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

DEPARTMENT OF HEALTH

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Electronically delivered

October 23, 2020

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

Re: Reinspection Results
Event ID: QFKP12 and E76Y11

Dear Administrator:

On October 20, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 23, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
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September 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 September 8, 2020, we informed you of imposed enforcement remedies.

On September 4, 2020, the Minnesota Department of Health completed a survey 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

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

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

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 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
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 09/04/2020

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 9/2/20, through 9/4/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5366159C with deficiencies cited. The following complaint was found to be unsubstantiated: H5366158C. 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 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		10/7/20

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

Electronically Signed | 10/02/2020

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 684	Continued From page 1 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor and provide treatment for a diabetic foot ulcer for 1 of 3 residents (R1) reviewed for wound care, who had a diabetic foot ulcer which was not properly monitored or treated by the facility. This resulted in actual harm to R1 when he developed an infection and an infestation of maggots, and required treatment at the emergency room, and R1 devoloped a new diabetic foot ulcer. Findings include: R1's Admission Record printed 9/3/20, indicated R1's diagnoses included traumatic complete amputation of two or more toes on the right foot, diabetes mellitus type 2 with foot ulcer, and bacterial wound infection. R1's admission Minimum Data Set (MDS) dated 6/23/20, indicated R1 had a infected wound of the foot. The MDS also indicated R1 required limited assistance with activities of daily living (ADLs), and had intact cognition. R1's Care Area Assessment (CAA) dated 7/1/20, indicated R1 had a current skin wound and infection of the foot. R1's care plan initiated 6/23/20, indicated R1 had a history of surgical amputation right foot toes. Staff interventions included implementing orders/treatments per MD/wound clinic, and follow facility skin protocol. R1's facility Risk/Benefit Tool completed 6/26/20,	F 684	R1 has had a comprehensive skin and wound assessment including review of treatments and orders. Care plan reviewed and revised to reflect current plan for R1 diabetic foot ulcer. Other residents with wounds have been reviewed and care plan revised to include plan for treatment and monitoring. Licensed nurses educated on treatment and monitoring expectations and standards of care for wounds, refusals of care, and notification of providers. DON or designee will complete audits of treatments and monitoring of wounds daily for one week then 3 times weekly for 2 weeks and then weekly to review compliance. Compliance date is: 10/7/20	

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F 684	Continued From page 2	F 684		

indicated R1 was at risk of surgical wound failure, risk of infection, loss of mobility to leg, risk of falls which could lead to significant injury, and hospitalization or death.

R1's wound treatment order received from wound clinic initiated 8/5/20, indicated wound care for right foot. Instructions included acetic acid (solution with antibacterial and antifungal properties) wash prior to dressing changes, rinse well and dry completely. Coat a ¼ plain packing strip with Gentamycin (antibiotic) to tunnel near base of third toe followed by Gentamycin to rest of wound bed covered with Aquacel (anti-microbial dressings) and quick pad (dressing), followed by Kerlix (wrap) and Setopress (compression dressing).

R1's treatment administration record (TAR) dated 8/1/20, through 8/30/20, indicated R1 refused wound care on 8/5, 8/6, 8/9, 8/11, 8/12, 8/13, 8/15, 8/18, 8/21, 8/22, 8/25, and 8/26. Record review lacked indication R1's physician or the wound clinic was notified of R1's refusal of wound care.

Review of R1's medical record including skin assessments and progress notes, indicated the facility failed to properly assess R1's wound status from 8/1/20, through 8/26/20, during the time period the facility nursing staff was responsible for R1's diabetic wound care. R1's medical record lacked documentation of an assessment of the diabetic wound status, measurements, or description from 8/1/20, through 8/26/20.

On 8/26/20, a progress note indicated R1 had been sent to the emergency department (ED) due

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F 684	Continued From page 3	F 684		

to to complaints of increased pain in the right foot.

