DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2020

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 08/21/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/19/20-8/21/20 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated with a deficiency cited at F689: H5366151C H5366152C The following complaints were found to be unsubstantiated: H5366153C H5366154C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		9/21/20

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

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess falls for causal factors in order to develop interventions to minimize the risk for further falls and/or injury for 2 of 4 residents (R2, R3) reviewed for falls. Findings include: R2's annual Minimum Data Set (MDS) dated 8/16/20, indicated R2 was cognitively intact and had diagnoses which included orthostatic hypotension, Parkinson's disease, benign prostatic hyperplasia, anxiety disorder and manic depression (bipolar disease), muscle wasting and atrophy, other lack of coordination, generalized muscle weakness, and repeated falls. The MDS also indicated R2 required limited assistance of one person for transfers, ambulation, locomotion on the unit, toilet use and personal hygiene and extensive assist of one person for dressing. The MDS further indicated R2 had experienced two or more falls without injury and two or more falls with injury (except major) since the previous assessment. R2's Falls Care Area Assessment (CAA) dated 8/19/20, identified falls were an actual problem for R2 who had physical performance limitations of balance, gait, strength and muscle endurance with difficulty maintaining sitting balance and impaired balance during transitions. The CAA	F 689	Resident # 2 falls assessments have been reviewed in a timeline to comprehensively assess and determine individualized comprehensive care plan. Resident #3 no longer resides at the community. All other residents who have had a fall in the past 60 days will have comprehensive fall assessment reviewing for causal factors and care plan revised with interventions added to minimize the risk for further falls and/or injury. Education provided to nursing staff on comprehensive assessment of all falls and individualized interventions to reduce and minimize risk for further falls and/or injuries. DON or designee will audit each fall within 24 hours for 30 days, then 2 X weekly for 30 days and then monthly for 30 days to ensure comprehensive review, interventions, and care planning are present. DON or designee will ensure compliance by 9/17/2020	

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F 689	Continued From page 2	F 689		

indicated R2 required assistance of one for bed mobility, transfers, toileting and was independent with set up for eating. R2 used a walker and wheelchair for locomotion. R2 self transferred and ambulated without staff assistance. He had been continent of bowel and bladder, took antidepressant medication and did not have skin integrity issues. The CAA indicated R2 was at risk and had experienced falls in the facility during 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 activities of daily living (ADL) related to Parkinson's disease, urinary tract infection (UTI), history of falls, bipolar disorder, anxiety disorder, and major depressive disorder and directed R2 required contact guard assistance with a four-wheeled walker and assistance of one person for toilet use, transfers and bed mobility. The Care Plan also indicated R2 was at risk for falls related to poor safety awareness, UTI, Parkinson's disease and unsteady gait. The care plan directed staff to provide the following interventions: anti-roll backs on wheelchair, bed at seated height, bell on walker, call don't fall sign in room, do not leave unnecessary items at bedside, grabber/reacher, walker within reach, have commonly used articles within easy reach, non-skid shoes, and do not leave in bathroom unattended. The care plan also indicated a risk versus benefit agreement was in place regarding R2's declining to have alarms placed. R2's care plan further indicated R2 was non-compliant with his plan of care and declined assistance with transfers and ambulating with walker and directed staff to seek R2's reasons for non-compliance and observe for percent of time in compliance. If alternatives are

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F 689	Continued From page 3	F 689		

appropriate, review for alterations or change if ineffective.

R2's Fall Risk Quarterly Review Tool dated 5/20/20, indicated R2 had had multiple falls since the last MDS. See risk management. R2 was currently working with therapies.

On 8/20/20, at 10:41 a.m. R2 was observed standing in his room by his beside, holding onto a walker. A housekeeper was in R2's room and stated she was going to use her mop and visited with R2 about what she was going to do. R2 ambulated slowly toward the door. The housekeeper left the room and went to a housekeeping cart located in the hall. The housekeeper returned to the room with a mop and proceeded to mop the bathroom floor. R2 turned around and ambulated back to the head of the bed with the use of his four-wheeled walker, taking small, slow, stuttering steps. R2 was wearing rubber-soled tennis shoes and his gait was slow, but steady.

Review of R2's clinical record from 7/3/20 to 8/20/20 revealed R2 experienced 7 falls:

-7/31/20 at 5:15 p.m. a nursing assistant (NA) found R2 laying on his left side in his room near his commode. R2 stated he slipped. R2 experienced a small abrasion measuring 1.0 centimeter (cm) x 1.0 cm to his left knee

-8/1/20, at 2:15 p.m. R2 was found on the floor next to his commode. R2 stated "I did not fall, just sat down." No injury.

