

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 September 8, 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 September4, 2020, we informed you of imposed enforcement remedies.

On August 21, 2020, the Minnesota Department of Health completed a survey/revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

This Department continues to recommend that CMS impose a 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.

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.

As we notified you in our letter of August 12, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 11, 2020. However, due to the extended survey the new NATCEP loss date is August 19, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

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 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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/INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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: 09/30/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	` '	E SURVEY PLETED
		245366	B. WING			1	C 21/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	00/	21/2020
CHRIS JI	FNSFN HFAI TH & RI	EHABILITATION CENTER			501 RICE LAKE ROAD		
	ENGEN NEAETH & N			E	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F0	000			
	completed at your tinvestigation. Your	0 an abbreviated survey was facility to conduct a complaint facility was found not to be in 2 CFR Part 483, Requirements a Facilities.					
		plaints were found to be a deficiency cited at F689:					
	H5366151C H5366152C						
	The following compunsubstantiated:	plaints were found to be					
	H5366153C H5366154C						
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required the first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	on-site revisit of yo validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					
	Free of Accident Ha CFR(s): 483.25(d)(azards/Supervision/Devices 1)(2)	F6	89			9/21/20
	§483.25(d) Accider The facility must er §483.25(d)(1) The						
LABORATOR)	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Electronically Signed 09/21/2020

