

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

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 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 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.

An equal opportunity employer.

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DAT COM	E SURVEY IPLETED
		245366	B. WING				C 04/2020
NAME OF F	PROVIDER OR SUPPLIER		· [S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
CHRIS JI	ENSEN HEALTH & RE	EHABILITATION CENTER			2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 0	000			
	was completed at y complaint investiga NOT in compliance Requirements for L The following comp	n 9/4/20, an abbreviated survey your facility to conduct a tion. Your facility was found with 42 CFR Part 483, ong Term Care Facilities. plaint was found to be 366159C with deficiencies					
	cited.						
	I he following comp unsubstantiated: F	plaint was found to be I5366158C.					
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 684 SS=G	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with	F 6	684			10/7/20
	§ 483.25 Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a re that residents recei accordance with pr	care fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

		AND HUMAN SERVICES	-		PRINTED: FORM OMB NO.	APPROVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245366	B. WING			04/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
CHRIS JI	ENSEN HEALTH & RE	EHABILITATION CENTER		2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	age 1	F 68	4		
	care plan, and the r This REQUIREMEI by:	residents' choices. NT is not met as evidenced				
	facility failed to mor a diabetic foot ulcer reviewed for wound ulcer which was no by the facility. This when he developed infestation of magg the emergency root diabetic foot ulcer.	v and document review, the nitor and provide treatment for r for 1 of 3 residents (R1) d care, who had a diabetic foot t properly monitored or treated resulted in actual harm to R1 d an infection and an jots, and required treatment at m, and R1 devoloped a new		R1 has had a comprehensive wound assessment including treatments and orders. Care reviewed and revised to reflee plan for R1 diabetic foot ulce Other residents with wounds reviewed and care plan revis plan for treatment and monite Licensed nurses educated of and monitoring expectations standards of care for wounds care, and notification of provi	acluding review of s. Care plan to reflect current bot ulcer. wounds have been an revised to include d monitoring. cated on treatment stations and wounds, refusals of of providers.	
	R1's Admission Re R1's diagnoses incl amputation of two o diabetes mellitus ty	ndings include: 's Admission Record printed 9/3/20, indicated 's diagnoses included traumatic complete iputation of two or more toes on the right foot betes mellitus type 2 with foot ulcer, and cterial wound infection.		DON or designee will complete treatments and monitoring of daily for one week then 3 tim 2 weeks and then weekly to compliance. Compliance date is: 10/7/20	ete audits of wounds es weekly for	
	6/23/20, indicated F foot. The MDS also	nimum Data Set (MDS) dated R1 had a infected wound of the b indicated R1 required limited ivities of daily living (ADLs), nition.				
		sessment (CAA) dated 7/1/20, current skin wound and				
a S o	a history of surgical Staff interventions i	ated 6/23/20, indicated R1 had I amputation right foot toes. included implementing per MD/wound clinic, and protocol.				
	R1's facility Risk/Be	enefit Tool completed 6/26/20,				

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING			C
		245366	B. WING				04/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS JI	ENSEN HEALTH & RE	EHABILITATION CENTER			2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	indicated R1 was at risk of infection, los which could lead to hospitalization or de R1's wound treatme clinic initiated 8/5/24 right foot. Instructio (solution with antiba- properties) wash pr well and dry comple strip with Gentamy base of third toe fol of wound bed cover (anti-microbial dres (dressing), followed Setopress (compre R1's treatment adm 8/1/20, through 8/3 wound care on 8/5, 8/15, 8/18, 8/21, 8/2 review lacked indica wound clinic was no care. Review of R1's med assessments and p facility failed to prop status from 8/1/20, time period the faci responsible for R1's medical record lack assessment of the	t risk of surgical wound failure, s of mobility to leg, risk of falls significant injury, and eath. ent order received from wound 0, indicated wound care for ins included acetic acid acterial and antifungal for to dressing changes, rinse etely. Coat a ¼ plain packing cin (antibiotic) to tunnel near llowed by Gentamycin to rest red with Aquacel isings) and quick pad d by Kerlix (wrap) and	F 6	i84			
		ress note indicated R1 had nergency department (ED) due					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DAT	E SURVEY	
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				
		245366	B. WING					
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CHRIS JI	ENSEN HEALTH & RE	HABILITATION CENTER			501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID			ID				(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG				DATE	
F 684	Continued From pa	ae 3	F 6	684		COMPLETED C 09/04/2020 T ADDRESS, CITY, STATE, ZIP CODE ICE LAKE ROAD TH, MN 55811 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
		increased pain in the right foot.						
	On 8/27/20, a progr	ess note indicated R1						
		ity with new orders for tibiotic) 500 mg 3 times daily						
	for seven days, and	I Zinc 50 milligrams (mg) 1						
	time daily to promot	te healing.						
		rge Orders from the ED dated						
		n. indicated R1 was treated for in his diabetic pressure ulcer,						
	and possible recurr	ent bacterial infection. The						
		ated R1 was started on a s in the ED, and was to						
	complete full course	e of antibiotics prescribed.						
		visit summary and wound						
	assessment details right foot trauma wo	dated 9/1/20, indicated R1's ound measured 4.5						
	centimeters (cm) in	length, 2.2 cm in width and						
		1's wound was described as ounts of serosanguineous						
		drainage which was red and e report also indicated R1						
		ional right foot dorsal (outer)						
		ured 2 cm in length, 1 cm in depth. R1's second right foot						
	wound was describ	ed as having large amounts of						
		inage, and was amber in right foot wounds were						
	classified as Grade	1 diabetic foot ulcer						
		through either the epidermis d dermis, but that do not						
		, capsule, or bone).						
		a.m. R1 was interviewed, and						
		to the ED recently, and was in his right foot wound. R1						
		id refused dressing changes						