-8/4/20, a 2:53 p.m. R2 was found on his knees next to his bed with the upper part of his body on

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F 689	Continued From page 4	F 689		

the bed, as if in a praying position. R2's commode was full of urine, also had a urinal with urine in it on his bedside table and his walker was still by his commode on the far side of the commode. R2 would not say what he was doing. Small scraped area to right knee.

-8/12/20, at 2:00 p.m. R2 was found on the floor in his room beside the recliner, lying on his right side with the walker sideways underneath him. R2 stated he got up from his bed to walk over to his recliner to fold his jacket. No injury.

-8/12/20 at 8:14 p.m. R2 was found on his left side on the floor facing his bed. He was getting himself ready for bed with no help. R2 was wearing socks only, took his shoes off and slipped on the floor. Motion sensor alarm placed on bed. R2 got hold of the cord and would not let go until he snapped the cord, breaking it. No apparent injury however, R2 was very upset an alarm was placed.

R2's clinical record lacked a comprehensive assessment to identify causal factors for the aforementioned falls.

On 8/20/20, at approximately 2:30 p.m. nursing assistant (NA)-A sated she was not very familiar with R2, however, indicated he was up in his room with the use of a walker. NA-A stated R2 was supposed to have stand by assistance for transfers and ambulation and that R2 was able to use his call light, however, he did not always wait for staff to arrive and would often self transfer. NA-A also indicated R2 required his bed at sitting height an stated, to her knowledge, he was not to be left in the bathroom alone.

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F 689	Continued From page 5	F 689		

On 8/20/20, at approximately 3:00 p.m. NA-B stated she was familiar with R2. NA-B stated R2 was very particular about his room and item placement and the staff tried to anticipate his needs. NA-B indicated R2 could be obsessive about his room and items in his room so the staff needed to keep personal items near him and in the same positions. She stated R2 could use the call light and ask for help but often self transferred before they would get to his room. NA-B stated the staff would remind R2 of the risks for falls and potential need to go to the 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

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F 689	Continued From page 6	F 689		

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 attention he received when would fall.

-At 10:21 a.m. R2's risk management and fall incident were reviewed with RN-A who explained the facility had recently underwent the development of a new process for falls and assessment of root cause. RN-A indicated from March through April, the facility had noted an issue with their system not prompting the appropriate assessment to be completed after a fall, but after that had been addressed they noted the system would group incidents together and only trigger one assessment for multiple incidents. RN-A stated the facility had been working through the issues. RN-A confirmed no post fall assessment or root cause analysis had been completed for R2's falls dated, 7/31, 8/1, 8/4 or 8/12, and verified the system was not right, yet. RN-A stated all of the interventions attempted for R2 were not reflected 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

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F 689	Continued From page 7	F 689		

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 sitting balance and impaired balance during transitions. The CAA indicated R2 was unsteady and unable to stabilize without staff assistance and had a history of falls. The CAA further indicated R2 had been independent to requiring assistance of two staff for bed mobility and toileting related to behaviors, independent for transfers, and independent with set up for eating. R2 used a walker for ambulating and needed cuing to use it. R2 refused cares often, had been incontinent of bladder, took antipsychotic and antidepressant medications, lived in a secure/locked unit and wore a wander guard (code alert). R2 did not see therapy for treatment.

R3's Care Plan revised 4/20/20, indicated R3 had deficits with ADL's related to medical/physical status and medications and diagnoses which could affect ADL's including dementia with behaviors, TIA and anxiety disorder. The Care Plan directed staff R3 required contact guard assistance (CGA) with ambulation and transfers, CGA with walker and cuing for locomotion. The Care Plan also indicated R3 was at risk for falls

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	245366	A. BUILDING _____ B. WING _____	C 08/21/2020

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

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F 689	Continued From page 8	F 689		

and had poor safety awareness and directed staff to implement the following interventions: bed at seated height, night light in bedroom, wheeled walker, encourage/assist with non-skid shoes, fall review per facility protocol, secure or locked unit placement, and wander alarm on right wrist.

R3's Fall Risk Quarterly Review Tool dated 4/10/20, indicated R3 was at risk for falls based off of Alzheimer's diagnosis and impaired cognition. R3 had a history of falls, could be forgetful and did not use assistive device.

Review of R3's clinical record from 3/5/20 to 4/18/20, revealed R3 experienced 3 falls.

