

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 11, 2021

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

RE: CCN: 245366 Cycle Start Date: November 5, 2020

Dear Administrator:

On January 7, 2021, we notified you a remedy was imposed. On February 9, 2021 the Minnesota Department(s) 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 February 4, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective January 23, 2021 be discontinued as of February 4, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 7, 2021, 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 January 23, 2021. 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,

Doverto Stateson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division

Chris Jensen Health & Rehabilitation Center February 11, 2021 Page 2 Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 24, 2020

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

RE: CCN: 245366 Cycle Start Date: November 5, 2020

Dear Administrator:

On November 23, 2020, we informed you that we may impose enforcement remedies.

On December 10, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

• Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 5, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 5, 2021.

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 Chris Jensen Health & Rehabilitation Center December 24, 2020 Page 2 payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 5, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Chris Jensen Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 5, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor Metro C District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us Office: (651) 201-3794 Mobile: (320) 249-2805

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 May 5, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

Daventes Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DAT CON	E SURVEY IPLETED
		245366	B. WING		_		C 10/2020
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STA	TE, ZIP CODE		
CHRIS JI	ENSEN HEALTH & RI	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	(EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F 0	00			
	was completed at y complaint investiga NOT to be in comp Requirements for L The following comp SUBSTANTIATED: with a deficiency ci The following comp SUBSTANTIATED: with with no citation by the facility prior to The facility's plan o	plaint was found to be : H5366172C/MN00067552, n issued due to actions taken					
F 760 SS=D	Department's acce Because you are e signature is not req page of the CMS-2 submission of the F verification of comp Upon receipt of an on-site revisit of yo validate that substa regulations has bee your verification. Residents are Free CFR(s): 483.45(f)(2	ptance. nrolled in ePOC, your juired at the bottom of the first 567 form. Your electronic POC will be used as bliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with e of Significant Med Errors 2)	F 7	50			1/6/21
	medication errors.	nsure that its- dents are free of any significant NT is not met as evidenced					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE			(X6) DATE 12/31/2020

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.

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/31/2020 APPROVED 0938-039
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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			501 RICE LAKE ROAD ULUTH, MN 55811		
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F 760	• • • • • • • • • • • • • • • • • • • •	age 1	F 7	60			
	 Continued From page 1 by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R1) reviewed for medication errors, was free of significant medication errors, when the facility failed to ensure the resident received two medications in accordance with provider orders for nineteen days following admission to the facility, failed to notify the prescribing physician or follow up with the pharmacy. Findings include: R1's Face Sheet dated 12/3/20, indicated R1 was admitted to the facility on 11/12/20, with Medicaid as payer source and with diagnoses including; asymptomatic human immunodeficiency virus disease (caused by the HIV virus that invades immune cells and damages the immune system which left untreated may become fatal), 				Resident #1 no longer resides at the community; however, his medication started, and the primary provider and pharmacy were updated on this medication omission. All residents admitted since 12/1/20 reviewed to ensure all medications w available and proper follow up complex with primary provider and pharmacy unavailable. Nursing administration team will be educated on proper process for medications that are not available or admission and requirements to conta provider and pharmacy when medications is not made available.	were vere leted if n act ation	
	11/19/20, included, required extensive ambulation. R1's hospital Disch 11/12/20, indicated hospital on 11/7/20 related to COVID-1 that attacks the res an infectious diseas that recommended antiretroviral medic reduce the amount disease) which incl	himum Data Set (MDS) dated R1 was cognitively intact and assistance with transfers and arge Summary dated R1 was admitted to the for acute respiratory failure 9 (a contagious viral illness spiratory system) and received se consult while at the hospital continuation of R1's station, (treatment used to of HIV virus and manage the uded the antiretroviral y and Descovy. R1's hospital			admissions for 90 days will be comp to ensure medications are available after admission. DON/designee will report findings of audits through QAPI process and continued changes will be made bas findings. Date of compliance is 1/6/2021	soon	

