

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 12, 2020

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

RE: CCN: 245366

Cycle Start Date: July 22, 2020

Dear Administrator:

On July 22, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 11, 2020.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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

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

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

practice will not recur.

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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

PRINTED: 10/22/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	H5366146C H5366147C H5366148C H5366149C H5366150C The facility's plan of	of correction (POC) will serve					
LAROPATORY	Department's acce	of compliance upon the ptance. Because you are your signature is not required	JATI IDE	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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	form. Your electron be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. Food Procurement, CFR(s): 483.60(i)(1)	e first page of the CMS-2567 ic submission of the POC will cion of compliance. acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with Store/Prepare/Serve-Sanitary)(2)	F 000		9/1/20
	approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision defacilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for \$483.60(i)(2) - Storn serve food in accorn standards for food standa	cure food from sources ered satisfactory by federal, rities. In food items obtained directly its, subject to applicable State gulations. The produce grown in facility compliance with applicable bod-handling practices. Toes not preclude residents ods not preclude residents ods not procured by the facility. The propers of the professional service safety. The produce of the professional service safety. The produce of the professional service safety. The professional service is a service of the professional service safety. The professional service is a service of the professional service safety. The professional service is a service of the professional service safety.		This plan of correction constitutes the facility s written allegation of complete for the deficiencies cited. This submof this plan of correction is not an admission of or agreement with the	iance

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F F C C K F F F F	Findings include: According to the M (MDH) website attps://www.health.ex.html undated, "Of Acinetobacter baurbacteria commonly especially in soil are numan infections of ungs, wounds, and are multidrug-resist difficult to treat." R1's Admission ReR1's diagnoses inconflammatory react staphylococcus autorganism). R1's quarterly Mini 6/25/20, identified leassistance with becommotion, and to dentified he had all requently incontined at the commotion of the commotio	dar unit at the facility. dinnesota Department of Health distate.mn.us/diseases/crab/ind Carbapenem-resistant mannii (CRAB) is a type of of found in the environment, and water. CRAB can cause of the blood, urinary tract, di other body sites. The bacteria attant, making infections very ecord dated 7/23/20, indicated cluded infection and ion, and methicillin resistant reus (a multi-drug resistant mum Data Set (MDS) dated R1 required extensive di mobility, transfers, ilet use. R1's MDS further in indwelling catheter and was	F 81	deficiencies or conclusions of the Department sinspection Directed Plan of Correction is indicated: Staff education has been condutilizing MedCom system for tracking of the education. Mutraining materials utilize CDC R #1 continues to live on the with Enhanced Barrier Precanegative affect has occurred this deficient practice. Residents who live on the Cocculd have been affected by practice. No negative outcombeen determined. Water pass practice has chainclude the use of disposable will be replaced after each use Staff have received education keeping items away from the uniform. Staff education has completed for sanitation. Audits of sanitation of water conducted 4 times weekly for then monthly for 2 months. Audits will be taken to QAPI review and recommendation	mpleted training and edCom cresources Cedar unit lutions. No related to edar unit this deficient mes have In regarding sir person and is been pass will be r 4 weeks,		

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F 812	blood and body flinfection. A progress note of indicated the facilipositive for CRAE R7's Admission R R7's diagnoses in R7's significant of identified R7 had required supervis On 7/21/20, at 8:5 precaution sign wouter room door. was noted, outside personal protective On 7/21/20, at 9:4 conducted with noted to be on. Note to be on. No	lated 3/20/20, at 5:03 p.m. ity was notified R1 had tested B. decord dated 7/23/20, indicated acluded Alzheimer's disease. hange MDS dated 6/15/20, severely impaired cognition and	F&	312		

CLIVILI	TO I OIL MEDICAILE	A WILDICAID SLIVICES				יסאו סואן.	0930-0391
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		another cup needed to be					
		. NA-E exited R24 and R36's					
		owards the Cedar nurses'					
	station. NA-E oper	ned a door near the Cedar					
	nurses' station, whi	ch indicated Staff Only. NA-E					
		nd removed the lid from the					
		I water from the mug into the					
		pened 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						
		nside the mug, and the scoop					
		t with the inner surface of the					
		ed the scoop from the mug,					
		n additional ice from the					
		n placed the scoop on the					
		and made contact with the					
		E closed the cooler lid and					
		n a holder on the side of the the sink faucet to fill the mug					
		laced the plastic lid. NA-E					
		ly room and walked towards					
		placed the mug on top of the					
		drawer bin outside of R1's					
	room. NA-E was ir	nterviewed at that time and					
		belonged to R1, and she					
		rom R1's room when he					
		efilled. NA-E stated R1 was					
		d barrier precautions due to a					
		A-E stated she was unsure of the resident's infection was.					
	where the source of	n the resident's infection was.					
	On 7/21/20, at 11:3	1 a.m. NA-F approached					
		ne would bring the mug to R1.					
		and an isolation gown, and					
	entered R1's room						
	On 7/21/20, at 12:0	08 p.m. NA-G was observed					
		cup and straw which was in a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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find a Notice of the second of	white cooler and user om the cooler and user on the fauce that used the fauce that a second and used the fauce that a second and used the fauce that a second and used the straw in the cooler of the	reses' station. NA-G opened the seed a scoop to transfer ice the cup. NA-G then closed the scoop in a holder located on, et to fill the cup with water. aff Only room and walked to foom and approached R7. It is straw from the wrapper and in the cup. NA-G leaned the cup. NA-G leaned the cup of water, and NA-G was the surveyor. NA-G confirmed to the promotion of the cup of water. Straw from a source is room. NA-G stated the cooler the removed right away. 10 p.m. an interview was the sensed practical nurse (LPN)-A was going to change the way to residents. LPN-A was the white cooler towards the	F8	12		