-3/5/20 at 4:00 a.m. R3 was wandering, restless and confused, fell and sustained a 3.0 cm x 1.0 cm skin tear to the right elbow. Fifteen minute checks were implemented immediately following the fall and the interdisciplinary team reviewed the fall and implemented a six day sleep study due to the time of the fall, continued the fifteen minute checks, and R3 was to be seen by the physician.

-3/24/20 at 12:00 a.m. R3 was found sitting on the floor opposite her bathroom door holding her head which was bleeding. She sustained a 3.0 cm long "abrasion" to the head. The IDT implemented a night light in the bedroom next to the bed.

-4/15/20 at 4:00 a.m. R3 was heard screaming and was found sitting on buttocks with legs extended and back against the bed. R3 sustained a left femoral neck fracture.

R3's clinical record lacked a comprehensive

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F 689	Continued From page 9	F 689		

assessment to identify causal factors for the aforementioned falls.

On 8/21/20, at 8:59 a.m. NA-C stated R3 liked to think she was independent and did not want help however, the staff still tried to help and would reapproach her if she refused. NA-C stated eventually they could usually convince R3 to accept help to change, bathe etc. NA-C stated R3 could transfer independently but needed to use a walker. NA-C could not recall any specific fall interventions required for R3 and indicated she was not working at the time of her falls. NA-C stated to her recollection, R3 had always been able to transfer and walk independently

On 8/21/2020, at 2:09 PM p.m. RN-B stated she recently became the manager of the unit so did not remember much about R3. RN-B verified she had been looking for the post fall assessment for R3's 4/15/20, fall and one could not be found. RN-B stated she believed the fall occurred at the time they were transitioning from paper to electronic processes. RN-B confirmed a post fall assessment should have been completed after each fall and interventions identified to minimize the risk for further falls.

On 8/21/2020, at 2:31 p.m. the director of nursing verified the facility fall documentation had recently transitioned from paper to a computer based system. DON also verified post fall assessments should be completed after each fall and reviewed by the IDT. DON confirmed the post fall assessment for R3's falls could not be found and also confirmed assessments for R2's falls had not been completed, as required.

The Accidents/Falls policy revised February 2014,

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F 689	Continued From page 10 directed each incident/accident or fall must be investigated and/or assessed to determine the cause of the episode to prevent any further injury. The policy also directed a post-fall assessment would be conducted following any fall episode within 24 hours post fall. Once the post-fall assessment was completed by nursing, the director of nurses or designee would seek additional input from the interdisciplinary team and other staff.	F 689		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/19/20-8/21/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found NOT to be compliance with the MN State Licensure. The following complaints were found to be SUBSTANTIATED with a corresponding licensing	2 000		

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2 000	Continued From page 1 order: H5366151C H5366152C The following complaints were found to be UNSUBSTANTIATED: H5366153C H5366154C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 830	Completed 9/21/2020	9/21/20

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2 830	Continued From page 2	2 830		

review, the facility failed to comprehensively assess falls for causal factors in order to develop interventions to minimize the risk for further falls and/or injury for 2 of 4 residents (R2, R3) reviewed for falls.

Findings include:

R2's annual Minimum Data Set (MDS) dated 8/16/20, indicated R2 was cognitively intact and had diagnoses which included orthostatic hypotension, Parkinson's disease, benign prostatic hyperplasia, anxiety disorder and manic depression (bipolar disease), muscle wasting and atrophy, other lack of coordination, generalized muscle weakness, and repeated falls. The MDS also indicated R2 required limited assistance of one person for transfers, ambulation, locomotion on the unit, toilet use and personal hygiene and extensive assist of one person for dressing. The MDS further indicated R2 had experienced two or more falls without injury and two or more falls with injury (except major) since the previous assessment.

R2's Falls Care Area Assessment (CAA) dated 8/19/20, identified falls were an actual problem for R2 who had physical performance limitations of balance, gait, strength and muscle endurance with difficulty maintaining sitting balance and impaired balance during transitions. The CAA indicated R2 required assistance of one for bed mobility, transfers, toileting and was independent with set up for eating. R2 used a walker and wheelchair for locomotion. R2 self transferred and ambulated without staff assistance. He had been continent of bowel and bladder, took antidepressant medication and did not have skin integrity issues. The CAA indicated R2 was at risk and had experienced falls in the facility during

