-A stated she was trained to "just protect myself" when cleaning a room with a resident who had CRAB.

On 7/22/20, at 10:48 a.m. an interview was conducted with LPN-A. LPN-A stated residents who had a CRAB infection were moved to the Cedar unit with the promise daily housekeeping would be provided. LPN-A stated housekeeping staff being assigned to the Cedar unit was "hit-and-miss" when the primary housekeeper was not scheduled.

On 7/22/20, at 11:31 a.m. an interview was conducted with the ADON. The ADON stated she was not aware of any housekeeping issues on the Cedar unit. The ADON stated no staff had

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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 Cedar unit.

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. The administrator stated ESD-A worked the floor

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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.

R8's quarterly MDS dated 6/8/20, indicated R8 had impaired cognition, and was dependent on staff for ambulation, and required minimal assistance of staff with all activities of daily living (ADLs).

R8's progress note dated 7/17/20, indicated R8 returned from the hospital, and was to remain on COVID-19 quarantine for 14 days, until 7/31/20.

On 7/21/20, at 9:16 a.m. R8's room was observed to have a clear bin outside of the room which included PPE, signage for enhanced barrier precaution,s and a red stop sign directing a 14 day quarantine was to be in effect until 7/31/20.

On 7/21/20, at 9:42 a.m. during continuous observation NA-A was observed entering R8's room with her face mask in place, and her eye shield resting on her chest. NA-A was observed standing next to R8's wheelchair, and talking. NA-A proceeded to clean off R8's tray table and exit room. NA-A was observed using alcohol based hand rub (ABHR) after placing R8's food

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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.

On 7/22/20, at 11:31 a.m. registered nurse (RN)-A stated staff were to be wearing eye shields while providing cares. RN-A stated all new admission were quarantined for 14 days, and staff had been instructed to don full PPE when in direct contact which included gown, eye shield/protection, and face mask. RN-A further stated it was important for staff to follow contact precautions in order to prevent spread of infection to staff and other residents.

On 7/22/20, at 1:56 p.m. the DON stated staff were to wear the appropriate PPE while providing cares for residents. The DON stated staff were to be wearing at a minimum a face mask and eye shield protection while providing cares at all times. The DON indicated failure to don proper PPE could increase the risk of contracting or spreading COVID-19 and other related infections.

The facility policy Isolation Precautions undated,

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directed staff to be wearing full PPE for all cares while in the facility to include eye protection for non-COVID-19 residents.

R9's Face Sheet printed 7/23/20, indicated R10's diagnoses included history of pneumonia and sepsis.

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).

R9's care plan initiated 8/29/19, indicated R9 had a bowel and bladder deficit related to indwelling catheter, and required total assistance toileting and catheter care.

R9's physician orders initiated 7/3/20, directed the facility to implement contact precautions, and place R8 in isolation until results of MRSA screening was obtained. If negative, may discontinue contact precautions and isolation. If positive, continue contact precautions/Isolation.

R9's progress note dated 7/14/20, indicated R9 had been transferred from Spruce unit to Cedar unit.

On 7/21/20, at 10:28 a.m. during continuous observation NA-A was observed donning PPE which included an isolation gown from another room. NA-A closed the door behind her. NA-E then entered R9's room wearing her face mask and eye shield/protection. NA-E immediately exited the room and walked across the hallway to get an isolation gown from another room. NA-E stated NA-A had told her she needed to go get a gown on since R9 required catheter care. NA-E

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 07/22/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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

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F 880	Continued From page 21	F 880		

R9 had been on full precautions prior to his in-house transfer from the Spruce Unit to the Cedar Unit.

On 7/22/20, at 11:31 a.m. registered nurse (RN)-A stated staff were made made aware of the residents that require isolation or precautions through the use of signage on doors, PPE bins placed outside of rooms, and group care sheets. RN-A stated staff providing cares for R9 due to his diagnosis of MRSA, should have been following full isolation precaution measures to reduce the risk of transmission of infection. RN-A stated R9 was transferred from Spruce unit to Cedar unit on 7/14/20, and contact precautions were not put in place when he transferred. RN-A stated there could be the risk of and spread of infection due to lack 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 transfer occurred on 7/14/20.

On 7/22/20, at 1:56 p.m. during interview the DON verified R9 required full precautions related to diagnosis of MRSA in urine. The DON stated failure to implement precautions when R9 transferred to Cedar unit on 7/14/20, increased the risk of spreading infection. The DON stated due to lack of signage, no PPE bin, nor was this on the group sheets, staff would not have known he was on precautions. The DON stated failure to implement precautions had the potential for spreading MRSA to residents.