On 8/27/20, a progress note indicated R1 returned to the facility with new orders for Cephalexin (oral antibiotic) 500 mg 3 times daily for seven days, and Zinc 50 milligrams (mg) 1 time daily to promote healing.

R1's Patient Discharge Orders from the ED dated 8/27/20, at 1:30 a.m. indicated R1 was treated for maggot infestation in his diabetic pressure ulcer, and possible recurrent bacterial infection. The orders further indicated R1 was started on a course of antibiotics in the ED, and was to complete full course of antibiotics prescribed.

Wound care clinic visit summary and wound assessment details dated 9/1/20, indicated R1's right foot trauma wound measured 4.5 centimeters (cm) in length, 2.2 cm in width and 0.1 cm in depth. R1's wound was described as having medium amounts of serosanguineous (serum and blood) drainage which was red and brown in color. The report also indicated R1 developed an additional right foot dorsal (outer) wound which measured 2 cm in length, 1 cm in width and 0.1 cm in depth. R1's second right foot wound was described as having large amounts of serous (serum) drainage, and was amber in color. Both of R1's right foot wounds were classified as Grade 1 diabetic foot ulcer (superficial wounds through either the epidermis or the epidermis and dermis, but that do not penetrate to tendon, capsule, or bone).

On 9/2/20, at 8:24 a.m. R1 was interviewed, and stated he had been to the ED recently, and was treated for maggots in his right foot wound. R1 further stated he had refused dressing changes

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F 684	Continued From page 4	F 684		

numerous times because he felt it was unnecessary. R1 stated he was previously going out to wound clinic but was not able to go out due to COVID-19 in the facility, and during that time the facility was providing wound care. R1 stated he is now going to the wound clinic for wound care twice weekly, and he would no longer be refusing wound care.

On 9/3/20, at 9:35 a.m. nursing assistant (NA)-A stated if a resident had a change in condition such as increased pain or change to skin she would report the change immediately to a nurse in charge. NA-A stated only licensed nurses are responsible for providing resident wound care. NA-A had no knowledge of R1's wound care or diabetic foot ulcer.

On 9/3/20, at 9:35 a.m. registered nurse (RN)-A stated nurses were responsible for completing wound care. RN-A stated R1 had been previously going out to the wound care clinic, but this had change the first part of August due to COVID-19 in the facility. RN-A stated all wound care then was completed in house and residents were not going out to the wound clinic during the facility COVID-19 outbreak. RN-A stated R1 frequently refused wound care. RN-A stated R1 had refused wound care for himself, however, neither R1's physician or the wound care clinic were contacted with those refusals. RN-A stated resident refusals of cares, and correspondence to physicians related to refusals of care were to be documented in the progress notes.

On 9/3/20, at 10:57 a.m. the director if nursing (DON) stated if a resident refused treatments, the physician was to be notified. The DON stated she was made aware of R1's maggot infestation to his

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F 684	Continued From page 5	F 684		

right foot wound upon his return from the ED on 8/27/20. The DON stated she would have expected R1's physician to have been notified of R1's refusing wound care. The DON stated failure to update the physician could increase the risk of developing an infection, and worsening of the wound. The DON stated notification to R1's physician should have been completed by nursing staff with each of R1's refusal of care.

On 9/3/20, at 12:15 p.m. RN-B was interviewed and stated she was the nurse manager for R1's unit. RN-B stated she personally never provided wound care or inspected R1's foot wound. RN-B stated she never provided education to R1 regarding the risks related to his refusal of care. RN-B stated she was made aware of R1's right foot maggot infestation on 8/27/20. RN-A verified the neither the wound clinic nor R1's physician were notified and updated regarding R1's wound care refusals. RN-B stated the facility failed, and they should have been letting the physician and wound clinic aware of R1's refusal of wound care.