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		AND HUMAN SERVICES					FORM	10/16/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		СОМ	E SURVEY PLETED
		245366	B. WING					_ 04/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	Е		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			501 RICE LAKE ROAD DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 684	out to wound clinic to COVID-19 in the the facility was provi- he is now going to t care twice weekly, a refusing wound care On 9/3/20, at 9:35 a stated if a resident such as increased p would report the ch in charge. NA-A sta responsible for prov- NA-A had no knowl diabetic foot ulcer. On 9/3/20, at 9:35 a stated nurses were wound care. RN-A previously going out this had change the COVID-19 in the fa- care then was com- were not going out facility COVID-19 o frequently refused wound neither R1's physici were contacted with resident refusals of physicians related t documented in the On 9/3/20, at 10:57 (DON) stated if a re- physician was to be	cause he felt it was tated he was previously going but was not able to go out due facility, and during that time viding wound care. R1 stated the wound clinic for wound and he would no longer be e. a.m. nursing assistant (NA)-A had a change in condition pain or change to skin she ange immediately to a nurse ated only licensed nurses are viding resident wound care. edge of R1's wound care or a.m. registered nurse (RN)-A responsible for completing stated R1 had been t to the wound care clinic, but e first part of August due to cility. RN-A stated all wound pleted in house and residents to the wound clinic during the utbreak. RN-A stated R1 wound care. RN-A stated R1 wound care. RN-A stated R1 care for himself, however, fan or the wound care clinic n those refusals. RN-A stated cares, and correspondence to o refusals of care were to be	F	584				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/16/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245366	B. WING _				C 04/2020
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS JI	ENSEN HEALTH & RE	HABILITATION CENTER			01 RICE LAKE ROAD		
	1			שנ	ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ae 5	F 68	34			
	right foot wound up	on his return from the ED on	1 00				
		stated she would have					
		ician to have been notified of d care. The DON stated failure					
		cian could increase the risk of					
		tion, and worsening of the					
		tated notification to R1's					
	staff with each of R	ive been completed by nursing 1's refusal of care.					
	On 9/3/20. at 12:15	p.m. RN-B was interviewed					
		the nurse manager for R1's					
		ne personally never provided					
		ected R1's foot wound. RN-B					
		ovided education to R1 related to his refusal of care.					
		as made aware of R1's right					
		tion on 8/27/20. RN-A verified					
		nd clinic nor R1's physician					
		odated regarding R1's wound					
		stated the facility failed, and een letting the physician and					
		of R1's refusal of wound care.					
		o.m. the wound clinic RN-C					
		N-C stated the facility had not					
		s wound care refusals. RN-C					
		ated via email by the hospital ding R1's wound condition and					
		on 8/27/20. RN-C stated R1					
	had not been seen	at the wound clinic from					
		27/20, due to an outbreak of					
		cility. RN-C stated the facility					
		R1's wound care during that					
		she would have expected the wound clinic of R1's refusals,					
		updated, R1's wound infection					
		tion may have been					
	prevented.	2					