The facility policy Isolation Precautions undated, directed the facility to prevent the transmission of infections within the facility through the use of Isolation Precautions. In addition to Standard

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F 880	Continued From page 22 Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items.	F 880		

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: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
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): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
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.cdc.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): 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:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
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. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
  - 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: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
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): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
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.cdc.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): 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:

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

transmission-based precautions (e.g., contact precautions).

- 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. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
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): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
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.cdc.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): 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:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
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 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/GuidanceforRCA.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.

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	C 07/22/2020

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/20/20, through 7/22/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	C 07/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 substantiated with correction orders issued: H5366146C H5366147C H5366148C H5366149C H5366150C	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi 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. Findings include: According to the Minnesota Department of Health (MDH) website https://www.health.state.mn.us/diseases/crab/index.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."	21015	Acknowledge receipt	9/1/20

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

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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).

R1's quarterly Minimum Data Set (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.

R1's care plan dated 1/27/16, indicated R1 had a chronic indwelling Foley catheter related to benign prostatic hyperplasia (prostate gland enlargement).

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 blood and body fluids is anticipated) to prevent infection.

A progress note dated 3/20/20, at 5:03 p.m. indicated the facility was notified R1 had tested positive for CRAB.

R7's Admission Record dated 7/23/20, indicated R7's diagnoses included Alzheimer's disease.

R7's significant change MDS dated 6/15/20, identified R7 had severely impaired cognition and required supervision eating.

On 7/21/20, at 8:57 a.m., an enhanced barrier precaution sign was noted to be posted on R1's outer room door. A white plastic three drawer bin

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was noted, outside of R1's room, which contained personal protective equipment (PPE) supplies.

On 7/21/20, at 9:42 a.m., an interview was conducted with nursing assistant (NA)-F. NA-F stated enhanced barrier precautions were used for R1 because he was diagnosed with CRAB.

On 7/21/20, at 11:19 a.m., R1's call light was noted to be on. Nursing assistant (NA)-E walked towards R1's room, and put on an isolation gown and gloves. NA-E 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 with water. NA-E held the large plastic mug against her upper uniform shirt by using both of her forearms (hugging motion). NA-E walked down the hallway and entered R24 and R36's room. A staff person who was inside R24 and R36's room asked NA-E about the mug. The staff person stated another cup needed to be used to fill the mug. NA-E exited R24 and R36's room and walked towards the Cedar nurses' station. NA-E opened a door near the Cedar nurses' station, which indicated Staff Only. NA-E entered the room and removed the lid from the mug. NA-E poured water from the mug into the sink. NA-E then opened a white ice cooler which was on a rolling cart. NA-E obtained a scoop which was on the side of the cooler, and transferred ice from the cooler to the mug. NA-E placed the scoop inside the mug, and the scoop made direct contact with the inner surface of the mug. NA-E removed the scoop from the mug, and used it to obtain additional ice from the cooler. NA-E again placed the scoop on the inside of the mug, and made contact with the inner surface. NA-E closed the cooler lid and

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placed the scoop in a holder on the side of the cooler. NA-E used the sink faucet to fill the mug with water, and replaced the plastic lid. NA-E exited the Staff Only room and walked towards R1's room. NA-E placed the mug on top of the white plastic three drawer bin outside of R1's room. NA-E was interviewed at that time and confirmed the mug belonged to R1, and she removed the mug from R1's room when he requested it to be refilled. NA-E stated R1 was placed on enhanced barrier precautions due to a CRAB infection. NA-E stated she was unsure where the source of the resident's infection was.

On 7/21/20, at 11:31 a.m. NA-F approached NA-E and stated she would bring the mug to R1. NA-F put on gloves and an isolation gown, and entered R1's room with the mug.

On 7/21/20, at 12:08 p.m. NA-G was observed carrying an empty cup and straw which was in a 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.

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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 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 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 dedicated equipment, potential for transmission, and staff contamination when staff removed R1's mug from his room.

The facility policy Procedure for Isolation: Initiation of Isolation Precautions undated, directed, "No special precautions are needed for dishes, cups, glasses, or eating utensils.

A facility policy for storing/handling ice was requested, but not provided.

R1's laboratory CRAB result was requested, but not provided.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing, or designee, could review policies, train staff, and monitor to assure sanitary service procedures are followed at all times.