On 9/4/20, at 2:29 p.m. the wound clinic RN-C was interviewed. RN-C stated the facility had not notified them of R1's wound care refusals. RN-C stated she was updated via email by the hospital social worker regarding R1's wound condition and maggot infestation on 8/27/20. RN-C stated R1 had not been seen at the wound clinic from 7/31/20, through 8/27/20, due to an outbreak of COVID-19 at the facility. RN-C stated the facility was responsible for R1's wound care during that time. RN-C stated she would have expected the facility to notify the wound clinic of R1's refusals, and had they been updated, R1's wound infection and maggot infestation may have been prevented.

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F 684	Continued From page 6 The ED physician was called 9/3/20, at 8:12 a.m. and a message was left, however, there was no response or return call. The facility policy Notification to Physician/Family/Resident Representative of Change in resident Health Status revised 5/20, directed the facility will consult the resident's physician when there is a need to alter treatment significantly (i.e. a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment). The facility policy Pressure Injury/Skin Integrity/Wound management revised 5/20, directed residents will receive treatment and services consistent with professional standards of practice to promote healing and prevent infection and prevent new pressure injuries from developing. The facility policy Treatment Record revised 5/20, all treatments provided must be ordered by the physician and documents, documentation to include reason for refusal of treatments.	F 684		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/7/20

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

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F 880	Continued From page 7 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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	245366	A. BUILDING _____ B. WING _____	C 09/04/2020

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F 880	Continued From page 8 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program to include the Centers for Medicaid and Medicare Services (CMS) COVID-19 recommendations to ensure active screening and surveillance of staff for potential COVID-19 symptoms before entering the facility and having contact with residents. These practices had the potential to affect all 128 residents who resided at the facility. Findings include: On 9/2/20, at 8:05 a.m. the facility lower level main entrance provided signage and information related to COVID-19 to ensure immediate screening and surveillance of staff and visitors for potential COVID-19 symptoms before entering the facility and having contact with residents. In addition, upon entrance signage directed those	F 880	Receptionist A; Business Office Worker A; Housekeeper A; Environmental Director A were educated on appropriate process for screening staff and visitors prior to entering community. Employees will be educated on the requirement to be screened prior to enter the community. The DON/designee will conduct daily audits for seven days to validate the screening logs against employee schedules. Daily screening audits for ancillary departments will be conducted by the respective department. Once compliance met, audits will decrease to three times per week for two weeks and then weekly to maintain compliance. The results of all audits will be reviewed	

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F 880	Continued From page 9 who entered to please sanitize hands, put on a mask, and be screened at reception desk. At the reception desk a sign was posted for staff to review signs and symptoms of COVID-19, and directed all staff must complete a daily screening for themselves to include temperature greater than 100 degrees, cough/congestion, increased confusion/delirium, inflammation/pus, nasal congestion, sore throat, diarrhea/vomiting, exposure to blood, rash, muscle ache, and loss of taste or smell. On 9/4/20, at 7:20 a.m. the front desk receptionist (R)-A was interviewed and stated all staff were to go to the reception desk for screening prior to starting their shifts. R-A stated staff members have their temperatures taken by the screener, but were responsible for reviewing and reporting any possible COVID-19 signs and symptoms to the screener. On 9/4/20, at 7:21 a.m. business office worker (BW)-A was observed entering the facility. BW-A was observed to sanitize her hands, and walked to the reception desk. BW-A had her temperature taken by R-A, however, R-A did not ask BW-A if she has COVID-19 signs or symptom, nor was there documentation of BW-A being asked the screening questions for signs and symptoms of COVID-19. On 9/4/20, at 7:25 a.m. the director of nursing (DON) was interviewed and verified the facility had not been actively screening staff for possible signs and symptoms of COVID-19. The DON stated only they were only taking staff temperatures. The DON stated this practice could result in possible exposure and spread of COVID-19. The DON stated guidance through	F 880	by the DON, IP and action will be taken as needed to educate and coach staff. Results of the audits and monitoring will be reviewed with the QAPI committee Compliance by: 10/7/20 DPOC- Active Screening: All resident could be affected by the alleged failure to properly screen employees. Policies/procedures/systems changes: The facility Infection Prevention and Control - Addendum: COVID-19 Coronavirus policy and procedure for screening rev. 7/28/20 were reviewed and found to be appropriate. The IDT met and did a RCA on the screening process and determined the lack of a cohesive process for screening all staff and monitoring the effectiveness of this system. The community has instituted a procedure to compare staffing schedules to the screening tools to ensure all staff who have entered the community have been screened. Training and Education Training has been and will continue to be provided to the staff on the need from active screening upon entering the community to ensure those with symptoms are not entering the patient care areas. Post-tests started and will continue to ensure understanding of the expectation of screening. Monitoring/Auditing The DON/designee will conduct daily audits for seven days to validate the	