AND DI AN OF CORRECTION IN INFRIENCE ATION NUMBER.		TIPLE CONSTRUCTION NG	COM	E SURVEY MPLETED		
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F 812	and staff contamina mug from his room The facility policy P Initiation of Isolation directed, "No special dishes, cups, glass	rocedure for Isolation: al precautions are needed for es, or eating utensils.	F 8	12		
	not provided. Infection Prevention CFR(s): 483.80(a)(§483.80 Infection C The facility must es infection prevention designed to provide comfortable environ	control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the cansmission of communicable	F 88	80		9/1/20
	program. The facility must es and control prograr a minimum, the foll §483.80(a)(1) A sys reporting, investiga and communicable staff, volunteers, vis providing services arrangement based	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(.	(X3) DATE SURVEY COMPLETED				
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F 880	accepted national §483.80(a)(2) Writ procedures for the but are not limited (i) A system of surpossible communi- infections before the persons in the faci (ii) When and to we communicable discreported; (iii) Standard and to be followed to pour (iv) When and how resident; including (A) The type and depending upon the involved, and (B) A requirement least restrictive pocircumstances. (v) The circumstances. (v) The circumstances. (v) The circumstances (vi) The hand hygie by staff involved in §483.80(a)(4) A sysidentified under the corrective actions §483.80(e) Linens Personnel must have proved the standard process.	ten standards, policies, and program, which must include, to: veillance designed to identify cable diseases or ney can spread to other lity; hom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: luration of the isolation, he infectious agent or organism that the isolation should be the esible for the resident under the loces under which the facility oyees with a communicable of skin lesions from direct ents or their food, if direct it the disease; and the procedures to be followed direct resident contact. Testem for recording incidents as facility's IPCP and the taken by the facility.	F 8	80			

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F 880	Continued From բ	page 8	F 8	80		
	IPCP and update This REQUIREMI by: Based on observer review, the facility bathroom was coaresident who was Carbapenem-resi (CRAB) infection reviewed for transaddition, the facility housekeeping selected reviewed for transaddition, the facility housekeeping selected reviewed for transaddition, the facility appropriate transform of 1 residents (Ratesistant staphylosinfection. In additiant appropriately wear (PPE) when in clock (PPE) when in clock (PPE) when in clock (PPE) who were place precautions (use situations in which fluids is anticipated potential to affect the Cedar nursing Findings include: According to the Information of th	I review. Induct an annual review of its their program, as necessary. ENT is not met as evidenced ation, interview, and document failed to ensure a shared insistently cleaned when used by as identified to have a stant Acinetobacter baumannii for 3 of 4 residents (R2, R3, R4) is mission based precautions. In the failed to ensure routine evices were provided on the intervices were provided to implement mission based precautions for 1 and interview in the facility failed to impersonal protective equipment of gowns and gloves beyond in exposure to blood and body and intervices had the all 37 residents who resided on in the facility. Minnesota Department of Health in state minus/diseases/crab/ind "Carbapenem-resistant umannii (CRAB) is a type of ly found in the environment,		R2 no longer resides in the negative affect has occurred this deficient practice. Resiles #8, and #9 did not sustain affect related to this deficient. Residents sharing a bathrown resident infected with Carber resistant Acinetobacter bau could be affected by this depractice. Residents residing unit have the potential to be this deficient practice. Resident #1 has been mover room with a private bathroom. Resident #10 has discharg however, he does not utilize bathroom at this time. Resident #9 MRSA is colon longer in isolation related to remains in enhanced precatorisk of the CRAB infection. Staff have been educated reproper use of PPE as well via MEDCOM. Housekeeping staff is assig Cedar unit and have receive regarding PPE use and pro	d related to dents #3, #4, any negative nt practice. om with a epenem mannii (CRAB) ficient g on the Cedar affected by ed to a private m. es plans, e the ized and no the MRSA but utions related n. egarding as sanitation and to the ed education in the ed education in the man in the ed education in the education in	

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F 880	especially in soil and human infections of lungs, wounds, and are multidrug-resist difficult to treat." Finfected with CRAB other patients via the healthcare workers medical equipment care environment. prevention and corpreventing CRAB to facilities." R2's Medical Diagrindicated R2's diagrobstruction, traumabypass. R2's quarterly Mini 5/22/20, identified cognition. R2's ME extensive assistant supervision with loth (surgical opening into leave the body), bladder. R2's care plan date bowel and bladder and urinary retention offering toileting upbedtime, and as not indicated R2 indep non-compliant with attached to ostomy ask for assistance also identified he was a second control of the property	age 9 and water. CRAB can cause of the blood, urinary tract, dother body sites. The bacteria stant, making infections very further, "Patients colonized or B can spread the bacteria to the contaminated hands of stant, or a contaminated health Implementing infection introl measures is critical to transmission in health care are mosis list dated 7/23/20, gnoses included intestinal atic brain injury, and intestinal atic brain injury, and intestinal atic brain injury, and he needed comotion. R2 had an ostomy into the abdomen to allow stool and was always continent of a deficit related to an ostomy, on. Interventions included on arising, between meals, at eeded. The care plan further endently used a urinal, was a his ileostomy bag (pouch of to collect stool), and "will not from staff." R2's care plan to the vas placed on enhanced a CRAB infection at his	F 880	Audits of proper PPE use will be conducted 4 times weeks, then monthly for 2 Audits will be taken to QA review and recommendat	s weekly for 4 2 months. API for further	

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F 880	indicated the facilit for CRAB. R3's Admission Re R3's diagnoses income side of the book R3's quarterly MDS BIMS score was 12 impaired cognition he required extens frequently incontine occasionally income R3's care plan date deficit with his bow included toilet upon bedtime, and as new R4's Admission Re R4's diagnoses income and was continent On 7/21/20, at 9:05 precaution signage R2's door. A white outside of R2's roccontained PPE supports and signage R2's roccontained R2'	atted 4/6/20, at 4:26 p.m. by notified R2 he tested positive accord dated 7/23/20, identified aluded hemiplegia (paralysis of dy), and muscle weakness. So dated 4/7/20, identified R3's 2 which indicated moderately R3's MDS further identified ive assistance toileting, was ant of bladder, and was tinent of bowel. Bed 9/8/17, indicated R3 had a rel and bladder. Interventions a arising, between meals, at seeded.	F 88	0		