Facility ID: 00598

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATI	E SURVEY PLETED
		245366	B. WING			C 09/04/20	
NAME OF F	PROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE	00/	04/2020
CHRIS J	ENSEN HEALTH & RE	HABILITATION CENTER		25	501 RICE LAKE ROAD		
				D	ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 6	F 6	84			
		vas called 9/3/20, at 8:12 a.m. s left, however, there was no call.					
	Change in resident directed the facility physician when the significantly (i.e. a r an existing form of consequences or to treatment). The facility policy P Integrity/Wound ma directed residents v services consistent	esident Representative of Health Status revised 5/20, will consult the resident's re is a need to alter treatment need to discontinue or change treatment due to adverse o commence a new form of					
F 880 SS=F	and prevent new pr developing. The facility policy Tr all treatments provis physician and docu include reason for r Infection Preventior CFR(s): 483.80(a)(§483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror	reatment Record revised 5/20, ded must be ordered by the ments, documentation to efusal of treatments. a & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program e a safe, sanitary and ment and to help prevent the ansmission of communicable	F 8	80			10/7/20

Facility ID: 00598

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	-	AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245366	B. WING	NG	C 09/04/2020	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/0	J4/2020
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER		2501 RICE LAKE ROAD		
	1		L	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(a) Infection program. The facility must est and control program a minimum, the folk §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communica- infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pre (iv)When and how i resident; including b (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos- circumstances. (v) The circumstance must prohibit emplor	n prevention and control stablish an infection prevention m (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment og to §483.70(e) and following standards; en standards, policies, and program, which must include, to: reillance designed to identify cable diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a	F 88	80		

		E & MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	CON	E SURVEY IPLETED
		245366	B. WING			C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		04/2020
				2501 RICE LAKE ROAD	OODL	
CHRIS J	ENSEN HEALTH & R	EHABILITATION CENTER		DULUTH, MN 55811		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLÉTIC DATE
F 880	Continued From page 8		F 88	b		
	•	ents or their food, if direct				
	contact will transm					
		ne procedures to be followed				
	by staff involved in	direct resident contact.				
		stem for recording incidents e facility's IPCP and the				
	corrective actions	taken by the facility.				
	§483.80(e) Linens.					
	Personnel must ha	andle, store, process, and				
	transport linens so infection.	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.					
		NT is not met as evidenced				
		tion, interview, and document		Receptionist A; Business (
		failed to implement a		A; Housekeeper A; Enviror		
		ection control program to		Director A were educated of		
		s for Medicaid and Medicare OVID-19 recommendations to		process for screening staff prior to entering community		
		ening and surveillance of staff		Employees will be educate		
		D-19 symptoms before entering		requirement to be screene		
		ing contact with residents.		the community.		
		ad the potential to affect all 128		The DON/designee will cor	nduct daily	
	residents who residents	ded at the facility.		audits for seven days to va		
	Findings include:			screening logs against emp schedules. Daily screening audits for a	-	
	On 9/2/20. at 8:05	a.m. the facility lower level		departments will be conduc		
	main entrance prov	vided signage and information		respective department.	,	
	related to COVID-	19 to ensure immediate		Once compliance met, auc		
		veillance of staff and visitors for		decrease to three times pe		
		9 symptoms before entering		weeks and then weekly to	maintain	
		ing contact with residents. In		compliance.	bo review	
addition, upon entrar		ance signage directed those		The results of all audits wil	i ne reviewed	