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F 880	Continued From page 10 CMS specified active screening, and the facility had not been following guidance. The DON stated this facility practice could have led to a breach in infection control and spread of COVID-19. On 9/4/20, at 7:41 a.m. housekeeper (H)-A was interviewed and stated she worked full time as a housekeeper. H-A stated she had not completed the COVID-19 screening at the reception desk prior to starting her shift. H-A further stated she had not had her temperature taken nor reviewed the signs and symptoms of COVID-19 for at least a month or greater. H-A stated she would start working without being screened, and had done this since the facility moved the screening desk to the lower level. On 9/4/20, at 8:19 the facility binder which included COVID-10 employee screening tools was reviewed. The binder revealed environmental director (ED)-A's COVID-19 screening tool had not been completed since 8/25/20. ED-A's work schedule from 8/21/20, through 9/3/20, indicated ED-A worked 8/26/20, 8/27/20, 8/28/20, 8/31/20, 9/1/20, and 9/2/20. ED-A was noted to be out sick 9/3/20. On 9/4/20, at 8:20 a.m. review of facility binder which included COVID-10 employee screening tools, revealed H-A's COVID-19 screening tool had not been completed since 8/1/20. H-A's working schedule from 8/1/20, through 9/4/20, indicated H-A worked on 8/3/20, 8/4/20, 8/5/20, 8/7/20, 8/9/20, 8/11/20, 8/12/20, 8/13/20, 8/14/20, 8/17/20, 8/18/20, 8/19/20, 8/21/20, 8/22/20, 8/23/20, 8/25/20, 8/26/20, 8/27/20, 8/28/20, 8/31/20, 9/1/20, 9/2/20, and 9/4/20.	F 880	screening logs against employee schedules. Daily screening audits for ancillary departments will be conducted by the respective department. Once compliance met, audits will decrease to three times per week for two weeks and then weekly to maintain compliance. The results of all audits will be reviewed by the DON, IP and action will be taken as needed to educate and coach staff. Results of the audits and monitoring will be reviewed with the QAPI committee F880- Receptionist A; Business Office Worker A; Housekeeper A; Environmental Director A were educated on appropriate process for screening staff and visitors prior to entering community. Employees will be educated on the requirement to be screened prior to enter the community. The DON/designee will conduct daily audits for seven days to validate the screening logs against employee schedules. Daily screening audits for ancillary departments will be conducted by the respective department. Once compliance met, audits will decrease to three times per week for two weeks and then weekly to maintain compliance. The results of all audits will be reviewed by the DON, IP and action will be taken as needed to educate and coach staff. Results of the audits and monitoring will	