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F 880	On 7/22/20, at 9:0 self-propel his who bathroom located which had a small a.m. the toilet in R be flushed. At 9:12 in his wheelchair, hand. On 7/22/20, at 9:3 conducted with nu confirmed R2, R3, NA-F stated R2 di told him "100 time empty his ostomy. the toilet, but empty his ostomy. The toilet had bethe known to use independently and on 7/22/20, at 10: conducted with NAR4 shared a bathr R2's CRAB infectionals obelieved R2's stated R2 liked to adjoining bathroom toilet independently his coffee cup out	6 a.m. R2 was observed to eelchair to the adjoining in his room. R2 carried a urinal amount of urine in it. At 9:09 2's bathroom was overheard to 2 a.m., R2 exited the bathroom with an empty urinal in his 7 a.m. an interview was rsing assistant (NA)-F. NA-F and R4 shared a bathroom. d things by himself, and staff is a day" not to independently NA-F stated R2 doesn't sit on tied his ostomy pouch into a alld leave it in the bathroom. hopped R2's bathroom several ause he "does not listen." NA-F assistance to use the ewiped the toilet with bleach	F 88				

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F 880	red spots to the are toileted himself. No good sometimes, be really with it." NA-Forces contamination and R4 would indepeathroom. NA-H sitthere "was a big med. On 7/22/20, at 10:4 conducted with lice LPN-A confirmed R with R2. LPN-A stated this ostomy site at was in his urine. LI his ostomy pouch in R4 was confused a independently. LPI nursing staff cleaned confirmed there was for R3 and R4 where shared with R2. On 7/24/20, at 10:5 self-propelling his was towards the Cedar. On 7/22/20, at 11:3 conducted with the (ADON). The ADO his ostomy pouch. provided education stated she did not kadjoining bathroom. On 7/22/20, at 1:57 conducted with the The DON stated she did not kated she did not	ea. NA-H confirmed R4 A-H stated R4's cognition was ut "a lot of times he is not d stated there was risk for in from "time-to-time" as R2 bendently use the adjoining tated R4 would notify staff if ess" in the bathroom. 8 a.m. an interview was insed practical nurse (LPN)-A. Is and R4 shared a bathroom and was unsure if the infection PN-A confirmed R2 emptied independently. LPN-A stated ind used the bathroom N-A stated she was unsure if ed the bathrooms. LPN-A is risk for cross contamination in they used the bathroom 15 p.m. R4 was observed wheelchair from his room, unit elevator. 1 a.m. an interview was assistant director of nursing N confirmed R2 played with The ADON stated R2 was but he continued. The ADON know if R3 or R4 used the	F 8	80			

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F 880	cross contamination a CRAB infection or residents who were stated she was unawho had a CRAB in those who were no she did not work at was given recommoutbreak at the fact beds existed at the survey. On 7/22/20, at 2:32 conducted with the administrator. The infections were idea, 2020. The adminimated resident who had some infection while hosp stated it was unable residents were infection. The exercised recommend private rooms to reinfection. The exercised recommendations are commode to reside infection and share who did not. The exercised bathroom was after a commode with the shared bathroom was a commode with the	d a bathroom with ints. The DON stated a risk for in existed if residents who had sed a shared a bathroom, with interior in the policy of the policy is a shared a bathroom, with interior infected. The DON is a peak to why residents infection shared bathrooms with it infected. The DON stated the facility when the facility endations related to the CRAB lity. The DON stated open facility at the time of the In p.m. an interview was executive director and administrator stated CRAB intified at the facility in February istrator stated they believed a ince died, acquired the ince died, acquired the ince died, acquired the ince died, acquired how other ince to be determined how other ince died, acquired the ince died, acquired the ince died, acquired the ince died at the facility in February is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a providing a ince died at the facility is tractor stated a ince died at the facility is tractor stated a ince died at the facili	F 88			

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F 880	R1's quarterly MDS required extensive transfers, locomotifurther identified he and was frequently R1's care plan date history of MRSA in resistive organism to enhanced barrie and gloves beyond to blood and body infection. R10's Admission R R10's diagnoses in communication defof legs and lower be R10's quarterly MD required extensive always incontinent incontinent of bower be always incontinent incontinent of bower be gracility infection sudated 7/20, indicated infected with CRAE On 7/21/20, at 12:1 (LPN)-A was inform room, located on the contaminated. LPI not assigned to the 7/21/20. On 7/22/20, at 9:37	S dated 5/25/20, identified R1 assistance with bed mobility, on, and toilet use. R1's MDS a had an indwelling catheter, incontinent of bowel. ed 1/8/20, indicated R1 had a his urine, and a carbapenem (CRAB). Staff were to adhere r precautions (use of gowns situations in which exposure fluids is anticipated) to prevent ecord dated 7/23/20, indicated cluded cognitive ficit, and paraplegia (paralysis ody). es dated 7/3/20, identified he assistance toileting, was of bladder, and frequently el. rveillance documentation ed R1, R2, and R10 were	F8	80			
	staff was "picky" ar	nd chose what floor they IA-F stated housekeeping staff					