		& MEDICAID SERVICES	0.00		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		0.45000				2
		245366	B. WING			04/2020
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
CHRIS J	ENSEN HEALTH & RE	HABILITATION CENTER		2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From na	ae 9	ES	80		
F 880	who entered to plea mask, and be scree reception desk a sig review signs and sy directed all staff mu for themselves to in than 100 degrees, of confusion/delirium, congestion, sore the exposure to blood, taste or smell. On 9/4/20, at 7:20 at (R)-A was interview go to the reception starting their shifts. have their temperate but were responsible any possible COVII the screener. On 9/4/20, at 7:21 at (BW)-A was observed to sate of the reception dest taken by R-A, howe she has COVID-19 there documentation screening questions COVID-19. On 9/4/20, at 7:25 at (DON) was interview had not been active signs and symptom stated only they we	ase sanitize hands, put on a ened at reception desk. At the gn was posted for staff to imptoms of COVID-19, and ist complete a daily screening include temperature greater cough/congestion, increased inflammation/pus, nasal roat, diarrhea/vomiting, rash, muscle ache, and loss of a.m. the front desk receptionist ed and stated all staff were to desk for screening prior to R-A stated staff members cures taken by the screener, le for reviewing and reporting D-19 signs and symptoms to a.m. business office worker red entering the facility. BW-A nitize her hands, and walked sk. BW-A had her temperature ever, R-A did not ask BW-A if signs or symptom, nor was n of BW-A being asked the s for signs and symptoms of a.m. the director of nursing wed and verified the facility ely screening staff for possible s of COVID-19. The DON	F 88	 by the DON, IP and ac needed to educate and Results of the audits a be reviewed with the C Compliance by: 10/7/2 DPOC- Active Screening: All resident could be a alleged failure to proper employees. Policies/procedures/sy The facility Infection P Control - Addendum: C Coronavirus policy and screening rev. 7/28/20 found to be appropriat The IDT met and did a screening process and lack of a cohesive proferation of this system. The community has in to compare staffing sc screening tools to ens have entered the compare staffing sc screening upon community to ensure the symptoms are not entered the staff or active screening upon community to ensure the symptoms are not entered and ensure understanding of screening. Monitoring/Auditing 	d coach staff. Ind monitoring will DAPI committee 20 ffected by the erly screen vstems changes: revention and COVID-19 d procedure for were reviewed and e. a RCA on the d determined the cess for screening g the effectiveness stituted a procedure hedules to the ure all staff who munity have been n will continue to be n the need from entering the chose with ering the patient will continue to	

Facility ID: 00598

If continuation sheet Page 10 of 13

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245366	B. WING			C 04/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER		2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
F 880	Continued From pa	ge 10	F 88	30		
	CMS specified activ had not been follow stated this facility p breach in infection of COVID-19. On 9/4/20, at 7:41 a interviewed and stat housekeeper. H-A s the COVID-19 scre- prior to starting her had not had her ten the signs and symp a month or greater. working without bei this since the facility the lower level. On 9/4/20, at 8:19 t included COVID-10 was reviewed. The director (ED)-A's CO not been completed schedule from 8/21 ED-A worked 8/26/2 9/1/20, and 9/2/20. sick 9/3/20. On 9/4/20, at 8:20 a which included COV tools, revealed H-A had not been comp working schedule fr indicated H-A worke 8/7/20, 8/9/20, 8/11 8/17/20, 8/18/20, 8/	 <i>ve</i> screening, and the facility <i>v</i> ing guidance. The DON ractice could have led to a control and spread of a.m. housekeeper (H)-A was ted she worked full time as a stated she had not completed ening at the reception desk shift. H-A further stated she nperature taken nor reviewed otoms of COVID-19 for at least H-A stated she would start ng screened, and had done y moved the screening desk to he facility binder which employee screening tools binder revealed environmental OVID-19 screening tool had d since 8/25/20. ED-A's work /20, through 9/3/20, indicated 20, 8/27/20, 8/28/20, 8/31/20, ED-A was noted to be out a.m. review of facility binder /ID-10 employee screening tool leted since 8/1/20. H-A's rom 8/1/20, through 9/4/20, ed on 8/3/20, 8/4/20, 8/5/20, /20, 8/12/20, 8/13/20, 8/14/20, '19/20, 8/21/20, 8/22/20, '26/20, 8/27/20, 8/28/20, '26/20, 8/27/20, 8/27/20, 8/28/20, '26/20, '26/20, *26/20, '		 screening logs against employee schedules. Daily screening audits for ancillar departments will be conducted by respective department. Once compliance met, audits will decrease to three times per week weeks and then weekly to maintar compliance. The results of all audits will be reiby the DON, IP and action will be needed to educate and coach star Results of the audits and monitor be reviewed with the QAPI comm F880- Receptionist A; Business Office W Housekeeper A; Environmental D were educated on appropriate proscreening staff and visitors prior the community. Employees will be educated on the requirement to be screened prior the community. The DON/designee will conduct of audits for seven days to validate screening logs against employee schedules. Daily screening audits for ancillar departments will be conducted by respective department. Once compliance met, audits will decrease to three times per week weeks and then weekly to maintar compliance. The results of all audits will be reiby the DON, IP and action will be reiby the DON, IP and action will be needed to educate and coach star Results of the audits and monitor 	viewed taken as ff. ing will ittee Vorker A; virector A pocess for o to enter laily the y the for two in viewed taken as ff.	