If continuation sheet Page 2 of 7

		AND HUMAN SERVICES				FORM	12/31/2020 APPROVED
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CHRIS JI	ENSEN HEALTH & RE	HABILITATION CENTER			2501 RICE LAKE ROAD DULUTH, MN 55811		
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		list indicated R1 was					
		y and Descovy daily while scharge to the facility on					
	11/12/20.						
	R1's hospital discha	arge orders dated 11/12/20,					
	included, Descovy 2	200-25 milligram (mg) tablet					
	, , , , , , , , , , , , , , , , , , ,	y and Tivicay 50 mg tablet oral					
	daily.						
	R1's facility contrac	ted pharmacy communication					
		care Workflow Claims Census					
		he pharmacy to the facility, icated Tivicay and Descovy					
		I. The communication					
	included, under "ac	tion required," that the cost					
	5	500 and exceeded the					
		under, "requested action," the n approved authorization prior					
	to dispensing.	r approved admonzation prior					
		ministration Record (MAR) 200-25 mg give 1 tablet by					
		ay with the start date of					
	11/13/20 and Tivica	y give 50 mg by mouth one					
		start date of 11/13/20. The					
		ed that the Descovy was not 11/13/20 through 12/1/20 and					
		12/2/20 and the Tivacay was					
	not administered fro	om 11/13/20 through 11/30/20					
		ily on 12/1/20. On the days					
		vicay were not administered as a daily annotation of "9"					
		"see nursing notes."					
	R1's Progress Note	s from 11/13/20 through					
	12/1/20, indicated th	he two medication were not					
		o not being available.					
	Progress Notes dur	ing 11/13/20 through 11/30/20,					

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		AND HUMAN SERVICES				FORM	12/31/2020 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED C
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NAME OF	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	EHABILITATION CENTER			501 RICE LAKE ROAD DULUTH, MN 55811		
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F 760	did not document of provider or the pha medication not bein R1's Community Ca (situation, backgrout recommendation not registered nurse (R doctor (MD)-A documedication errors: and tivicay [sic] (and here on 11/12/2020 medications until 3 Descovy will be cor R1's provider note practitioner (NP)-B Jensen Nursing Ho antiretroviral's until receive them during error has been report During interview on stated that after he "They didn't have the I went without them During interview on stated R1 was not a Descovy for more that admission to the far notified of the medid days after they wer expectation is if a mavailable the facility that day. NP-B state omission would affer	ommunication with the rmacy regarding the ng available or administered. are Team Nursing SBAR and, assessment and ote) dated 12/1/20, from N)-A to R1's provider medical amented, "Update on He was to resume Descovey tiviral drugs) when arrived 0. We did not get the days ago for tivicay [sic] and ming tonight." dated 12/3/20, by nurse documented, "CJNH [Chris ime] did not have 11/28, so patient did not g this time. This medication	F 7	60			

Facility ID: 00598

If continuation sheet Page 4 of 7

		AND HUMAN SERVICES				FC	RM APPF	ROVED
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	FCORRECTION	IDENTIFICATION NUMBER:	l` í				COMPLETE	
		245366	B. WING				C	
NAME OF F	PROVIDER OR SUPPLIER	240000			TREET ADDRESS, CITY, STATE, ZIP CODE		12/10/20	20
	ENSEN HEALTH & RE	EHABILITATION CENTER		2	501 RICE LAKE ROAD			
				D	ULUTH, MN 55811			
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F 700			1					
F 760	• • • • • • • • • • • • • • • • • • • •	ge 4 at the facility and had been	F 7	60				
	notified of the omis							
		12/10/20, at 12:30 p.m.						
		tist (CP)-D stated the Descovy of dispensed on 11/12/20, due						
	to being withheld du	ue to a high dollar limit agreed						
		y and the pharmacy did not payer sources until the						
) stated there was no						
		unication from the facility that the medications were						
		ilable at the facility. CP-D						
		was first sent to the facility on						
		escovy was first sent to the CP-D stated there was no						
		hy they were released on						
		jectured there may of been bal communication with the						
	facility at the time th	ne two antiretroviral medication						
	administration was	started.						
		12/9/20, at 2:15 p.m. RN-D						
		with R1 during the time R1 ed his antiretrovirals. RN-D						
	stated, "I brought th	is to the attention of my						
		en when I came back to work everal days, I noticed they still						
	weren't there. There	n I filled out the SBAR						
	communication to S Care on December	St. Louis County Community						
		101.						
	5	12/9/20, at 12:24 p.m. RN-E						
		d not have documentation the with the pharmacy or notified						
	the provider regard	ing R1 not receiving the						
		ations. RN-E stated she communication by phone or						
		medications but there was no						