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2 830	Continued From page 3 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 activities of daily living (ADL) related to Parkinson's disease, urinary tract infection (UTI), history of falls, bipolar disorder, anxiety disorder, and major depressive disorder and directed R2 required contact guard assistance with a four-wheeled walker and assistance of one person for toilet use, transfers and bed mobility. The Care Plan also indicated R2 was at risk for falls related to poor safety awareness, UTI, Parkinson's disease and unsteady gait. The care plan directed staff to provide the following interventions: anti-roll backs on wheelchair, bed at seated height, bell on walker, call don't fall sign in room, do not leave unnecessary items at bedside, grabber/reacher, walker within reach, have commonly used articles within easy reach, non-skid shoes, and do not leave in bathroom unattended. The care plan also indicated a risk versus benefit agreement was in place regarding R2's declining to have alarms placed. R2's care plan further indicated R2 was non-compliant with his plan of care and declined assistance with transfers and ambulating with walker and directed staff to seek R2's reasons for non-compliance and observe for percent of time in compliance. If alternatives are appropriate, review for alterations or change if ineffective. R2's Fall Risk Quarterly Review Tool dated 5/20/20, indicated R2 had had multiple falls since the last MDS. See risk management. R2 was currently working with therapies. On 8/20/20, at 10:41 a.m. R2 was observed standing in his room by his beside, holding onto a	2 830		

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2 830	Continued From page 4	2 830		

walker. A housekeeper was in R2's room and stated she was going to use her mop and visited with R2 about what she was going to do. R2 ambulated slowly toward the door. The housekeeper left the room and went to a housekeeping cart located in the hall. The housekeeper returned to the room with a mop and proceeded to mop the bathroom floor. R2 turned around and ambulated back to the head of the bed with the use of his four-wheeled walker, taking small, slow, stuttering steps. R2 was wearing rubber-soled tennis shoes and his gait was slow, but steady.

Review of R2's clinical record from 7/3/20 to 8/20/20 revealed R2 experienced 7 falls:

-7/31/20 at 5:15 p.m. a nursing assistant (NA) found R2 laying on his left side in his room near his commode. R2 stated he slipped. R2 experienced a small abrasion measuring 1.0 centimeter (cm) x 1.0 cm to his left knee

-8/1/20, at 2:15 p.m. R2 was found on the floor next to his commode. R2 stated "I did not fall, just sat down." No injury.

-8/4/20, a 2:53 p.m. R2 was found on his knees next to his bed with the upper part of his body on the bed, as if in a praying position. R2's commode was full of urine, also had a urinal with urine in it on his bedside table and his walker was still by his commode on the far side of the commode. R2 would not say what he was doing. Small scraped area to right knee.

-8/12/20, at 2:00 p.m. R2 was found on the floor in his room beside the recliner, lying on his right side with the walker sideways underneath him. R2 stated he got up from his bed to walk over to

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2 830	Continued From page 5 his recliner to fold his jacket. No injury. -8/12/20 at 8:14 p.m. R2 was found on his left side on the floor facing his bed. He was getting himself ready for bed with no help. R2 was wearing socks only, took his shoes off and slipped on the floor. Motion sensor alarm placed on bed. R2 got hold of the cord and would not let go until he snapped the cord, breaking it. No apparent injury however, R2 was very upset an alarm was placed. R2's clinical record lacked a comprehensive assessment to identify causal factors for the aforementioned falls. On 8/20/20, at approximately 2:30 p.m. nursing assistant (NA)-A sated she was not very familiar with R2, however, indicated he was up in his room with the use of a walker. NA-A stated R2 was supposed to have stand by assistance for transfers and ambulation and that R2 was able to use his call light, however, he did not always wait for staff to arrive and would often self transfer. NA-A also indicated R2 required his bed at sitting height an stated, to her knowledge, he was not to be left in the bathroom alone. On 8/20/20, at approximately 3:00 p.m. NA-B stated she was familiar with R2. NA-B stated R2 was very particular about his room and item placement and the staff tried to anticipate his needs. NA-B indicated R2 could be obsessive about his room and items in his room so the staff needed to keep personal items near him and in the same positions. She stated R2 could use the call light and ask for help but often self transferred before they would get to his room. NA-B stated the staff would remind R2 of the risks for falls and potential need to go to the	2 830		

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2 830	Continued From page 6	2 830		

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 attention he received when would fall.