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21015	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. 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 addition, the facility failed to ensure routine housekeeping services were provided on the Cedar nursing unit to prevent the potential spread of multi-drug resistant organisms (MDROs). In addition, the facility failed to implement appropriate transmission based precautions for 1 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, R9) who wer placed on enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to blood and body fluids is anticipated). These practices had the potential to affect all 37 residents who resided on the Cedar nursing unit at the facility.	21375	Acknowledge receipt	9/1/20

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21375	Continued From page 7 Findings include: According to the Minnesota Department of Health (MDH) website https://www.health.state.mn.us/diseases/crab/index.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." R2's Medical Diagnosis list dated 7/23/20, indicated R2's diagnoses included intestinal obstruction, traumatic brain injury, and intestinal bypass. R2's quarterly Minimum Data Set (MDS) dated 5/22/20, identified R2 had moderately impaired cognition. R2's MDS further identified he required extensive assistance toileting, and he needed supervision with locomotion. R2 had an ostomy (surgical opening into the abdomen to allow stool to leave the body), and was always continent of bladder. R2's care plan dated 6/30/20, indicated R2 had a bowel and bladder deficit related to an ostomy, and urinary retention. Interventions included	21375		

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offering toileting upon arising, between meals, at bedtime, and as needed. The care plan further indicated R2 independently used a urinal, was non-compliant with his ileostomy bag (pouch attached to ostomy to collect stool), and "will not ask for assistance from staff." R2's care plan also identified he was placed on enhanced precautions due to a CRAB infection at his ostomy site.

A progress note dated 4/6/20, at 4:26 p.m. indicated the facility notified R2 he tested positive for CRAB.

R3's Admission Record dated 7/23/20, identified R3's diagnoses included hemiplegia (paralysis of one side of the body), and muscle weakness.

R3's quarterly MDS dated 4/7/20, identified R3's BIMS score was 12 which indicated moderately impaired cognition. R3's MDS further identified he required extensive assistance toileting, was frequently incontinent of bladder, and was occasionally incontinent of bowel.

R3's care plan dated 9/8/17, indicated R3 had a deficit with his bowel and bladder. Interventions included toilet upon arising, between meals, at bedtime, and as needed.

R4's Admission Record dated 7/23/20, indicated R4's diagnoses included muscle weakness and unsteadiness on feet.

R4's quarterly MDS dated 7/15/20, identified R4 had severely impaired cognition. R4's MDS further identified he required supervision toileting, and was continent of bowel and bladder.

On 7/21/20, at 9:05 a.m. enhanced barrier

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precaution signage was observed to be fixated to R2's door. A white plastic three drawer bin was outside of R2's room. The white plastic bin contained PPE supplies. R2's bathroom was shared with R3 and R4's room. R2 was observed lying in bed. An empty urinal was hanging on R2's bed rail.

On 7/22/20, at 9:06 a.m. R2 was observed to self-propel his wheelchair to the adjoining bathroom located in his room. R2 carried a urinal which had a small amount of urine in it. At 9:09 a.m. the toilet in R2's bathroom was overheard to be flushed. At 9:12 a.m., R2 exited the bathroom in his wheelchair, with an empty urinal in his hand.

On 7/22/20, at 9:37 a.m. an interview was conducted with nursing assistant (NA)-F. NA-F confirmed R2, R3, and R4 shared a bathroom. NA-F stated R2 did things by himself, and staff told him "100 times a day" not to independently empty his ostomy. NA-F stated R2 doesn't sit on the toilet, but emptied his ostomy pouch into a graduate, and would leave it in the bathroom. NA-F stated she mopped R2's bathroom several times per day because he "does not listen." NA-F stated R3 required assistance to use the bathroom, and she wiped the toilet with bleach prior to R3 using it. NA-F stated R4 independently used the adjoining bathroom, and was very confused. NA-F confirmed a risk for cross contamination existed as R2 and R4 both were known to use the shared bathroom independently and without staff knowledge.

On 7/22/20, at 10:17 a.m. an interview was conducted with NA-H. NA-H confirmed R3 and R4 shared a bathroom with R2. NA-H stated R2's CRAB infection was at his ostomy site, and

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also believed R2's urine was infected. NA-H stated R2 liked to empty his ostomy pouch in the adjoining bathroom, and dumped his urine in the toilet independently. NA-H stated R2 also rinsed his coffee cup out in the bathroom sink. NA-H stated R2 played with his ostomy site, and had red spots to the area. NA-H confirmed R4 toileted himself. NA-H stated R4's cognition was good sometimes, but "a lot of times he is not really with it." NA-H stated there was risk for cross contamination from "time-to-time" as R2 and R4 would independently use the adjoining bathroom. NA-H stated R4 would notify staff if there "was a big mess" in the bathroom.