Facility ID: 00598

If continuation sheet Page 11 of 13

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
						С
		245366	B. WING			04/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CHRIS J	ENSEN HEALTH & R	EHABILITATION CENTER		2501 RICE LAKE ROAD DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From pa	age 11	F 8	80		
	On 9/4/20, at 8:47 interviewed. The ac ED had not been s consistently screen entering the facility staff and visitors sh signs and symptom a temperature chec administrator state COVID-19 screenin exposure to COVID On 9/4/20, at 10:42 facility had not bee screening all facility guidance through O Department of Hea screening, and the guidance. The DOI could have led to a spread of COVID-1 The facility policy In Control - Addendur dated 3/14/20, dire screening for employees who de COVID-19 (as desc keep their cloth fac and leave the work referred for testing	a.m. the administrator was dministrator verified H-A and creened for COVID-19 ned for COVID-19 prior to . The administrator stated all nould be actively screened for ns of COVID-19 which included ck and questions. The d failure to do complete ng could increase the risk of D-19 for residents and staff. 2 a.m. the DON verified the n consistently and actively y staff. The DON stated CMS and the Minnesota alth (MDH) specified active facility had not been following N stated this facility practice breach in infection control and		be reviewed with the QAPI of Compliance by: 10/7/20 DPOC- Active Screening: All resident could be affected alleged failure to properly sc employees. Policies/procedures/systems The facility Infection Prevent Control - Addendum: COVIE Coronavirus policy and process screening rev. 7/28/20 were found to be appropriate. The IDT met and did a RCA screening process and deter lack of a cohesive process fr all staff and monitoring the e of this system. The community has institute to compare staffing schedule screening tools to ensure all have entered the community screened. Training and Education Training has been and will co provided to the staff on the r active screening upon entering t care areas. Post-tests started and will co ensure understanding of the of screening. Monitoring/Auditing The DON/designee will cond audits for seven days to valid	d by the reen s changes: tion and 0-19 edure for reviewed and on the rmined the or screening offectiveness d a procedure es to the staff who r have been ontinue to be need from ing the with he patient ontinue to expectation	

Facility ID: 00598

		AND HUMAN SERVICES				FORM	10/16/2020 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245366	B. WING				C 04/2020
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		25	TREET ADDRESS, CITY, STATE, ZIP CODE 501 RICE LAKE ROAD I'ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	Continued From pa	age 12	F	380	departments will be conducted respective department. Once compliance met, audits wild decrease to three times per we weeks and then weekly to main compliance. The results of all audits will be aby the DON, IP and action will be needed to educate and coach as Results of the audits and monit be reviewed with the QAPI com	vill ek for two itain reviewed be taken as staff. coring will	



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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

An equal opportunity employer.

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

Minnesc	ta Department of He	ealth				ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE COMP	SURVEY PLETED
		00598	B. WING		09/0	C)4/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RI	FHARILITATION C	E LAKE ROA , MN 55811	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Rev When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	was conducted to c State Licensure. Yo	TS: 9/4/20, an abbreviated survey determine compliance with our facility was found NOT to the MN State Licensure.				
		plaint was found to be				
LABORATOR'	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE 10/02/20

Electronically Signed

6899

If continuation sheet 1 of 12

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00598	B. WING			09/04/2020	
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
CHRIS J	ENSEN HEALTH & RE	-HABILITATION C	E LAKE ROA , MN 55811	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
2 000	Continued From pa	ge 1	2 000				
	substantiated: H53 cited.	66159C with deficiencies					
	The following comp unsubstantiated: H	laint was found to be 5366158C.					
	signature is not req page of state form. electronic plan of c	ed in ePOC and therefore a uired at the bottom of the first Please indicate your orrection that you have er, and identify the date when ed					
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			10/7/20	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident a bed.					
	by: Based on interview facility failed to mor a diabetic foot ulcer reviewed for wound ulcer which was no	ent is not met as evidenced and document review, the nitor and provide treatment for r for 1 of 3 residents (R1) d care, who had a diabetic foot t properly monitored or treated resulted in actual harm to R1		Completed			