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F 880	did not want to comstated some house resident rooms to so NA-F stated some confused, and she trained. On 7/22/20, at 10:1 conducted with NA housekeeping staff were supposed to she emptied garban housekeeping staff all the time. On 7/22/20, at 10:3 conducted with househe did not know if assigned to the Ceprimary Cedar houseveryone cleaned in some staff only cleastated she was train when cleaning a rock CRAB. On 7/22/20, at 10:4 conducted with LPI who had a CRAB in Cedar unit with the would be provided.	ne to the Cedar unit. NA-F keeping staff did not go in sweep, mop, or clean toilets. housekeeping staff looked believed they were not well 7 a.m. an interview was		380			
	On 7/22/20, at 11:3 conducted with the was not aware of a	n the primary housekeeper 1 a.m. an interview was ADON. The ADON stated she ny housekeeping issues on e ADON stated no staff had					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: (X2) MULTIPLE CONSTRUCTION NUMBER: (X3) MULTIPLE CONSTRUCTION NUMBER: (X4) MULTIPLE CONSTRUCTION NUMBER: (X5) MULTIPLE CONSTRUCTION NUMBER: (X6) MULTIPLE CONSTRUCTION NUMBER: (X7) MULTIPLE CONSTRUCTION NUMBER: (X8) MULTIPLE CONSTRUCTION NUMBER: (X9) MULTIPLE CONSTRUCTION NUMBER: (X9) MULTIPLE CONSTRUCTION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: (X9) MULTIPLE CONSTRUCTION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: (X2) MULTIPLE CONSTRUCTION NUMBER: (X2) MULTIPLE CONSTRUCTION NUMBER: (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: (X2) MULTIPLE CONSTRUCTION NUMBER: (X2) MULTIPLE CONSTRUCTION NUMBER: (X3) PROVIDER/SUPPLIER/CLIA (X3) PROVIDER/SUPPLIER/CLIA (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLI			(X3) DATE SURVEY COMPLETED			
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F 880	expressed concerr availability. On 7/22/20, at 12:5 conducted with the director (ESD)-A. was assigned to the vacation. ESD-A subathrooms were clarouble with a house Cedar unit, as they duty, and later quit us a lot." ESD-A sonot scheduled on a staff were expected and "do what they stated residents, factions that were when staff declined unit, she assigned On 7/22/20, at 1:57 conducted with the had concerns if ho Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit. The Doliked to have had a she knew when the Cedar unit.	a about housekeeping 52 p.m. an interview was environmental services ESD-A stated a staff person e Cedar unit, but was on stated public areas and eaned. ESD-A stated she had eakeeper who worked on the hurt their wrist, were on light . ESD-A stated "this devastated tated when a housekeeper was Cedar unit, other housekeeping d to clean their primary wing can" on the Cedar unit. ESD-A milies, and other staff did not ESD-A stated housekeepers leaning the Cedar unit due to e on the unit. ESD-A stated d to be assigned to the Cedar	F 88				

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F 880	a lot when open s The facility policy Control (General) system is in place reports, investigat communicable dis volunteers, visitor providing services arrangement and standards." R8's Face Sheet p diagnoses include R8's quarterly MD had impaired cog staff for ambulatic assistance of staf (ADLs). R8's progress not returned from the COVID-19 quarar On 7/21/20, at 9:1 to have a clear bir included PPE, sig precaution,s and a day quarantine way On 7/21/20, at 9:4 observation NA-A room with her face shield resting on h standing next to F NA-A proceeded to exit room. NA-A	hifts were identified. Infection Prevention and dated 11/16, directed, "A that prevents, identified, es, and controls infections and sease for all residents, staff, s, and other individuals a under a contractual following accepted national printed 7/23/20, indicated R8's	F8	80			

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F 880	tray on the cart. No her chest throughood on 7/21/20, at 9:42 entered R8's room, next to R8 without to R8 room with her face shield still resting of standing next to R8 proceeded go to R8 of latex gloves and then used ABHR are face shield remains observation. On 7/22/20, at 11:3 (RN)-A stated staff shields while provide admission were questaff had been instrained it was imported to staff and other results of the	A-A's face shield remained on ut the observation. It a.m. NA-A verified she had and had been standing right the face shield in place. It a.m. during continuous was observed entering R8's mask in place, and her eye in her chest. NA-A was b's wheelchair. NA-A B's bathroom, gathered a pair handed them to R8. NA-A and exited R8's room. NA-A's ed on her chest throughout the armatined for 14 days, and fucted to don full PPE when in included gown, eye and face mask. RN-A further tant for staff to follow contact or to prevent spread of infection		80			

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	while in the facility non-COVID-19 res R9's Face Sheet prodiagnoses included sepsis. R9's quarterly Minit 6/8/20, indicated R cognition, and requactivities of daily live R9's care plan initia a bowel and bladded catheter, and requiand catheter care. R9's physician ordefacility to implement place R8 in isolation screening was obtained discontinue contact positive, continue of R9's progress note had been transferred unit. On 7/21/20, at 10:20 observation NA-A which included an incom. NA-A closed then entered R9's rand eye shield/protexited the room and	wearing full PPE for all cares to include eye protection for idents. rinted 7/23/20, indicated R10's history of pneumonia and mum Data Set (MDS) dated 10 had severe impaired irred assistance with all	F8	80			

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F 880	stated isolation pro R9 on the daily ca signage to notify s further stated she precautions were At 10:37 a.m. NA- room wearing only shield/protection. I room, and stated I should have had o providing cares fo have been no way to wear an isolatio room, since there nor was a PPE bir On 7/21/20, at 10: facility implemente on resident's door communication gr when enhanced pi precautions were LPN-A stated she hospice on 7/20/2 required contact a related to his diag LPN-A verified R9 and a PPE bin, bo indicated to staff o barrier precautions R9's room. LPN-A known he required On 7/21/20, at 3:5 agency staff was i hospice nurse had with concerns that	ecaution was not indicated for re sheets, nor was there taff of the precautions. NA-E had no idea isolation required for R9. D was observed entering R9's wher face mask and eye NA-D immediately exited the NA-A and NA-E told her she complete PPE in place when r R9. NA-D stated there would of knowing she was required in gown prior to entering R9's had not been a sign in place, in outside R9's door.	F 88				