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F 880	Continued From page 11 On 9/4/20, at 8:47 a.m. the administrator was interviewed. The administrator verified H-A and ED had not been screened for COVID-19 consistently screened for COVID-19 prior to entering the facility. The administrator stated all staff and visitors should be actively screened for signs and symptoms of COVID-19 which included a temperature check and questions. The administrator stated failure to do complete COVID-19 screening could increase the risk of exposure to COVID-19 for residents and staff. On 9/4/20, at 10:42 a.m. the DON verified the facility had not been consistently and actively screening all facility staff. The DON stated guidance through CMS and the Minnesota Department of Health (MDH) specified active screening, and the facility had not been following guidance. The DON stated this facility practice could have led to a breach in infection control and spread of COVID-19. The facility policy Infection Prevention and Control - Addendum: COVID-19 Coronavirus dated 3/14/20, directed employees will be screened before each shift for fever and/or symptoms of COVID-19. The screener will actively take their temperature and document absence of symptoms consistent with COVID-19 on the screening form. The screener will have employees who develop symptoms similar to COVID-19 (as described on the screening form) keep their cloth face covering or facemask on and leave the workplace. The employee will be referred for testing, medical evaluation recommendations, and return to work instructions	F 880	be reviewed with the QAPI committee Compliance by: 10/7/20 DPOC- Active Screening: All resident could be affected by the alleged failure to properly screen employees. Policies/procedures/systems changes: The facility Infection Prevention and Control - Addendum: COVID-19 Coronavirus policy and procedure for screening rev. 7/28/20 were reviewed and found to be appropriate. The IDT met and did a RCA on the screening process and determined the lack of a cohesive process for screening all staff and monitoring the effectiveness of this system. The community has instituted a procedure to compare staffing schedules to the screening tools to ensure all staff who have entered the community have been screened. Training and Education Training has been and will continue to be provided to the staff on the need from active screening upon entering the community to ensure those with symptoms are not entering the patient care areas. Post-tests started and will continue to ensure understanding of the expectation of screening. Monitoring/Auditing The DON/designee will conduct daily audits for seven days to validate the screening logs against employee schedules. Daily screening audits for ancillary	

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F 880	Continued From page 12	F 880	departments will be conducted by the respective department. Once compliance met, audits will decrease to three times per week for two weeks and then weekly to maintain compliance. The results of all audits will be reviewed by the DON, IP and action will be taken as needed to educate and coach staff. Results of the audits and monitoring will be reviewed with the QAPI committee	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 23, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: E76Y11

Dear Administrator:

The above facility was surveyed on September 2, 2020 through September 4, 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
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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

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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 9/2/20, through 9/4/20, 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 complaint was found to be	2 000		

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2 000	Continued From page 1 substantiated: H5366159C with deficiencies cited. The following complaint was found to be unsubstantiated: H5366158C. 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 interview and document review, the facility failed to monitor and provide treatment for a diabetic foot ulcer for 1 of 3 residents (R1) reviewed for wound care, who had a diabetic foot ulcer which was not properly monitored or treated by the facility. This resulted in actual harm to R1	2 830	Completed	10/7/20

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2 830	Continued From page 2	2 830		

when he developed an infection and an infestation of maggots, and required treatment at the emergency room, and R1 devoloped a new diabetic foot ulcer.

Findings include:

R1's Admission Record printed 9/3/20, indicated R1's diagnoses included traumatic complete amputation of two or more toes on the right foot, diabetes mellitus type 2 with foot ulcer, and bacterial wound infection.

R1's admission Minimum Data Set (MDS) dated 6/23/20, indicated R1 had a infected wound of the foot. The MDS also indicated R1 required limited assistance with activities of daily living (ADLs), and had intact cognition.

R1's Care Area Assessment (CAA) dated 7/1/20, indicated R1 had a current skin wound and infection of the foot.

R1's care plan initiated 6/23/20, indicated R1 had a history of surgical amputation right foot toes. Staff interventions included implementing orders/treatments per MD/wound clinic, and follow facility skin protocol.

R1's facility Risk/Benefit Tool completed 6/26/20, indicated R1 was at risk of surgical wound failure, risk of infection, loss of mobility to leg, risk of falls which could lead to significant injury, and hospitalization or death.