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
			71. BOILBIN	<u> </u>		
		245366	B. WING _		08/2	21/2020
	PROVIDER OR SUPPLIER ENSEN HEALTH & R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observa review, the facility assess falls for ca interventions to mi and/or injury for 2 reviewed for falls. Findings include: R2's annual Minim 8/16/20, indicated had diagnoses wh hypotension, Park prostatic hyperplas depression (bipola atrophy, other lack muscle weakness also indicated R2 one person for trai on the unit, toilet u extensive assist of MDS further indica more falls without injury (except majo assessment. R2's Falls Care Ar 8/19/20, identified R2 who had physic balance, gait, street	age 1 It hazards as is possible; and In resident receives adequate sistance devices to prevent ENT is not met as evidenced ation, interview and document failed to comprehensively usal factors in order to develop inimize the risk for further falls of 4 residents (R2, R3) The management of the previous The management of the previous of the previous The management of the previous of the previous The previous of the previo	F 68	Resident # 2 falls assessments habeen reviewed in a timeline to comprehensively assess and deterindividualized comprehensive care Resident #3 no longer resides at the community. All other residents who have had a the past 60 days will have comprefall assessment reviewing for caus factors and care plan revised with interventions added to minimize the for further falls and/or injury. Education provided to nursing staff comprehensive assessment of all and individualized interventions to and minimize risk for further falls a injuries. DON or designee will audit each face 24 hours for 30 days, then 2 X weee 30 days and then monthly for 30 days and then monthly for 30 days and care planning and present. DON or designee will ensure company 9/17/2020	fall in nensive al erisk on falls reduce nd/or Il within ekly for ays to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS	TRUCTION	COM	E SURVEY MPLETED	
		245366	B. WING				C / 21/2020	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811			1 00/	00/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 689	indicated R2 require mobility, transfers, with set up for eating wheelchair for locoland ambulated with been continent of the antidepressant me integrity issues. The risk and had experduring the assessma wareness and lime. R2's Care Plan prohad deficits with accepted to Parkinson infection (UTI), his anxiety disorder, and directed R2 reassistance with a frassistance of one pand bed mobility. R2 was at risk for fawareness, UTI, Punsteady gait. The provide the following on wheelchair, bed walker, call don't faunnecessary items walker within reach within easy reach, leave in bathroom also indicated a riswas in place regard alarms placed. R2 R2 was non-compled declined assistance with walker and direasons for non-compled to the reach walker and direasons for non-complete in the reach walker and direasons for non-co	red assistance of one for bed toileting and was independent ng. R2 used a walker and motion. R2 self transferred nout staff assistance. He had bowel and bladder, took dication and did not have skin ne CAA indicated R2 was at ienced falls in the facility during nent period due to poor safety	F6	89				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245366	B. WING		08	C / 21/2020
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811		72172020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From pa	age 3	F 6	89		
	appropriate, review ineffective.	for alterations or change if				
	5/20/20, indicated I the last MDS. See currently working w On 8/20/20, at 10:4	11 a.m. R2 was observed				
	walker. A houseke stated she was goi with R2 about what ambulated slowly to housekeeper left th housekeeper return and proceeded to rurned around and the bed with the us taking small, slow,	m by his beside, holding onto a seper was in R2's room and ing to use her mop and visited at she was going to do. R2 oward the door. The ne room and went to a located in the hall. The ned to the room with a mop mop the bathroom floor. R2 ambulated back to the head of e of his four-wheeled walker, stuttering steps. R2 was ed tennis shoes and his gait dy.				
		ical record from 7/3/20 to 2 experienced 7 falls:				
	found R2 laying on his commode. R2 experienced a sma	m. a nursing assistant (NA) his left side in his room near stated he slipped. R2 ll abrasion measuring 1.0 1.0 cm to his left knee				
		n. R2 was found on the floor de. R2 stated "I did not fall, injury.				
		. R2 was found on his knees n the upper part of his body on				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
		245366	B. WING			C / 21/2020
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 2501 RICE LAKE ROAD DULUTH, MN 55811		72172020
(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 CC ((EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	commode was full urine in it on his be still by his commode. R2 wood Small scraped area -8/12/20, at 2:00 p. in his room beside side with the walke R2 stated he got up his recliner to fold he -8/12/20 at 8:14 p.r side on the floor fact himself ready for be wearing socks only slipped on the floor on bed. R2 got hold go until he snapped apparent injury how alarm was placed.	raying position. R2's of urine, also had a urinal with dside table and his walker was to on the far side of the ald not say what he was doing. It to right knee. m. R2 was found on the floor the recliner, lying on his right resideways underneath him. It is from his bed to walk over to his jacket. No injury. m. R2 was found on his left cing his bed. He was getting ed with no help. R2 was record to his shoes off and record and would not let to the cord, breaking it. No wever, R2 was very upset an lacked a comprehensive notify causal factors for the	F 6	89		
	assistant (NA)-A sa with R2, however, i room with the use of was supposed to h transfers and ambut use his call light, ho for staff to arrive ar NA-A also indicated	roximately 2:30 p.m. nursing ated she was not very familiar indicated he was up in his of a walker. NA-A stated R2 ave stand by assistance for ulation and that R2 was able to owever, he did not always wait and would often self transfer. It R2 required his bed at sitting ther knowledge, he was not to born alone.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245366	B. WING		08/21/2020	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (2501 RICE LAKE ROAD DULUTH, MN 55811		72172020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	On 8/20/20, at ap stated she was fa was very particular placement and the needs. NA-B individuals about his room an needed to keep puthe same position call light and ask transferred before NA-B stated the srisks for falls and hospital due to in the hospital. NA-about waiting for wheelchair on dains bed at a sitting made sure to kee could steady hims verified R2 had estated he needed use of a walker for the could steady hims verified R2 continuated involve allow R2 to make fully understood to transfers/ambulation obsessive qualities agree with him, he leave her alone a stated God was whis time to go it wounderstood one of transfers/ambulatidid go sixteen dailour states of the country of t	proximately 3:00 p.m. NA-B smilliar with R2. NA-B stated R2 ar about his room and item e staff tried to anticipate his icated R2 could be obsessive and items in his room so the staff personal items near him and in as. She stated R2 could use the for help but often self e they would get to his room. Staff would remind R2 of the potential need to go to the jury as he did not like going to B stated R2 had been better help and that R2 used a ys he felt weaker and needed g height. NA-B stated she also spe the walker by R2's bed so he self if he did self transfer. NA-B experienced a lot of falls and stand by assistance with the or ambulation. 