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F 880	R9 had been on fuin-house transfer for Cedar Unit. On 7/22/20, at 11:3 (RN)-A stated staff residents that requite through the use of placed outside of rRN-A stated staff phis diagnosis of Ml following full isolation reduce the risk of stated R9 was transtead there could infection due to lack of information an RN manager or verified R9's order. R9's in-house transferred to Cedar the risk of spreading to lack of signature to l	age 21 Il precautions prior to his rom the Spruce Unit to the 31 a.m. registered nurse were made made aware of the ire isolation or precautions signage on doors, PPE bins ooms, and group care sheets. Providing cares for R9 due to RSA, should have been on precaution measures to transmission of infection. RN-A asferred from Spruce unit to 1/20, and contact precautions ce when he transferred. RN-A be the risk of and spread of the signage, no PPE bin, and on group sheets. RN-A stated of licensed nurse should have to ensure accuracy when sfer occurred on 7/14/20. 35 p.m. during interview the equired full precautions related as in urine. The DON stated are unit on 7/14/20, increased and infection. The DON stated age, no PPE bin, nor was this tes, staff would not have known ions. The DON stated failure to	F 88	,			
	spreading MRSA to The facility policy I directed the facility infections within th	ions had the potential for presidents. solation Precautions undated, to prevent the transmission of the facility through the use of the solution to Standard					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245366	B. WING		1	C 07/22/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811	1 0111	22/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 880	residents known or microorganisms th direct or indirect co	age 22 Contact Precautions for r suspected to be infected with at can be easily transmitted by ontact, such as handling faces or resident-care items.	F8	80			



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.cd

c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): 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

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

Healthcare Infection Prevention and Control FAQs for COVID-19:

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MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

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

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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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 12, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: TFUX11

Dear Administrator:

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

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

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

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

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

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

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

> Teresa Ament, Unit Supervisor Email: teresa.ament@state.mn.us

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

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the deficient herein are not corrected shall with a schedule of the Minnesota Dep					
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was comple complaint investiga to be not in complia	TS: h 7/22/20, an abbreviated ted at your facility to conduct tions. Your facility was found ance with 42 CFR Part 483, ong Term Care Facilities.				
	The following comp	plaints were found to be				

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

Electronically Signed 08/14/20

TITLE

STATE FORM 6899 If continuation sheet 1 of 21 TFUX11

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		DULUTH,	MN 55811			
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	substantiated with 6 H5366146C H5366147C H5366148C H5366149C H5366150C	correction orders issued:				
21015	5 MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi		21015			9/1/20
	Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to handle ice under sanitary conditions, to prevent cross contamination from infectious sources. This practice had the potential to affect all 37 who resided on the Cedar unit at the facility.			Acknowledge receipt		
	Findings include:					
	(MDH) website https://www.health.ex.html undated, "CAcinetobacter baum bacteria commonly especially in soil and human infections of lungs, wounds, and	innesota Department of Health state.mn.us/diseases/crab/ind Carbapenem-resistant nannii (CRAB) is a type of found in the environment, ad water. CRAB can cause of the blood, urinary tract, I other body sites. The bacteria tant, making infections very				

Minnesota Department of Health

STATE FORM 6899 TFUX11 If continuation sheet 2 of 21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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Minnesota Department of Health