R1's wound treatment order received from wound clinic initiated 8/5/20, indicated wound care for right foot. Instructions included acetic acid (solution with antibacterial and antifungal properties) wash prior to dressing changes, rinse

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2 830	Continued From page 3	2 830		

well and dry completely. Coat a ¼ plain packing strip with Gentamycin (antibiotic) to tunnel near base of third toe followed by Gentamycin to rest of wound bed covered with Aquacel (anti-microbial dressings) and quick pad (dressing), followed by Kerlix (wrap) and Setopress (compression dressing).

R1's treatment administration record (TAR) dated 8/1/20, through 8/30/20, indicated R1 refused wound care on 8/5, 8/6, 8/9, 8/11, 8/12, 8/13, 8/15, 8/18, 8/21, 8/22, 8/25, and 8/26. Record review lacked indication R1's physician or the wound clinic was notified of R1's refusal of wound care.

Review of R1's medical record including skin assessments and progress notes, indicated the facility failed to properly assess R1's wound status from 8/1/20, through 8/26/20, during the time period the facility nursing staff was responsible for R1's diabetic wound care. R1's medical record lacked documentation of an assessment of the diabetic wound status, measurements, or description from 8/1/20, through 8/26/20.

On 8/26/20, a progress note indicated R1 had been sent to the emergency department (ED) due to to complaints of increased pain in the right foot.

On 8/27/20, a progress note indicated R1 returned to the facility with new orders for Cephalexin (oral antibiotic) 500 mg 3 times daily for seven days, and Zinc 50 milligrams (mg) 1 time daily to promote healing.

R1's Patient Discharge Orders from the ED dated 8/27/20, at 1:30 a.m. indicated R1 was treated for maggot infestation in his diabetic pressure ulcer,

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2 830	Continued From page 4	2 830		

and possible recurrent bacterial infection. The orders further indicated R1 was started on a course of antibiotics in the ED, and was to complete full course of antibiotics prescribed.

Wound care clinic visit summary and wound assessment details dated 9/1/20, indicated R1's right foot trauma wound measured 4.5 centimeters (cm) in length, 2.2 cm in width and 0.1 cm in depth. R1's wound was described as having medium amounts of serosanguineous (serum and blood) drainage which was red and brown in color. The report also indicated R1 developed an additional right foot dorsal (outer) wound which measured 2 cm in length, 1 cm in width and 0.1 cm in depth. R1's second right foot wound was described as having large amounts of serous (serum) drainage, and was amber in color. Both of R1's right foot wounds were classified as Grade 1 diabetic foot ulcer (superficial wounds through either the epidermis or the epidermis and dermis, but that do not penetrate to tendon, capsule, or bone).

On 9/2/20, at 8:24 a.m. R1 was interviewed, and stated he had been to the ED recently, and was treated for maggots in his right foot wound. R1 further stated he had refused dressing changes numerous times because he felt it was unnecessary. R1 stated he was previously going out to wound clinic but was not able to go out due to COVID-19 in the facility, and during that time the facility was providing wound care. R1 stated he is now going to the wound clinic for wound care twice weekly, and he would no longer be refusing wound care.

On 9/3/20, at 9:35 a.m. nursing assistant (NA)-A stated if a resident had a change in condition such as increased pain or change to skin she

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	00598	A. BUILDING: _____ B. WING _____	C 09/04/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5	2 830		

would report the change immediately to a nurse in charge. NA-A stated only licensed nurses are responsible for providing resident wound care. NA-A had no knowledge of R1's wound care or diabetic foot ulcer.

On 9/3/20, at 9:35 a.m. registered nurse (RN)-A stated nurses were responsible for completing wound care. RN-A stated R1 had been previously going out to the wound care clinic, but this had change the first part of August due to COVID-19 in the facility. RN-A stated all wound care then was completed in house and residents were not going out to the wound clinic during the facility COVID-19 outbreak. RN-A stated R1 frequently refused wound care. RN-A stated R1 had refused wound care for himself, however, neither R1's physician or the wound care clinic were contacted with those refusals. RN-A stated resident refusals of cares, and correspondence to physicians related to refusals of care were to be documented in the progress notes.