36 a.m. registered nurse (RN)-A stand to fall and continued to be really and continued to the resks and ramifications of self tion. RN-A stated R2 had some as and if R2's sister did not bout it. RN-A stated R2 had watching out for him and if it was that time to go, and that R2	Fe	689		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED	
		245366	B. WING		08	C / 21/2020	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	them. RN-A state call lights, signs in R2's obsessive powith them constant also moved R2 to desk, and also trivith a reversed beincrease independamong those with therapy. RN-A stated R2 had also attention he receivanted receival assessment of roward through Appropriate assessment of roward through Appropriate assessment of roward through appropriate assessing the system would only trigger one and incidents. RN-A sworking through the post fall assessment of roward through the system would only trigger one and incidents. RN-A sworking through the post fall assessment of roward through the system would only trigger one and incidents. RN-A sworking through the post fall assessment of roward through the system would only trigger one and incidents. RN-A sworking through the post fall assessment of roward through the system would only trigger one and incidents. RN-A sworking through the system completed for 8/12, and verifications.	ed the facility had tried different in the room and bells, however ersonality caused him to fiddle intly. In addition, the facility had a room closer to the nursing ed a U-step walker (a walker raking system designed to dence and eliminate falling in neurological conditions) and ated R2 liked the U-step walker, in to fall on purpose. RN-A so indicated he liked the ved when would fall. Es risk management and fall dewed with RN-A who explained dently underwent the enew process for falls and not cause. RN-A indicated from foril, the facility had noted an essment to be completed after a had been addressed they noted a group incidents together and sessment for multiple stated the facility had been the issues. RN-A confirmed no ent or root cause analysis had for R2's falls dated, 7/31, 8/1, 8/4 and the system was not right, yet. If the interventions attempted for cted in R2's documentation.	F	689			
	indicated R3 had and diagnoses what disease, dementing	hange MDS dated 4/10/20, severe cognitive impairment hich included Alzheimer's a, anxiety disorder, depression,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245366	B. WING _		80	3/21/2020
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	transient ischemic without residual ef and postpolio sync R3 required extense personal hygiene a for all other activiti MDS also indicate falls since the preventage of the pr	ait and mobility, history of attacks and cerebral infarction fects, dizziness and giddiness drome. The MDS also indicated sive assistance with dressing, and toilet use and supervision es of daily living (ADL). The d R3 had not experienced any	F 68	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245366	B. WING _		08	C / 21/2020	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 2501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	to implement the for seated height, night walker, encourage, review per facility pulacement, and war R3's Fall Risk Quar 4/10/20, indicated off of Alzheimer's ocognition. R3 had forgetful and did not review of R3's clim 4/18/20, revealed From skin tear to the checks were implested fall and the interpretate to the fall and timplemented and implemented to the time of the fall and the interpretate to the time of the fall and implemented and backs was found sitting the bed. -4/15/20 at 4:00 a. I and was found sitting extended and backs sustained a left ferrom the fall and the fall and was found sitting extended and backs sustained a left ferrom the fall and the	age 8 by awareness and directed staff following interventions: bed at at light in bedroom, wheeled fassist with non-skid shoes, fall protocol, secure or locked unit ander alarm on right wrist. Interly Review Tool dated R3 was at risk for falls based liagnosis and impaired a history of falls, could be at use assistive device. Incal record from 3/5/20 to R3 experienced 3 falls. In R3 was wandering, restless and sustained a 3.0 cm x 1.0 right elbow. Fifteen minute mented immediately following endisciplinary team reviewed tented a six day sleep study the fall, continued the fifteen did R3 was to be seen by the sustained a 3.0 cm. In R3 was found sitting on the bathroom door holding her beding. She sustained a 3.0 cm. R3 was found sitting on the bathroom door holding her beding. She sustained a 3.0 cm. R3 was heard screaming and on buttocks with legs a against the bed. R3 moral neck fracture.	F 68	39			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245366	B. WING _		08	3/21/2020
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	aforementioned fa On 8/21/20, at 8:59 think she was inde however, the staff reapproach her if s eventually they cou accept help to cha R3 could transfer i use a walker. NA-0 fall interventions re she was not workin NA-C stated to her been able to transf On 8/21/2020, at 2 recently became th not remember muc had been looking f R3's 4/15/20, fall a RN-B stated she b time they were tran- electronic process assessment should each fall and intervithe risk for further On 8/21/2020, at 2 verified the facility transitioned from p system. DON also should be complet by the IDT. DON o assessment for R3 also confirmed assi been completed, a	ntify causal factors for the lls. 2 a.m. NA-C stated R3 liked to pendent and did not want help still tried to help and would the refused. NA-C stated ald usually convince R3 to ange, bathe etc. NA-C stated andependently but needed to a could not recall any specific equired for R3 and indicated ange at the time of her falls. 3 recollection, R3 had always for and walk independently 3 recollection, R3-B stated she are manager of the unit so did about R3. RN-B verified she for the post fall assessment for and one could not be found. The elieved the fall occurred at the assitioning from paper to a completed after ventions identified to minimize falls. 3 p.m. the director of nursing fall documentation had recently apper to a computer based overified post fall assessments and after each fall and reviewed confirmed the post fall sessments for R2's falls had not be sessments for R2's falls had not				