Minnesota Department of Health STATE FORM

E76Y11

If continuation sheet 2 of 12

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY	
			A. BUILDING:				
		00598	B. WING			C 09/04/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
HRIS J	ENSEN HEALTH & R		E LAKE ROAD , MN 55811)			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE	
2 830	Continued From pa	age 2	2 830				
1	infestation of mage	d an infection and an gots, and required treatment at m, and R1 devoloped a new					
	Findings include:						
	R1's diagnoses inc amputation of two	ecord printed 9/3/20, indicated cluded traumatic complete or more toes on the right foot, /pe 2 with foot ulcer, and fection.					
	6/23/20, indicated foot. The MDS also	nimum Data Set (MDS) dated R1 had a infected wound of the p indicated R1 required limited tivities of daily living (ADLs), nition.	3				
		sessment (CAA) dated 7/1/20, current skin wound and t.					
	a history of surgical Staff interventions	ated 6/23/20, indicated R1 had Il amputation right foot toes. included implementing per MD/wound clinic, and protocol.					
	indicated R1 was a risk of infection, los	enefit Tool completed 6/26/20, at risk of surgical wound failure as of mobility to leg, risk of falls a significant injury, and eath.					
	clinic initiated 8/5/2 right foot. Instruction (solution with antib	ent order received from wound 20, indicated wound care for ons included acetic acid acterial and antifungal rior to dressing changes, rinse					

	ta Department of He		1			APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
						с
		00598	B. WING			04/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
יוסופ וו	ENSEN HEALTH & R	EHABILITATION C 2501 RIC	E LAKE ROAI	D		
		DULUTH	, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 3	2 830			
	well and dry compl strip with Gentamy base of third toe fo of wound bed cove (anti-microbial dress (dressing), followed Setopress (compress R1's treatment adm 8/1/20, through 8/2 wound care on 8/5 8/15, 8/18, 8/21, 8/ review lacked indic wound clinic was n care. Review of R1's me assessments and p facility failed to pro	etely. Coat a ¼ plain packing cin (antibiotic) to tunnel near llowed by Gentamycin to rest red with Aquacel ssings) and quick pad d by Kerlix (wrap) and				
	time period the fac responsible for R1' medical record lacl assessment of the measurements, or through 8/26/20.	ility nursing staff was s diabetic wound care. R1's ked documentation of an diabetic wound status, description from 8/1/20, ress note indicated R1 had				
	been sent to the er to to complaints of	nergency department (ED) due increased pain in the right foot				
	returned to the faci Cephalexin (oral ar	ress note indicated R1 lity with new orders for ntibiotic) 500 mg 3 times daily d Zinc 50 milligrams (mg) 1 te healing.				
maarta	8/27/20, at 1:30 a.r	arge Orders from the ED dated n. indicated R1 was treated for in his diabetic pressure ulcer,				

If continuation sheet 4 of 12

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:	<u> </u>			
		00598	B. WING			C 09/04/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	ENSEN HEALTH & R	EHABILITATION C 2501 RIC	E LAKE ROAD)			
	ENSEN HEALTH & K	DULUTH	, MN 55811				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 4	2 830				
	orders further indic course of antibiotic complete full course Wound care clinic assessment details right foot trauma w centimeters (cm) in 0.1 cm in depth. F having medium an (serum and blood) brown in color. Th developed an addi wound which meas width and 0.1 cm i wound was descrift serous (serum) dra color. Both of R1's classified as Grade (superficial wound	rent bacterial infection. The cated R1 was started on a cs in the ED, and was to se of antibiotics prescribed. visit summary and wound s dated 9/1/20, indicated R1's round measured 4.5 n length, 2.2 cm in width and R1's wound was described as nounts of serosanguineous drainage which was red and e report also indicated R1 tional right foot dorsal (outer) sured 2 cm in length, 1 cm in n depth. R1's second right foo bed as having large amounts of ainage, and was amber in s right foot wounds were e 1 diabetic foot ulcer s through either the epidermis nd dermis, but that do not					
	On 9/2/20, at 8:24 stated he had been treated for maggot further stated he h numerous times be unnecessary. R1 out to wound clinic to COVID-19 in the the facility was pro he is now going to care twice weekly, refusing wound ca On 9/3/20, at 9:35 stated if a resident	n, capsule, or bone). a.m. R1 was interviewed, and n to the ED recently, and was s in his right foot wound. R1 ad refused dressing changes ecause he felt it was stated he was previously going but was not able to go out due e facility, and during that time viding wound care. R1 stated the wound clinic for wound and he would no longer be re. a.m. nursing assistant (NA)-A had a change in condition pain or change to skin she					

TATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00598	B. WING			C 04/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ENSEN HEALTH & RE	-ΗΔΒΙΙ ΙΤΔΤΙΟΝ C	E LAKE ROAD , MN 55811	0		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
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2 830	Continued From pa	Continued From page 5				
	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.					
	stated nurses were wound care. RN-A previously going out this had change the COVID-19 in the fa care then was com were not going out facility COVID-19 of frequently refused w had refused wound neither R1's physic were contacted with resident refusals of	a.m. registered nurse (RN)-A responsible for completing stated R1 had been it to the wound care clinic, but e first part of August due to cility. RN-A stated all wound pleted in house and residents to the wound clinic during the utbreak. RN-A stated R1 wound care. RN-A stated R1 care for himself, however, ian or the wound care clinic in those refusals. RN-A stated cares, and correspondence to to refusals of care were to be progress notes.				
	(DON) stated if a rephysician was to be was made aware o right foot wound up 8/27/20. The DON expected R1's phys R1's refusing woun to update the physi developing an infec- wound. The DON s	a.m. the director if nursing esident refused treatments, the enotified. The DON stated she f R1's maggot infestation to his on his return from the ED on stated she would have sician to have been notified of d care. The DON stated failure cian could increase the risk of ction, and worsening of the tated notification to R1's ave been completed by nursing 1's refusal of care.	3			
	and stated she was	p.m. RN-B was interviewed the nurse manager for R1's he personally never provided				

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CHRIS JI	ENSEN HEALTH & RE	FHABILITATION C	E LAKE ROAD , MN 55811	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	0	2 830			
	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					
	had not been seen 7/31/20, through 8/2 COVID-19 at the fa was responsible for time. RN-C stated s facility to notify the	on 8/27/20. RN-C stated R1 at the wound clinic from 27/20, due to an outbreak of icility. RN-C stated the facility r R1's wound care during that she would have expected the wound clinic of R1's refusals, updated, R1's wound infection				
	and maggot infesta prevented. The ED physician v	vas called 9/3/20, at 8:12 a.m. s left, however, there was no				
	response or return The facility policy N Physician/Family/R Change in resident directed the facility	call.				
	significantly (i.e. a r an existing form of	treatment due to adverse commence a new form of				

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STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	-HABILITATION C	E LAKE ROAD , MN 55811)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	ge 7	2 830			
	directed residents v services consistent practice to promote and prevent new pr developing. The facility policy T all treatments provi physician and docu	ressure Injury/Skin anagement revised 5/20, will receive treatment and with professional standards of the healing and prevent infection ressure injuries from reatment Record revised 5/20, ded must be ordered by the ments, documentation to refusal of treatments.				
	SUGGESTED MET The administrator of (DON) or designee revise policies and treatments for would for all residents is in administrator or the designee could dev policies and proced notified with change treatments. The ad designee could edu the policies and pro- DON or designee of	THOD OF CORRECTION: or the director of nursing could develop, review, and/or procedures to ensure nds are provided per MD order n place. In addition, the e director of nursing (DON) or velop, review and/or revise lures to ensure physicians are es in a resident's condition or ministrator or the DON or ucate all appropriate staff on bocedures. The administrator of ould develop monitoring ongoing compliance.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			10/7/20
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and				