STATE FORM 6899 TFUX11 If continuation sheet 3 of 21

Minnesota Department of Health

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CHRIS J	ENSEN HEALTH & RE	HABILITATION C		E LAKE ROA	.D		
				MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21015	Continued From page 3		21015				
	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.						
	noted to be on. Nu towards R1's room,	9 a.m., R1's call light rsing assistant (NA)- and put on an isolat entered R1's room, a	E walked tion gown				
	with a large plastic with water. NA-E h against her upper use her forearms (hugg down the hallway at room. A staff person R36's room asked I staff person stated used to fill the mugaroom and walked to station. NA-E open nurses' station, while entered the room a mug. NA-E poured sink. NA-E then op was on a rolling car which was on the si transferred ice from placed the scoop in made direct contact mug. NA-E remove	9 a.m. NA-E exited Finug which was particled the large plastic niform shirt by using ing motion). NA-E was endented R24 and on who was inside R2NA-E about the muganother cup needed. NA-E exited R24 a lowerds the Cedar nuted a door near the Cech indicated Staff Or not removed the lid from water from the mugaened a white ice coot. NA-E obtained a side of the cooler, and the cooler to the muside the mug, and the with the inner surfaced the scoop from the additional ice from	ally filled mug both of valked R36's 24 and The to be nd R36's rses' Cedar hly. NA-E om the into the oler which coop dug. NA-E ne scoop ce of the e mug,				
	cooler. NA-E again inside of the mug, a	i placed the scoop or and made contact wi E closed the cooler li	n the th the				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00598		B. WING			C 22/2020
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROA	STATE, ZIP CODE D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY I SC IDENTIFYING INFORMA'	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21015	cooler. NA-E used with water, and reprexited the Staff Onl R1's room. NA-E purple white plastic three croom. NA-E was in confirmed the mug removed the mug frequested it to be replaced on enhance CRAB infection. Nowhere the source of On 7/21/20, at 11:3 NA-E and stated should not	a holder on the side the sink faucet to fill the sink faucet the plastic lid. It is proom and walked to laced the mug on top drawer bin outside of terviewed at that time belonged to R1, and from R1's room when efilled. NA-E stated Filled. NA-E stated Filled barrier precautions A-E stated she was ure the resident's infection and an isolation gow	the mug NA-E pwards of the R1's e and she he R1 was due to a nsure fon was. hed g to R1. rn, and served vas in a Only room bened the er ice losed the ted on, ater. lked to R7. per and dA-G was anfirmed la-G was urce the cooler y. ras	21015			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING		l l	C 22/2020
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21015	LPN-A stated R1 has stated the facility was water was brought observed pushing tunit elevator on a way. On 7/22/20, at 11:3 conducted with the (ADON). The ADO themselves by remand placing it again confirmed the ice was touched the large publiced it back in the many other areas was well. On 7/22/20, at 1:57 conducted with the The DON stated the dedicated equipme and staff contaminaming from his room. The facility policy Punitiation of Isolation directed, "No special dishes, cups, glass A facility policy for strequested, but not pushes, cups and provided. SUGGESTED MET The Director of Nurreview policies, trained and staff contamination of the second contamination of	ad CRAB in his urine as going to change the to residents. LPN-A whe white cooler towar heeled cart. 1 a.m. an interview wassistant director of N stated staff contant oving a mug from R1 st their scrubs. The was contaminated who lastic mug with the secooler. The ADON would had been contained to the was concerns for not potential for transfation when staff removed in Precautions undated all precautions are need, or eating utensils storing/handling ice was coring/handling ice was coring in precautions in precautions are need to the coring was coring/handling ice was coring in precautions in precautions are need to the coring was coring	was rds the vas nursing ninated l's room ADON en staff coop and stated aminated, as DON). mission, oved R1's ed, eeded for i. vas sted, but FION: buld to assure	21015			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE :	
		00598	B. WING		07/2	; 2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	•	
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	E LAKE ROA , MN 55811	ND.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 6	21015			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21375	5 MN Rule 4658.0800 Subp. 1 Infection Control; Program		21375			9/1/20
	home must establis	on control program. A nursing the and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility fa bathroom was cons a resident who was Carbapenem-resist (CRAB) infection fo reviewed for transm addition, the facility housekeeping servi Cedar nursing unit of multi-drug resista addition, the facility appropriate transmi of 1 residents (R1), resistant staphyloco infection. In additio appropriately wear (PPE) when in close R9) who wer placed precautions (use of situations in which of fluids is anticipated	ant Acinetobacter baumannii r 3 of 4 residents (R2, R3, R4) hission based precautions. In failed to ensure routine ces were provided on the to prevent the potential spread ant organisms (MDROs). In failed to implement ssion based precautions for 1 who had a methicillin occus aureus (MRSA) n, the facility failed to personal protective equipment e contact with 2 residents (R8, d on enhanced barrier gowns and gloves beyond exposure to blood and body). These practices had the II 37 residents who resided on		Acknowledge receipt		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONTROL	IDENTIFICATION NOMBER.	A. BUILDING:			
		00598	B. WING		07/2	2/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CHDI6 I	ENSEN HEALTH & RE	ELIABILITATION C 2501 RIC	E LAKE ROA	ND.		
CHKIS J	ENSEN HEALTH & RE	DULUTH	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 7	21375			
	Findings include:					