If continuation sheet Page 5 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/31/2020 APPROVED
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AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			
		245366	B. WING				C 10/2020
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		
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F 760	Continued From pa	qe 5	F 7	60			
	•	ose communications.					
	During interview on director of nursing (documented comm that indicated R1 was antiretroviral's was missed 19 days of t the facility did not re- error due the facility was not available. cover payment for t and conjectured the 12/1/20 as a result that was not docum Infectious Disease antiretrovirals not be stated that staff edu communication with pharmacy if medica available had not be During interview on stated, when a med available the practio and the ordering pro- those communication stated, when a med available the facility pharmacy which is a provider of the miss document both com- notes. During interview on	12/9/20, at 4:26 p.m. the (DON) confirmed the first unication with the provider as not receiving his ordered on 12/1/20, after R1 had the medication. DON stated eport this as a medication DON stated Medicaid would he antiretroviral medications e medications were started on of telephone communication tented. DON confirmed had been notified of the eing administered. DON ucation regarding n provider and contracted ations are ordered and not een performed. 12/9/20, at 1:28 p.m. RN-B lication is ordered and not ce is to notify the pharmacy ovider and documentation ons in the progress notes. 12/10/20, at 11:00 a.m. RN-C fication is ordered and not practice is to notify the available 24/7 and notify the sed dose of medication and munications in the progress 12/10/20, at 7:53 a.m. NP-E					
	stated the expectati	ion is if an ordered medication facility should notify the					

If continuation sheet Page 6 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3		IPLETED C
		245366	B. WING				10/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CHRIS J	ENSEN HEALTH & RE	HABILITATION CENTER			2501 RICE LAKE ROAD DULUTH, MN 55811		
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F 760	provider immediate call 24/7 to address During interview on stated the expectation ordered and not avain working with the respectation informing them that available and contain information and door notes. During interview on medical director (M when a resident is of facility, the high doll to the facility prior to stated that once a r medication ordered facility is expected to immediately and door A facility procedure undated, included, for interagency cover so Omnicare. Any medio obtained from Omnion unavailable in Omnion CVS for the first even arrive in the evening [sic] in by nurse. Do manager reviews tho up on missing items The pharmacy will r [Executive Director]	ly and there is a provider on	F 7	760			

If continuation sheet Page 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 24, 2020

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

Re: State Nursing Home Licensing Orders Event ID: G7MZ11

Dear Administrator:

The above facility was surveyed on December 9, 2020 through December 10, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Karen Aldinger, Unit Supervisor Metro C District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us Office: (651) 201-3794 Mobile: (320) 249-2805

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,

Dovertes Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program

Chris Jensen Health & Rehabilitation Center December 24, 2020 Page 3 Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 24, 2020

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

Re: State Nursing Home Licensing Orders Event ID: G7MZ11

Dear Administrator:

The above facility was surveyed on December 9, 2020 through December 10, 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.