				E SURVEY MPLETED		
		245366	B. WING			C / 21/2020
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2501 RICE LAKE ROAD DULUTH, MN 55811		21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	directed each incide investigated and/or cause of the episod. The policy also dire would be conducted within 24 hours possassessment was condirector of nurses of the conducted in the conducted within 24 hours possassessment was condirector of nurses of the conducted in the cond	ent/accident or fall must be assessed to determine the de to prevent any further injury. Exceed a post-fall assessment of following any fall episode of fall. Once the post-fall completed by nursing, the or designee would seek on the interdisciplinary team	F 6	89		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 8, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: KFXI11

Dear Administrator:

The above facility was surveyed on August 19, 2020 through August 21, 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 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

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00598	B. WING		08/2	2 1/2020	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	1 00:2		
CHRIS J	ENSEN HEALTH & RE	HABII ITATION C	E LAKE ROA , MN 55811	AD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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)	LD BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated during the deficiency of the survey of	hether a violation has been					
	that may result from orders provided that the Department with notice of assessme INITIAL COMMENT On 8/19/20-8/21/20 conducted to deterr Licensure. Your fac	hearing on any assessments in non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance. TS: I, an abbreviated survey was mine compliance with State ility was found NOT to be a MN State Licensure.					
		plaints were found to be with a corresponding licensing					

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

09/21/20 **Electronically Signed**

STATE FORM 6899 If continuation sheet 1 of 12 KFXI11

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E SURVEY PLETED			
		00598		B. WING			21/2020
	PROVIDER OR SUPPLIER	HABII ITATION C	2501 RICE	DRESS, CITY, SELAKE ROAMN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FI SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	UNSUBSTANTIATE H5366153C H5366154C The facility is enroll signature is not req page of state form. electronic plan of content of the state of the s	ed in ePOC and therefuired at the bottom of Please indicate your orrection that you have er, and identify the dat	fore a the first	2 000			
2 830	Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from tresident must rema prefers to remain in	general. A resident me and treatment, person supervision based on d preferences as identification resident assessment ascribed in parts 4658.0 ing home resident must possible unless there he attending physician in bed or the resident	nust onal and tified in and 400 and st be out is a that the nt	2 830			9/21/20
	by: Based on observati	on, interview and docu	ument		Completed 9/21/2020		

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00598		B. WING			C 21/2020
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICE	DRESS, CITY, S E LAKE ROA MN 55811	TATE, ZIP CODE D		
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	review, the facility fassess falls for cau interventions to mir and/or injury for 2 or reviewed for falls. Findings include: R2's annual Minimu 8/16/20, indicated Fhad diagnoses which hypotension, Parkir prostatic hyperplaside depression (bipolar atrophy, other lack muscle weakness, also indicated R2 reone person for tran on the unit, toilet us extensive assist of MDS further indicat more falls without in	ge 2 ailed to comprehens sal factors in order to sal factors (R2, R) am Data Set (MDS) or a sal factor of the sa	dated tact and tic gn and manic asting and eralized The MDS tance of ecomotion ene and sing. The ced two or e falls with	2 830			
	8/19/20, identified from R2 who had physical balance, gait, strend with difficulty maintain impaired balance dindicated R2 requires mobility, transfers, with set up for eating wheelchair for locol and ambulated with been continent of bantidepressant mediated integrity issues. The	a Assessment (CAA alls were an actual palls were an actual pall performance limitagth and muscle endianing sitting balance uring transitions. The assistance of ontoileting and was indug. R2 used a walke motion. R2 self transout staff assistance owel and bladder, to dication and did not late CAA indicated R2 enced falls in the face	problem for ations of curance e and he CAA he for bed he pendent er and he sferred he had book have skin was at				