On 9/3/20, at 10:57 a.m. the director if nursing (DON) stated if a resident refused treatments, the physician was to be notified. The DON stated she was made aware of R1's maggot infestation to his right foot wound upon his return from the ED on 8/27/20. The DON stated she would have expected R1's physician to have been notified of R1's refusing wound care. The DON stated failure to update the physician could increase the risk of developing an infection, and worsening of the wound. The DON stated notification to R1's physician should have been completed by nursing staff with each of R1's refusal of care.

On 9/3/20, at 12:15 p.m. RN-B was interviewed and stated she was the nurse manager for R1's unit. RN-B stated she personally never provided

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2 830	Continued From page 6 wound care or inspected R1's foot wound. RN-B stated she never provided education to R1 regarding the risks related to his refusal of care. RN-B stated she was made aware of R1's right foot maggot infestation on 8/27/20. RN-A verified the neither the wound clinic nor R1's physician were notified and updated regarding R1's wound care refusals. RN-B stated the facility failed, and they should have been letting the physician and wound clinic aware of R1's refusal of wound care. On 9/4/20, at 2:29 p.m. the wound clinic RN-C was interviewed. RN-C stated the facility had not notified them of R1's wound care refusals. RN-C stated she was updated via email by the hospital social worker regarding R1's wound condition and maggot infestation on 8/27/20. RN-C stated R1 had not been seen at the wound clinic from 7/31/20, through 8/27/20, due to an outbreak of COVID-19 at the facility. RN-C stated the facility was responsible for R1's wound care during that time. RN-C stated she would have expected the facility to notify the wound clinic of R1's refusals, and had they been updated, R1's wound infection and maggot infestation may have been prevented. The ED physician was called 9/3/20, at 8:12 a.m. and a message was left, however, there was no response or return call. The facility policy Notification to Physician/Family/Resident Representative of Change in resident Health Status revised 5/20, directed the facility will consult the resident's physician when there is a need to alter treatment significantly (i.e. a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment).	2 830		

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2 830	Continued From page 7 The facility policy Pressure Injury/Skin Integrity/Wound management revised 5/20, directed residents will receive treatment and services consistent with professional standards of practice to promote healing and prevent infection and prevent new pressure injuries from developing. The facility policy Treatment Record revised 5/20, all treatments provided must be ordered by the physician and documents, documentation to include reason for refusal of treatments. SUGGESTED METHOD OF CORRECTION: The administrator or the director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure treatments for wounds are provided per MD order for all residents is in place. In addition, the administrator or the director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure physicians are notified with changes in a resident's condition or treatments. The administrator or the DON or designee could educate all appropriate staff on the policies and procedures. The administrator or DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		10/7/20

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21375	Continued From page 8 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a comprehensive infection control program to include the Centers for Medicaid and Medicare Services (CMS) COVID-19 recommendations to ensure active screening and surveillance of staff for potential COVID-19 symptoms before entering the facility and having contact with residents. These practices had the potential to affect all 128 residents who resided at the facility. Findings include: On 9/2/20, at 8:05 a.m. the facility lower level main entrance provided signage and information related to COVID-19 to ensure immediate screening and surveillance of staff and visitors for potential COVID-19 symptoms before entering the facility and having contact with residents. In addition, upon entrance signage directed those who entered to please sanitize hands, put on a mask, and be screened at reception desk. At the reception desk a sign was posted for staff to review signs and symptoms of COVID-19, and directed all staff must complete a daily screening for themselves to include temperature greater than 100 degrees, cough/congestion, increased confusion/delirium, inflammation/pus, nasal congestion, sore throat, diarrhea/vomiting, exposure to blood, rash, muscle ache, and loss of taste or smell. On 9/4/20, at 7:20 a.m. the front desk receptionist (R)-A was interviewed and stated all staff were to go to the reception desk for screening prior to	21375	Completed	

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starting their shifts. R-A stated staff members have their temperatures taken by the screener, but were responsible for reviewing and reporting any possible COVID-19 signs and symptoms to the screener.