On 7/22/20, at 10:48 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A confirmed R3 and R4 shared a bathroom with R2. LPN-A stated R2 had a CRAB infection at his ostomy site and was unsure if the infection was in his urine. LPN-A confirmed R2 emptied his ostomy pouch independently. LPN-A stated R4 was confused and used the bathroom independently. LPN-A stated she was unsure if nursing staff cleaned the bathrooms. LPN-A confirmed there was risk for cross contamination for R3 and R4 when they used the bathroom shared with R2.

On 7/24/20, at 10:55 p.m. R4 was observed self-propelling his wheelchair from his room, towards the Cedar unit elevator.

On 7/22/20, at 11:31 a.m. an interview was conducted with the assistant director of nursing (ADON). The ADON confirmed R2 played with his ostomy pouch. The ADON stated R2 was provided education, but he continued. The ADON stated she did not know if R3 or R4 used the adjoining bathroom shared with R2.

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21375	Continued From page 11 On 7/22/20, at 1:57 p.m. an interview was conducted with the director of nursing (DON). The DON stated she believed commodes were being used for residents who had a CRAB infection and shared a bathroom with non-infected residents. The DON stated a risk for cross contamination existed if residents who had a CRAB infection used a shared a bathroom, with residents who were not infected. The DON stated she was unable to speak to why residents who had a CRAB infection shared bathrooms with those who were not infected. The DON stated she did not work at the facility when the facility was given recommendations related to the CRAB outbreak at the facility. The DON stated open beds existed at the facility at the time of the survey. On 7/22/20, at 2:32 p.m. an interview was conducted with the executive director and administrator. The administrator stated CRAB infections were identified at the facility in February , 2020. The administrator stated they believed a resident who had since died, acquired the infection while hospitalized. The administrator stated it was unable to be determined how other residents were infected. The executive director stated recommendations included providing private rooms to residents who had a CRAB infection. The executive director stated recommendations also included providing a commode to residents who had the CRAB infection and shared a bathroom with a resident who did not. The executive director stated a shared bathroom was supposed to be cleaned after a commode was emptied. R1's Admission Record dated 7/23/20, indicated R1's diagnoses included infection and	21375		

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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.

R1's care plan dated 1/8/20, indicated R1 had a history of MRSA in his urine, and a carbapenem resistive organism (CRAB). Staff were to adhere to enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to blood and body fluids is anticipated) to prevent infection.

R10's Admission Record dated 7/23/20, indicated R10's diagnoses included cognitive communication deficit, and paraplegia (paralysis of legs and lower body).

R10's quarterly MDS dated 7/3/20, identified he required extensive assistance toileting, was always incontinent of bladder, and frequently incontinent of bowel.

Facility infection surveillance documentation dated 7/20, indicated R1, R2, and R10 were infected with CRAB.

On 7/21/20, at 12:10 p.m. licensed practical nurse (LPN)-A was informed a sink in the Staff Only room, located on the Cedar nursing unit, was contaminated. LPN-A stated a housekeeper was not assigned to the Cedar unit on 7/20/20, or 7/21/20.

On 7/22/20, at 9:37 a.m. an interview was

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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.

On 7/22/20, at 10:17 a.m. an interview was conducted with NA-H. NA-H stated housekeeping staff went into resident rooms, and were supposed to clean bathrooms. NA-H stated she emptied garbages on the unit because housekeeping staff was unable to be everywhere all the time.

On 7/22/20, at 10:33 a.m. an interview was conducted with housekeeper (H)-A. H-A stated she did not know if a housekeeper was always assigned to the Cedar unit. H-A stated the primary Cedar housekeeper was on vacation, and everyone cleaned rooms differently. H-A stated some staff only cleaned bathrooms. HSK-A stated she was trained to "just protect myself" when cleaning a room with a resident who had CRAB.

On 7/22/20, at 10:48 a.m. an interview was conducted with LPN-A. LPN-A stated residents who had a CRAB infection were moved to the Cedar unit with the promise daily housekeeping would be provided. LPN-A stated housekeeping staff being assigned to the Cedar unit was "hit-and-miss" when the primary housekeeper was not scheduled.

On 7/22/20, at 11:31 a.m. an interview was conducted with the ADON. The ADON stated she

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	00598	A. BUILDING: _____ B. WING _____	C 07/22/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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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.

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 Cedar unit.

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.