If continuation sheet 8 of 12

TATEMEN	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	:		
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HRIS JI	ENSEN HEALTH & R	FHARII ITATION C	E LAKE RO	AD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	CTION	(X5)
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21375	Continued From pa	age 8	21375			
	sanitary environme	ent.				
	This MN Requirem	nent is not met as evidenced				
	by:			O a manufacta al		
	Based on observation, interview, and document review, the facility failed to implement a			Completed		
	comprehensive inf	ection control program to				
	-	s for Medicaid and Medicare OVID-19 recommendations to				
	ensure active scre	ening and surveillance of staff				
		D-19 symptoms before entering ring contact with residents.	3			
		ad the potential to affect all 128				
	residents who resi					
	Findings include:					
		a.m. the facility lower level				
		vided signage and information 19 to ensure immediate				
		veillance of staff and visitors for	r			
		9 symptoms before entering				
		ring contact with residents. In rance signage directed those				
	who entered to ple	ase sanitize hands, put on a				
		ened at reception desk. At the				
		ign was posted for staff to symptoms of COVID-19, and				
	directed all staff m	ust complete a daily screening				
		nclude temperature greater cough/congestion, increased				
		, inflammation/pus, nasal				
	congestion, sore th	nroat, diarrhea/vomiting,	_			
	exposure to blood, taste or smell.	, rash, muscle ache, and loss o	T			
	On 9/4/20, at 7:20	a.m. the front desk receptionis	t			
	(R)-A was interview	wed and stated all staff were to				
	go to the reception	e desk for screening prior to				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	-ΗΔΒΙΙ ΙΤΔΤΙΟΝ C	E LAKE ROAE , MN 55811)		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
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21375	Continued From pa	ige 9	21375			
	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.					
	(BW)-A was observ was observed to sa to the reception des taken by R-A, howe she has COVID-19 there documentation	a.m. business office worker ved entering the facility. BW-A anitize her hands, and walked sk. BW-A had her temperature ever, R-A did not ask BW-A if signs or symptom, nor was on of BW-A being asked the s for signs and symptoms of				
	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.		1			
	interviewed and sta housekeeper. H-As the COVID-19 scre prior to starting her had not had her ter the signs and symp a month or greater. working without bei	a.m. housekeeper (H)-A was ted she worked full time as a stated she had not completed ening at the reception desk shift. H-A further stated she nperature taken nor reviewed otoms of COVID-19 for at least H-A stated she would start ng screened, and had done y moved the screening desk to				

STATEMEN	o <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
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21375	Continued From pa	ge 10	21375			
	the lower level.					
	included COVID-10 was reviewed. The director (ED)-A's C not been completed schedule from 8/21 ED-A worked 8/26/2	the facility binder which employee screening tools binder revealed environmenta OVID-19 screening tool had since 8/25/20. ED-A's work /20, through 9/3/20, indicated 20, 8/27/20, 8/28/20, 8/31/20, ED-A was noted to be out	1			
	which included CO ¹ tools, revealed H-A had not been comp working schedule fr indicated H-A work 8/7/20, 8/9/20, 8/11 8/17/20, 8/18/20, 8/	a.m. review of facility binder VID-10 employee screening 's COVID-19 screening tool bleted since 8/1/20. H-A's rom 8/1/20, through 9/4/20, ed on 8/3/20, 8/4/20, 8/5/20, /20, 8/12/20, 8/13/20, 8/14/20, /19/20, 8/21/20, 8/22/20, /26/20, 8/27/20, 8/28/20, 2/20, and 9/4/20.				
	interviewed. The ac ED had not been so consistently screen entering the facility. staff and visitors sh signs and symptom a temperature chec administrator stated COVID-19 screenin	a.m. the administrator was dministrator verified H-A and creened for COVID-19 ed for COVID-19 prior to . The administrator stated all nould be actively screened for the of COVID-19 which included ck and questions. The d failure to do complete ing could increase the risk of 0-19 for residents and staff.	4			
	On 9/4/20, at 10:42 facility had not been screening all facility guidance through C	a.m. the DON verified the n consistently and actively / staff. The DON stated CMS and the Minnesota Ith (MDH) specified active				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 09/04/2020	
	00598					
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
CHRIS JI	ENSEN HEALTH & RI	ΕΗΔΒΙΙ ΙΤΔΤΙΟΝ C	E LAKE ROAD MN 55811)		
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21375	Continued From page 11		21375			
	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.					
	Control - Addendur dated 3/14/20, dire screened before ea symptoms of COVI actively take their to absence of sympto on the screening for employees who de COVID-19 (as deso keep their cloth fac and leave the work	nfection Prevention and m: COVID-19 Coronavirus cted employees will be ach shift for fever and/or ID-19. The screener will emperature and document ms consistent with COVID-19 orm. The screener will have velop symptoms similar to cribed on the screening form) ec covering or facemask on place. The employee will be medical evaluation and return to work				
	Director of Nursing systems to ensure for all employees e Director of Nursing Prevention Nurse of staff on the policies Director of Nursing monitoring systems compliance.	THOD OF CORRECTION: The , or designee, could develop active screening is completed intering the facility. The , or designee, and Infection could educate all appropriate s and procedures. The , or designee, could develop s to ensure ongoing R CORRECTION: Twenty-one				
	(21) days	R CORRECTION: Twenty-one				

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