	(MDH) website https://www.health.ex.html undated, "CAcinetobacter baum bacteria commonly especially in soil and human infections or lungs, wounds, and are multidrug-resist difficult to treat." Fuinfected with CRAB other patients via the healthcare workers medical equipment care environment. In prevention and con	state.mn.us/diseases/crab/ind Carbapenem-resistant nannii (CRAB) is a type of found in the environment, ad water. CRAB can cause of the blood, urinary tract, di other body sites. The bacteria tant, making infections very purther, "Patients colonized or of can spread the bacteria to the contaminated hands of through contaminated to or a contaminated health dimplementing infection trol measures is critical to cansmission in health care				
	indicated R2's diag	nosis list dated 7/23/20, noses included intestinal ttic brain injury, and intestinal				
	5/22/20, identified F cognition. R2's MD extensive assistant supervision with loc (surgical opening ir	mum Data Set (MDS) dated R2 had moderately impaired DS further identified he required be toileting, and he needed comotion. R2 had an ostomy and the abdomen to allow stool and was always continent of				
		ed 6/30/20, indicated R2 had a deficit related to an ostomy,				

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and urinary retention. Interventions included

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00598	B. WING		07/2	; 2/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	0112	2/2020
CHRIS J	ENSEN HEALTH & RI	EHABII ITATION C 2501 RICI	E LAKE ROA			
	Г	DULUTH,	MN 55811	DDO//DEDIO DI AN OF CODDECTI	ON!	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 8	21375			
	bedtime, and as ne indicated R2 independent indicated R2 independent with attached to ostomy ask for assistance also identified he was precautions due to ostomy site.	on arising, between meals, at seded. The care plan further endently used a urinal, was his ileostomy bag (pouch to collect stool), and "will not from staff." R2's care plan as placed on enhanced a CRAB infection at his ted 4/6/20, at 4:26 p.m. y notified R2 he tested positive				
	R3's Admission Re R3's diagnoses inc	cord dated 7/23/20, identified luded hemiplegia (paralysis of ly), 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.					
		cord dated 7/23/20, indicated luded muscle weakness and et.				
	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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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII		` ′	E CONSTRUCTION		SURVEY PLETED
				A. BUILDING:			_
		00598		B. WING			C 22/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	EHABILITATION C		E LAKE ROA MN 55811	.D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21375	precaution signage R2's door. A white outside of R2's rook contained PPE supshared with R3 and lying in bed. An em R2's bed rail. On 7/22/20, at 9:06 self-propel his wheel bathroom located in which had a small as.m. the toilet in R2 be flushed. At 9:12 in his wheelchair, whand. On 7/22/20, at 9:37 conducted with nurconfirmed R2, R3, NA-F stated R2 did told him "100 times empty his ostomy. The toilet, but emptigraduate, and would NA-F stated she mitimes per day becastated R3 required bathroom, and she prior to R3 using it. independently used was very confused. Cross contamination were known to use independently and On 7/22/20, at 10:1 conducted with NA-F contains and the prior to R3 using it. Independently and On 7/22/20, at 10:1 conducted with NA-F condu	was observed to be plastic three drawer m. The white plastic plies. R2's bathroom R4's room. R2 was apty urinal was hanging a.m. R2 was observed his room. R2 carriamount of urine in it. P's bathroom was over a.m., R2 exited the with an empty urinal in a man an interview was in a said things by himself, a said a day" not to independ R4 shared a bath opped R2's bathroom use he "does not list assistance to use the wiped the toilet with NA-F stated R4 the adjoining bathroom without staff knowled T a.m. an interview when the shared bathroom without staff knowled T a.m. an interview when. NA-H confirmed T a.m. an interview when.	bin was bin was bin was observed ing on /ed to ng ed a urinal At 9:09 erheard to bathroom n his as F. NA-F hroom. nd staff endently sn't sit on n into a room. n several en." NA-F e bleach boom, and risk for R4 both n dge. was R3 and	21375			
		oom with R2. NA-H s on was at his ostomy					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00598	B. WING		07/2	2/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	0112	.2/2020
	ENSEN HEALTH & RI	EHARII ITATION C 2501 RICE	LAKE ROA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21375	also believed R2's stated R2 liked to e adjoining bathroom toilet independently his coffee cup out is stated R2 played wred spots to the are toileted himself. No good sometimes, breally with it." NA-Foross contaminatio and R4 would independently at his ostomy site a was in his urine. LI his ostomy pouch in R4 was confused a independently. LPI nursing staff cleaned confirmed there was for R3 and R4 whe shared with R2. On 7/24/20, at 10:5 self-propelling his was towards the Cedar On 7/22/20, at 11:3 conducted with the (ADON). The ADO his ostomy pouch. provided education	urine was infected. NA-H empty his ostomy pouch in the and dumped his urine in the and the bathroom sink. NA-H ith his ostomy site, and had be and the bathroom sink. NA-H and the	21375			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00598	B. WING		C 07/22/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	E LAKE ROA MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From page 11		21375			
	conducted with the The DON stated sh being used for residenter infection and share non-infected residences contamination a CRAB infection unresidents who were stated she was unawho had a CRAB in those who were not she did not work at was given recommon outbreak at the faci	nts. The DON stated a risk for n existed if residents who had sed a shared a bathroom, with not infected. The DON able to speak to why residents affection shared bathrooms with infected. The DON stated the facility when the facility endations related to the CRAB lity. 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					