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21375	Continued From page 15 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. R8's quarterly MDS dated 6/8/20, indicated R8 had impaired cognition, and was dependent on staff for ambulation, and required minimal assistance of staff with all activities of daily living (ADLs). R8's progress note dated 7/17/20, indicated R8 returned from the hospital, and was to remain on COVID-19 quarantine for 14 days, until 7/31/20. On 7/21/20, at 9:16 a.m. R8's room was observed to have a clear bin outside of the room which included PPE, signage for enhanced barrier precaution,s and a red stop sign directing a 14 day quarantine was to be in effect until 7/31/20. On 7/21/20, at 9:42 a.m. during continuous observation NA-A was observed entering R8's room with her face mask in place, and her eye shield resting on her chest. NA-A was observed standing next to R8's wheelchair, and talking. NA-A proceeded to clean off R8's tray table and exit room. NA-A was observed using alcohol based hand rub (ABHR) after placing R8's food	21375		

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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.

On 7/22/20, at 11:31 a.m. registered nurse (RN)-A stated staff were to be wearing eye shields while providing cares. RN-A stated all new admission were quarantined for 14 days, and staff had been instructed to don full PPE when in direct contact which included gown, eye shield/protection, and face mask. RN-A further stated it was important for staff to follow contact precautions in order to prevent spread of infection to staff and other residents.

On 7/22/20, at 1:56 p.m. the DON stated staff were to wear the appropriate PPE while providing cares for residents. The DON stated staff were to be wearing at a minimum a face mask and eye shield protection while providing cares at all times. The DON indicated failure to don proper PPE could increase the risk of contracting or spreading COVID-19 and other related infections.

The facility policy Isolation Precautions undated, directed staff to be wearing full PPE for all cares

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while in the facility to include eye protection for non-COVID-19 residents.

R9's Face Sheet printed 7/23/20, indicated R10's diagnoses included history of pneumonia and sepsis.

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).

R9's care plan initiated 8/29/19, indicated R9 had a bowel and bladder deficit related to indwelling catheter, and required total assistance toileting and catheter care.

R9's physician orders initiated 7/3/20, directed the facility to implement contact precautions, and place R8 in isolation until results of MRSA screening was obtained. If negative, may discontinue contact precautions and isolation. If positive, continue contact precautions/Isolation.

R9's progress note dated 7/14/20, indicated R9 had been transferred from Spruce unit to Cedar unit.

On 7/21/20, at 10:28 a.m. during continuous observation NA-A was observed donning PPE which included an isolation gown from another room. NA-A closed the door behind her. NA-E then entered R9's room wearing her face mask and eye shield/protection. NA-E immediately exited the room and walked across the hallway to get an isolation gown from another room. NA-E stated NA-A had told her she needed to go get a gown on since R9 required catheter care. NA-E stated isolation precaution was not indicated for R9 on the daily care sheets, nor was there

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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 R9 had been on full precautions prior to his in-house transfer from the Spruce Unit to the Cedar Unit.

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21375	Continued From page 19 On 7/22/20, at 11:31 a.m. registered nurse (RN)-A stated staff were made made aware of the residents that require isolation or precautions through the use of signage on doors, PPE bins placed outside of rooms, and group care sheets. RN-A stated staff providing cares for R9 due to his diagnosis of MRSA, should have been following full isolation precaution measures to reduce the risk of transmission of infection. RN-A stated R9 was transferred from Spruce unit to Cedar unit on 7/14/20, and contact precautions were not put in place when he transferred. RN-A stated there could be the risk of and spread of infection due to lack 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 transfer occurred on 7/14/20. On 7/22/20, at 1:56 p.m. during interview the DON verified R9 required full precautions related to diagnosis of MRSA in urine. The DON stated failure to implement precautions when R9 transferred to Cedar unit on 7/14/20, increased the risk of spreading infection. The DON stated due to lack of signage, no PPE bin, nor was this on the group sheets, staff would not have known he was on precautions. The DON stated failure to implement precautions had the potential for spreading MRSA to residents. The facility policy Isolation Precautions undated, directed the facility to prevent the transmission of infections within the facility through the use of Isolation Precautions. In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling	21375		

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21375	Continued From page 20 environmental surfaces or resident-care items. SUGGESTED METHOD OF CORRECTION: The Director of Nursing, or designee, could develop systems to ensure areas shared by infectious residents, and non-infectious residents, are free from infectious sources prior to use. The Director of Nursing, or designee, could educate all appropriate staff on implementation of appropriate transmission based precautions. The Director of Nursing, or designee, and Environmental Services Director could develop policies to ensure environmental cleaning is consistently performed on nursing units with known multi-drug resistant organisms. The Director of Nursing, or designee, and Environmental Services Director could educate all appropriate staff on the policies and procedures. The Director of Nursing, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		