On 9/4/20, at 7:21 a.m. business office worker (BW)-A was observed entering the facility. BW-A was observed to sanitize her hands, and walked to the reception desk. BW-A had her temperature taken by R-A, however, R-A did not ask BW-A if she has COVID-19 signs or symptom, nor was there documentation of BW-A being asked the screening questions for signs and symptoms of COVID-19.

On 9/4/20, at 7:25 a.m. the director of nursing (DON) was interviewed and verified the facility had not been actively screening staff for possible signs and symptoms of COVID-19. The DON stated only they were only taking staff temperatures. The DON stated this practice could result in possible exposure and spread of COVID-19. The DON stated guidance through CMS specified active screening, and the facility had not been following guidance. The DON stated this facility practice could have led to a breach in infection control and spread of COVID-19.

On 9/4/20, at 7:41 a.m. housekeeper (H)-A was interviewed and stated she worked full time as a housekeeper. H-A stated she had not completed the COVID-19 screening at the reception desk prior to starting her shift. H-A further stated she had not had her temperature taken nor reviewed the signs and symptoms of COVID-19 for at least a month or greater. H-A stated she would start working without being screened, and had done this since the facility moved the screening desk to

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21375	Continued From page 10 the lower level. On 9/4/20, at 8:19 the facility binder which included COVID-10 employee screening tools was reviewed. The binder revealed environmental director (ED)-A's COVID-19 screening tool had not been completed since 8/25/20. ED-A's work schedule from 8/21/20, through 9/3/20, indicated ED-A worked 8/26/20, 8/27/20, 8/28/20, 8/31/20, 9/1/20, and 9/2/20. ED-A was noted to be out sick 9/3/20. On 9/4/20, at 8:20 a.m. review of facility binder which included COVID-10 employee screening tools, revealed H-A's COVID-19 screening tool had not been completed since 8/1/20. H-A's working schedule from 8/1/20, through 9/4/20, indicated H-A worked on 8/3/20, 8/4/20, 8/5/20, 8/7/20, 8/9/20, 8/11/20, 8/12/20, 8/13/20, 8/14/20, 8/17/20, 8/18/20, 8/19/20, 8/21/20, 8/22/20, 8/23/20, 8/25/20, 8/26/20, 8/27/20, 8/28/20, 8/31/20, 9/1/20, 9/2/20, and 9/4/20. On 9/4/20, at 8:47 a.m. the administrator was interviewed. The administrator verified H-A and ED had not been screened for COVID-19 consistently screened for COVID-19 prior to entering the facility. The administrator stated all staff and visitors should be actively screened for signs and symptoms of COVID-19 which included a temperature check and questions. The administrator stated failure to do complete COVID-19 screening could increase the risk of exposure to COVID-19 for residents and staff. On 9/4/20, at 10:42 a.m. the DON verified the facility had not been consistently and actively screening all facility staff. The DON stated guidance through CMS and the Minnesota Department of Health (MDH) specified active	21375		

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screening, and the facility had not been following guidance. The DON stated this facility practice could have led to a breach in infection control and spread of COVID-19.

The facility policy Infection Prevention and Control - Addendum: COVID-19 Coronavirus dated 3/14/20, directed employees will be screened before each shift for fever and/or symptoms of COVID-19. The screener will actively take their temperature and document absence of symptoms consistent with COVID-19 on the screening form. The screener will have employees who develop symptoms similar to COVID-19 (as described on the screening form) keep their cloth face covering or facemask on and leave the workplace. The employee will be referred for testing, medical evaluation recommendations, and return to work instructions.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing, or designee, could develop systems to ensure active screening is completed for all employees entering the facility. The Director of Nursing, or designee, and Infection Prevention Nurse could educate all appropriate staff on the policies and procedures. The Director of Nursing, or designee, could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days