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	(X3) DATE SURVEY COMPLETED						
00598 B. WING	C 07/22/2020						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)							
continued From page 12 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 tollet 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.							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				7. BOILDING.			С
		00598		B. WING			22/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	EHABILITATION C		E LAKE ROA MN 55811	AD .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	conducted with NA staff was "picky" ar wanted to clean. N did not want to comstated some house resident rooms to s NA-F stated some confused, and she trained. On 7/22/20, at 10:1 conducted with NA housekeeping staff were supposed to she emptied garbachousekeeping staff all the time. On 7/22/20, at 10:3 conducted with housekeeping staff all the time. On 7/22/20, at 10:3 conducted with housekeeping staff all the ceprimary Cedar housekeeping staff all the time. On 7/22/20, at 10:4 conducted staff only cleastated she was train when cleaning a rock CRAB. On 7/22/20, at 10:4 conducted with LPI who had a CRAB in Cedar unit with the would be provided. staff being assigne "hit-and-miss" when was not scheduled.	-F. NA-F stated housed chose what floor the IA-F stated housekeen to the Cedar unit. Ekeeping staff did not sweep, mop, or clean housekeeping staff lobelieved they were not a.m. an interview vH. NA-H stated fowent into resident roclean bathrooms. Nages on the unit because was unable to be every a housekeeper (H)-A. H-A a housekeeper was dar unit. H-A stated it sekeeper was on vactorial to "just protect mom with a resident work. LPN-A stated reflection were moved promise daily housed to the Cedar unit win the primary housekeeper was done to the Cedar unit was	eping staff NA-F go in toilets. boked oot well vas boms, and A-H stated use erywhere vas A stated always the cation, and A stated sk-A hyself" ho had vas esidents to the keeping ekeeping exeper	21375			
		ADON. The ADON :					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00598	B. WING			C 22/2020	
PROVIDER OR SUPPLIER	HABILITATION C 250	1 RICE LAKE RO	AD			
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
was not aware of at the Cedar unit. The expressed concern availability. On 7/22/20, at 12:5 conducted with the director (ESD)-A. Expressed to the vacation. ESD-A st bathrooms were cleated trouble with a house Cedar unit, as they duty, and later quit. us a lot." ESD-A st not scheduled on C staff were expected and "do what they estated residents, far have complaints. Expressed that they confections that were when staff declined unit, she assigned so the concerns if hou Cedar unit. The DO liked to have had concerns if hou Cedar unit. The DO additional cleaning Cedar unit. On 7/22/20, at 2:32 conducted with the	ny housekeeping issues of a ADON stated no staff hat about housekeeping 2 p.m. an interview was environmental services ESD-A stated a staff person at ESD-A stated a staff person at ESD-A stated she have been a housekeeper who worked on the hurt their wrist, were on like ESD-A stated "this devastated when a housekeeper at the Cedar unit, other housekeeper and their primary wire can" on the Cedar unit. ESM illes, and other staff did SD-A stated housekeeper eaning the Cedar unit due to be assigned to the Cersomeone else. p.m. an interview was DON. The DON stated she would have bonversations with ESD-A stated she would have onversations with ESD-A stated she did not know was being completed on the p.m. an interview was executive director and	had he ght tated was sping ng SD-A not ss to d dar				
housekeeper assig	ned to the Cedar unit was	on				
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa was not aware of at the Cedar unit. The expressed concern availability. On 7/22/20, at 12:5 conducted with the director (ESD)-A. If was assigned to the vacation. ESD-A st bathrooms were cle trouble with a house Cedar unit, as they duty, and later quit. us a lot." ESD-A st not scheduled on C staff were expected and "do what they of stated residents, fa have complaints. E had no concerns cle infections that were when staff declined unit, she assigned s On 7/22/20, at 1:57 conducted with the had concerns if hou Cedar unit. The DO liked to have had or she knew when the Cedar unit. The DO additional cleaning Cedar unit. On 7/22/20, at 2:32 conducted with the administrator. The housekeeper assig	OF CORRECTION O0598 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 was not aware of any housekeeping issues of the Cedar unit. The ADON stated no staff has 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 is trouble with a housekeeper who worked on the Cedar unit, as they hurt their wrist, were on lied uty, and later quit. ESD-A stated "this devas us a lot." ESD-A stated when a housekeeper not scheduled on Cedar unit, other housekees staff were expected to clean their primary wir and "do what they can" on the Cedar unit. ESD-A stated no concerns cleaning the Cedar unit due infections that were on the unit. ESD-A stated when a sasigned 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 shad concerns if housekeeping was not on the Cedar unit. The DON stated she would have liked to have had conversations with ESD-A she knew when there was short staffing on the Cedar unit. The DON stated she did not know 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 housekeeper assigned to the Cedar unit was	OF CORRECTION ODS98 STREET ADDRESS, CITY 2501 RICE LAKE RO DULUTH, MN 55811 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 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	OF CORRECTION DENTIFICATION NUMBER: B. WING	OF CORRECTION ODS98 STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC DENTIFYMS INFORMATION) COntinued From page 14 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 public areas and bathrooms were cleaned. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00598		B. WING			C 22/2020
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
CHRIS J	ENSEN HEALTH & RE	HABILITATION C		E LAKE ROA MN 55811	D		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		MUST BE PRECEDED BY SC IDENTIFYING INFORM		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLÉTE DATE
21375	Continued From pa	ge 15		21375			
	The administrator s a lot when open shi	tated ESD-A worked fts were identified.	the floor				
	Control (General) d system is in place the reports, investigated communicable dise volunteers, visitors, providing services to	ifection Prevention a ated 11/16, directed, hat prevents, identifics, and controls infect ase for all residents, and other individual under a contractual ollowing accepted na	"A ed, tions and staff, s				
	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).						
	returned from the h	dated 7/17/20, indicated ospital, and was to rune for 14 days, until	emain on				
	to have a clear bin included PPE, signal precaution,s and a	a.m. R8's room was outside of the room v age for enhanced ba red stop sign directir to be in effect until	which rrier ng a 14				
	observation NA-A waroom with her face shield resting on he standing next to R8 NA-A proceeded to exit room. NA-A war	a.m. during continue /as observed enterin mask in place, and her chest. NA-A was on 's wheelchair, and ta clean off R8's tray to as observed using all BHR) after placing R	g R8's her eye bserved ilking. able and cohol				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING			C 22/2020
	NAME OF PROVIDER OR SUPPLIER CHRIS JENSEN HEALTH & REHABILITATION C DULUTH				STATE, ZIP CODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	tray on the cart. Naher chest throughod On 7/21/20, at 9:42 entered R8's room, next to R8 without to Con 7/21/20, at 9:46 observation, NA-A room with her face shield still resting of standing next to R8 proceeded go to R8 of latex gloves and then used ABHR are face shield remained observation. On 7/22/20, at 11:3 (RN)-A stated staff shields while provious admission were questaff had been instrained it was imported it was imported it was imported by the control of the staff and other results of the control of t	A-A's face shield renut the observation. a.m. NA-A verified and had been stand he face shield in place a.m. during continuous observed enterimask in place, and in her chest. NA-A wis wheelchair. NA-A's shathroom, gather handed them to R8 and exited R8's room. It a.m. registered number to be wearing a ling cares. RN-A standarantined for 14 days ucted to don full PP in included gown, eyend face mask. RN-A tant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for staff to follow to prevent spread of the stant for st	she had ding right ace. ous ng R8's her eye was A red a pair NA-A NA-A's aghout the arse eye ted all new s, and E when in extreme to contact of infection and eye at all n proper infections. undated,	21375			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00598		B. WING			C 22/2020
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	TATE, ZIP CODE		
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21375	while in the facility to non-COVID-19 resing residence of the properties of the prop	o include eye protectidents. inted 7/23/20, indicate history of pneumonianum Data Set (MDS) 10 had severe impaire ired assistance with a	ed R10's and dated ed II dated welling ileting ected the and A ation. If colation. Ited R9 codar ous PPE nother NA-E mask ately allway to . NA-E go get a . NA-E	21375			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING		C 07/22/2020		
NAME OF		00598			0772	2/2020	
	PROVIDER OR SUPPLIER	2501 RICE	E LAKE ROA	STATE, ZIP CODE D			
CHRIS J	ENSEN HEALTH & RI	FHABILITATION C	MN 55811	_			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ige 18	21375				
	signage to notify staff of the precautions. NA-E further stated she had no idea isolation precautions were required for R9.						
	room wearing only shield/protection. N room, and stated N should have had co providing cares for have been no way to wear an isolation	was observed entering R9's her face mask and eye A-D immediately exited the A-A and NA-E told her she emplete PPE in place when R9. NA-D stated there would of knowing she was required a gown prior to entering R9's had not been a sign in place, 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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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		00598	D. WING		07/2	2/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	-HABII ITATION C	E LAKE ROA MN 55811	.D		
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21375	Continued From pa	ge 19	21375			
	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					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:				
		00598	B. WING			C 22/2020		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE		
21375	environmental surface SUGGESTED MET Director of Nursing, systems to ensure a residents, and nonfrom infectious sou of Nursing, or design appropriate staff on appropriate transmining Director of Nursing, Environmental Service policies to ensure econsistently perform known multi-drug responsible to the Director of Nursing, Environmental Service policies to ensure econsistently perform known multi-drug responsistently perform known multi-drug responsistently perform known multi-drug responsistently perform the Director of Nursing, Environmental Service propriate staff on The Director of Nurdevelop monitoring compliance.	aces or resident-care items. THOD OF CORRECTION: 1, or designee, could develop areas shared by infectious infectious residents, are freces prior to use. The Direction procession based precautions. It implementation of ission based precautions. It is or designee, and vices Director could develop environmental cleaning is ned on nursing units with esistant organisms. The	The ector The eall s.					

Minnesota Department of Health STATE FORM