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2 830	Continued From page 7 -At 10:21 a.m. R2's risk management and fall incident were reviewed with RN-A who explained the facility had recently underwent the development of a new process for falls and assessment of root cause. RN-A indicated from March through April, the facility had noted an issue with their system not prompting the appropriate assessment to be completed after a fall, but after that had been addressed they noted the system would group incidents together and only trigger one assessment for multiple incidents. RN-A stated the facility had been working through the issues. RN-A confirmed no post fall assessment or root cause analysis had been completed for R2's falls dated, 7/31, 8/1, 8/4 or 8/12, and verified the system was not right, yet. RN-A stated all of the interventions attempted for R2 were not reflected 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	2 830		

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2 830	Continued From page 8	2 830		

sitting balance and impaired balance during transitions. The CAA indicated R2 was unsteady and unable to stabilize without staff assistance and had a history of falls. The CAA further indicated R2 had been independent to requiring assistance of two staff for bed mobility and toileting related to behaviors, independent for transfers, and independent with set up for eating. R2 used a walker for ambulating and needed cuing to use it. R2 refused cares often, had been incontinent of bladder, took antipsychotic and antidepressant medications, lived in a secure/locked unit and wore a wander guard (code alert). R2 did not see therapy for treatment.

R3's Care Plan revised 4/20/20, indicated R3 had deficits with ADL's related to medical/physical status and medications and diagnoses which could affect ADL's including dementia with behaviors, TIA and anxiety disorder. The Care Plan directed staff R3 required contact guard assistance (CGA) with ambulation and transfers, CGA with walker and cuing for locomotion. The Care Plan also indicated R3 was at risk for falls and had poor safety awareness and directed staff to implement the following interventions: bed at seated height, night light in bedroom, wheeled walker, encourage/assist with non-skid shoes, fall review per facility protocol, secure or locked unit placement, and wander alarm on right wrist.

R3's Fall Risk Quarterly Review Tool dated 4/10/20, indicated R3 was at risk for falls based off of Alzheimer's diagnosis and impaired cognition. R3 had a history of falls, could be forgetful and did not use assistive device.

Review of R3's clinical record from 3/5/20 to 4/18/20, revealed R3 experienced 3 falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	C 08/21/2020

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

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2 830	Continued From page 9 -3/5/20 at 4:00 a.m. R3 was wandering, restless and confused, fell and sustained a 3.0 cm x 1.0 cm skin tear to the right elbow. Fifteen minute checks were implemented immediately following the fall and the interdisciplinary team reviewed the fall and implemented a six day sleep study due to the time of the fall, continued the fifteen minute checks, and R3 was to be seen by the physician. -3/24/20 at 12:00 a.m. R3 was found sitting on the floor opposite her bathroom door holding her head which was bleeding. She sustained a 3.0 cm long "abrasion" to the head. The IDT implemented a night light in the bedroom next to the bed. -4/15/20 at 4:00 a.m. R3 was heard screaming and was found sitting on buttocks with legs extended and back against the bed. R3 sustained a left femoral neck fracture. R3's clinical record lacked a comprehensive assessment to identify causal factors for the aforementioned falls. On 8/21/20, at 8:59 a.m. NA-C stated R3 liked to think she was independent and did not want help however, the staff still tried to help and would reapproach her if she refused. NA-C stated eventually they could usually convince R3 to accept help to change, bathe etc. NA-C stated R3 could transfer independently but needed to use a walker. NA-C could not recall any specific fall interventions required for R3 and indicated she was not working at the time of her falls. NA-C stated to her recollection, R3 had always been able to transfer and walk independently	2 830		

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2 830	Continued From page 10 On 8/21/2020, at 2:09 PM p.m. RN-B stated she recently became the manager of the unit so did not remember much about R3. RN-B verified she had been looking for the post fall assessment for R3's 4/15/20, fall and one could not be found. RN-B stated she believed the fall occurred at the time they were transitioning from paper to electronic processes. RN-B confirmed a post fall assessment should have been completed after each fall and interventions identified to minimize the risk for further falls. On 8/21/2020, at 2:31 p.m. the director of nursing verified the facility fall documentation had recently transitioned from paper to a computer based system. DON also verified post fall assessments should be completed after each fall and reviewed by the IDT. DON confirmed the post fall assessment for R3's falls could not be found and also confirmed assessments for R2's falls had not been completed, as required. The Accidents/Falls policy revised February 2014, directed each incident/accident or fall must be investigated and/or assessed to determine the cause of the episode to prevent any further injury. The policy also directed a post-fall assessment would be conducted following any fall episode within 24 hours post fall. Once the post-fall assessment was completed by nursing, the director of nurses or designee would seek additional input from the interdisciplinary team and other staff. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) , or designee, could review and/or revise policies and procedures related to falls, post fall assessments and the implementation of interventions. The DON , or designee could educate all staff on the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 11 completion of assessments including the identification of causal factors of the fall. The DON or designee, could develop an auditing system to ensure compliance and report results of the monitoring to the facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		