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 3 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00509				00/2	
		00598			08/2	1/2020
	PROVIDER OR SUPPLIER	2501 RICE	E LAKE ROA	D CODE		
CHRIS J	ENSEN HEALTH & RI	FHABILITATION C	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 3	2 830			
	during the assessment period due to poor safety awareness and limited mobility. R2's Care Plan provided 8/21/20, indicated R1					
	had deficits with ac related to Parkinso infection (UTI), hist anxiety disorder, ar and directed R2 reassistance with a form assistance of one pand bed mobility. R2 was at risk for form awareness, UTI, Paunsteady gait. The provide the following on wheelchair, bed walker, call don't faunnecessary items walker within reach within easy reach, leave in bathroom unalso indicated a risk	tivities of daily living (ADL) n's disease, urinary tract ory of falls, bipolar disorder, nd major depressive disorder quired contact guard our-wheeled walker and person for toilet use, transfers The Care Plan also indicated alls related to poor safety arkinson's disease and a care plan directed staff to ng interventions: anti-roll backs at seated height, bell on all sign in room, do not leave at bedside, grabber/reacher, have commonly used articles non-skid shoes, and do not unattended. The care plan k versus benefit agreement				
	alarms placed. R2 R2 was non-complideclined assistance with walker and direct reasons for non-copercent of time in cappropriate, review ineffective. R2's Fall Risk Quant 5/20/20, indicated F	ding R2's declining to have 's care plan further indicated iant with his plan of care and e with transfers and ambulating ected staff to seek R2's impliance and observe for compliance. If alternatives are for alterations or change if items of the received that the received received the received received the received				
	currently working w On 8/20/20, at 10:4	risk management. R2 was vith therapies. 11 a.m. R2 was observed m by his beside, holding onto a				

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 4 of 12

Minnesota Department of Health

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 21/2020
	PROVIDER OR SUPPLIER	EHABILITATION C	2501 RICI	DRESS, CITY, SELAKE ROA	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	walker. A houseker stated she was goin with R2 about what ambulated slowly to housekeeper left th housekeeping cart housekeeping cart housekeeper return and proceeded to not urned around and the bed with the use taking small, slow, wearing rubber-sole was slow, but stead Review of R2's clini 8/20/20 revealed R-7/31/20 at 5:15 p.m found R2 laying on his commode. R2 experienced a sma centimeter (cm) x 1 -8/1/20, at 2:15 p.m next to his commodity in the bed, as if in a promode was full ourine in it on his bed still by his commodity commode. R2 would small scraped area	eper was in R2's roong to use her mop are she was going to do ward the door. The eroom and went to located in the hall. I need to the room with mop the bathroom floambulated back to the of his four-wheeled stuttering steps. R2 ed tennis shoes and ly. I cal record from 7/3/2 experienced 7 falls in. a nursing assistant his left side in his root stated he slipped. Rated he slipped. Rated he slipped. Rated he slipped. Rated in his left kneed. R2 was found on the R2 stated "I did rate injury. R2 was found on his the upper part of his raying position. R2's of urine, also had a und side table and his we can the far side of the lot oright kneed.	and visited b. R2 a Fine a mopoor. R2 ne head of walker, was his gait 20 to state (NA) om near 2 g 1.0 ee not fall, as knees a body on a urinal with valker was he vas doing.	2 830			
	in his room beside side with the walker	m. R2 was found on the recliner, lying on r sideways undernea o from his bed to wal	his right th him.				

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 5 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00598	B. WING		I	C 21/2020
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	HABILITATION C 2501	EET ADDRESS, CITY, S I RICE LAKE ROA UTH, 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 OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	his recliner to fold has recliner to fold has reside on the floor factoring socks only slipped on the floor on bed. R2 got hold go until he snapped apparent injury how alarm was placed. R2's clinical record assessment to idente aforementioned fall. On 8/20/20, at approximate apparent injury how alarm was placed. R2's clinical record assessment to idente aforementioned fall. On 8/20/20, at approximate approximate to indicate the intervention of the interventi	is jacket. No injury. n. R2 was found on his lefting his bed. He was getting with no help. R2 was at took his shoes off and and took his shoes off and and would not the cord, breaking it. No rever, R2 was very upset a lacked a comprehensive tify causal factors for the ls. Is oximately 2:30 p.m. nursing the she was not very family and cated he was up in his of a walker. NA-A stated Fave stand by assistance for lation and that R2 was above wer, he did not always and would often self transfer later knowledge, he was reserved.	ced t let an ng liar R2 or le to wait r. tting not to R2 re staff in e the			

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 6 of 12

Minnesota Department of Health

A. BUILDING:	
= ::::::a	1/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2501 RICE LAKE ROAD	
CHRIS JENSEN HEALTH & REHABILITATION C DULUTH, MN 55811	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830 Continued From page 6 hospital due to injury as he did not like going to the hospital. NA-B stated R2 had been better about waiting for help and that R2 used a wheelchair on days he felt weaker and needed his bed at a sitting height. NA-B stated she also made sure to keep the walker by R2's bed so he could steady himself if he did self transfer. NA-B verified R2 had experienced a lot of falls and stated he needed stand by assistance with the use of a walker for ambulation. On 8/21/20, at 9:36 a.m. registered nurse (RN)-A verified R2 continued to fall and continued to direct his own care. RN-A stated R2's sister remained involved who was of the opinion to allow R2 to make his own decisions because he fully understood the risks and ramifications of self transfers/ambulation. RN-A stated R2 had some obsessive qualities and if R2's sister did not agree with him, he would badger her and not leave her alone about it. RN-A stated R2 had stated God was watching out for him and if it was his time to go it was his time to go, and that R2 understood one of the risks of self transfers/ambulation, was death. RN-A stated R2 did go sixteen days without a fall when alarms were in use, but R2 has since refused to use them. RN-A stated the facility had tried different call lights, signs in the room and bells, however R2's obsessive personality caused him to fiddle with them constantly. In addition, the facility had also moved R2 to a room closer to the nursing desk, and also tried a U-step walker (a walker with a reversed braking system designed to increase independence and eliminate falling among those with neurological conditions) and therapy. RN-A stated R2 liked the U-step walker, but would threaten to fall on purpose. RN-A stated R2 had also indicated he liked the	

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 7 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY	
741212741	or connection	ISERTII IOMITOMINISER.	A. BUILDING:			
	00598		B. WING		08/2	21/2020
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	incident were review the facility had rece development of a nassessment of root March through Apri issue with their systappropriate assess fall, but after that had the system would gonly trigger one assincidents. RN-A staworking through the post fall assessment been completed for or 8/12, and verified RN-A stated all of the	risk management and fall wed with RN-A who explained ntly underwent the ew process for falls and cause. RN-A indicated from I, the facility had noted an item not prompting the ment to be completed after a ad been addressed they noted roup incidents together and itessment for multiple ated the facility had been existed the facility had been at or root cause analysis had at R2's falls dated, 7/31, 8/1, 8/4 at the system was not right, yet the interventions attempted for ead in R2's documentation.				
	R3's significant change MDS dated 4/10/20, indicated R3 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, anxiety disorder, depression, psychotic disorder, schizophrenia, other abnormalities of gait and mobility, history of transient ischemic attacks and cerebral infarction without residual effects, dizziness and giddiness and postpolio syndrome. The MDS also indicated R3 required extensive assistance with dressing, personal hygiene and toilet use and supervision for all other activities of daily living (ADL). The MDS also indicated R3 had not experienced any falls since the previous assessment. R3's Fall CAA dated 4/13/20, identified falls were an actual problem for R3 who had physical performance limitations of balance, gait, strength and muscle endurance with difficulty maintaining					

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 8 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						>
		00598	B. WING		08/2	1/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	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
2 830	sitting balance and transitions. The CA and unable to stabi and had a history o indicated R2 had be assistance of two stoileting related to be transfers, and indep R2 used a walker focuing to use it. R2 incontinent of bladd antidepressant med secure/locked unit a (code alert). R2 did treatment. R3's Care Plan revideficits with ADL's instatus and medicate could affect ADL's is behaviors, TIA and Plan directed staff If assistance (CGA) were Care Plan also indicated had poor safety to implement the foseated height, night walker, encourage/review per facility per placement, and ware R3's Fall Risk Quare 4/10/20, indicated for of Alzheimer's decognition. R3 had a forgetful and did not recommend to the stable process.	impaired balance during A indicated R2 was unsteady lize without staff assistance If falls. The CAA further Item independent to requiring Itaff for bed mobility and Item independent for Item independent for Item independent for Item independent independent with set up for eating. Item independent independent independent with set up for eating. Item independent ind	2 830			

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 9 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
	00598		B. WING			C 21/2020	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION C		E LAKE ROA MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9		2 830			
	and confused, fell a cm skin tear to the checks were impler the fall and the inte the fall and implem- due to the time of the	R3 was wandering, and sustained a 3.0 cright elbow. Fifteen mented immediately rdisciplinary team reented a six day sleep ne fall, continued the IR3 was to be seen	cm x 1.0 minute following viewed o study fifteen				
	the floor opposite h head which was ble cm long "abrasion"	.m. R3 was found sit er bathroom door ho eding. She sustaine to the head. The ID nt light in the bedroor	olding her ed a 3.0 T				
	and was found sittir	n. R3 was heard scrong on buttocks with loagainst the bed. R3 noral neck fracture.	egs				
		lacked a compreher tify causal factors fo s.					
	think she was indep however, the staff s reapproach her if sl eventually they cou accept help to chan R3 could transfer in use a walker. NA-C fall interventions re- she was not workin NA-C stated to her	a.m. NA-C stated Rependent and did not westill tried to help and whe refused. NA-C stated Id usually convince Fage, bathe etc. NA-Condependently but need could not recall any quired for R3 and incompact the time of her farecollection, R3 had arr and walk independent	want help would ated R3 to Stated eded to specific dicated alls. always				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED		
		00598		B. WING		I	C 21/2020
	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 DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	On 8/21/2020, at 2: recently became the not remember muchad been looking for R3's 4/15/20, fall ar RN-B stated she betime they were transelectronic processe assessment should each fall and intervethe risk for further for System. DON also should be complete by the IDT. DON coassessment for R3' also confirmed assebeen completed, as The Accidents/Falls directed each incide investigated and/or cause of the episod The policy also direwould be conducted within 24 hours possassessment was codirector of nurses of the decimal process of the episod assessment was codirector of nurses of the episod and the episod assessment was codirector of nurses of the episod and the episod assessment was codirector of nurses of the episod and the episod assessment was codirector of nurses of the episod and the episod assessment was codirector of nurses of the episod and the episod assessment was codirector of nurses of the episod assessment was codirector of nurses of the episod and the episod assessment was codirector of nurses of the episod assessment was codirector of nurses of the episod and the episod a	09 PM p.m. RN-B size manager of the unith about R3. RN-B voor the post fall assessed one could not be felieved the fall occurrisitioning from paper is. RN-B confirmed at have been complete entions identified to reall documentation has aper to a computer be verified post fall assed after each fall and onfirmed the post fall is falls could not be freessments for R2's falls	it so did erified she sment for ound. red at the to a post fall ed after minimize of nursing ad recently ased essments reviewed l ound and lls had not uary 2014, ust be ine the her injury. ssment bisode -fall the ek	2 830			
	Director of Nursing review and/or revise related to falls, post implementation of it	THOD OF CORRECT (DON), or designee e policies and proced t fall assessments ar nterventions. The DO locate all staff on the	, could dures nd the				

Minnesota Department of Health

STATE FORM 6899 KFXI11 If continuation sheet 11 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00598	B. WING			C 21/2020
	PROVIDER OR SUPPLIER ENSEN HEALTH & RE	HARILITATION C 2501 RIC	DDRESS, CITY, SELAKE ROA, MN 55811	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	completion of assest identification of cau DON or designee, or system to ensure confidence of the monitoring to committee.	ge 11 ssments including the sal factors of the fall. The could develop an auditing ompliance and report results the facility quality assurance R CORRECTION: Twenty-one	2 830			

Minnesota Department of Health