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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,

Doverto Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program

Chris Jensen Health & Rehabilitation Center December 24, 2020 Page 3 Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
		(X1) PROVDERSUPPLEACLAN (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 00598 B. WING (CONFLICTION 00598 STREET ADDRESS, GTV, STATE, ZIP CODE C 201001 STREET ADDRESS, GTV, STATE, ZIP CODE C 201011 STREET ADDRESS, GTV, STATE, ZIP CODE COMPLETE 201011 STREET ADDRESS, GTV, STATE, ZIP CODE COMPLETE 201011 STREET ADDRESS, GTV, STATE, ZIP CODE COMPLETE 201011 PREMABILITATION C COMPLETE 201011 PREPAY (EQAH CONRECTIVE ACTION SHOULD BE 201011 STREET ADDRESS (STV, STATE, ZIP CODE COMPLETE 201011 PREPAY (EQAH CONRECTIVE ACTION SHOULD BE COMPLETE STREET ADDRESS (STV, STATE, ZIP CODE CONSTRUE COMPLETE COMPLETE STATEMENT OF OREFLOENCIES PREPAY (EQAH CONRECTIVE ACTION SHOULD BE COMPLETE STATEMENT STREET ADDRESS (STV, STATE, ZIP CODE COMPLETE COMPLETE				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING: COMPLETED 00598 B WING C C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE. 2IP CODE 2501 RICE LAKE ROAD (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PREVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PROVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PROVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PROVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES PROVIDER'S PLAN OF CORRECTION (VAL)D SUMMARY STREEMENT OF DEFICIENCES 2000 PREVINE (VAL)D SUMMARY STREEMENT OF DEFICIENCES						
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	HABILITATION C		D		
PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. hether a violation has been compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon iny item of multi-part rule will ment of a fine even if the item				
	You may request a that may result from orders provided that the Department with notice of assessme INITIAL COMMENT On 12/9/20 and 12/ was conducted to d	n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. TS: 10/20, an abbreviated survey				
	Your facility was fou with the MN State L your electronic plan	icensure. Please indicate in of correction that you have				
		ER/SUPPLIER REPRESENTATIVE'S SIG	NTIFICATION NUMBER: A BUILDING: COMPLETED C 12/10/2020 STREET ADDRESS, CITY, STATE, ZIP CODE TATION C 2501 RICE LAKE ROAD DULUTH, MN S5811 DF DEFICIENCIES PRECEDED BY FULL PRECEDED BY FULL PRECEDED BY FULL PRECEDED BY FULL 2 000 ***** ECTION ORDER 2 000 ***** ECTION ORDER 2 000			

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00598	B. WING		C 12/10/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ENSEN HEALTH & RE	HARILITATION C	E LAKE ROAD , MN 55811)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	they will be complet	ted.				
	SUBSTANTIATED:	laint was found to be H5366171C - MN00067845, er 1545 Medication Errors.				
	SUBSTANTIATED:	laint was found to be H5366172C - MN00067552 , ssued due to actions taken by urvey.				
		ed in ePOC and therefore a uired at the bottom of the first				
21545	MN Rule 4658.1320	0 A.B.C Medication Errors	21545			12/31/2
	percent as describe Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long- incorporated by refe purposes of this pa (1) a discrepan prescribed and wha administered to res (2) the adminis medications. B. It is free of a error. A significant (1) an error y discomfort or jeopa safety; or	on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of is Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired				

If continuation sheet 2 of 9

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		00598	B. WING			0 10/2020
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
HRIS JI	ENSEN HEALTH & R	FHABILITATION C	E LAKE RO , MN 55811	AD		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 2	21545			
	toxicity. All medica prescribed. An inder error report must be that occurs. Any s resident reactions physician or the phy resident or the resident or the resident designated represe must be made in th C. All medicat prescribed. An inder report must be filled occurs. Any signifi- resident reactions physician or the phy- resident or the resident or the resident or the resident represed	surrence of symptoms or tions are administered as cident report or medication be filed for any medication error ignificant medication errors or must be reported to the hysician's designee and the ident's legal guardian or entative and an explanation he resident's clinical record. ions are administered as cident report or medication error d for any medication errors or must be reported to the hysician's designee and the ident's legal guardian or entative and an explanation he resident's clinical record.				
	by: Based on interview facility failed to ens reviewed for medications significant medications failed to ensure the medications in acc for nineteen days f facility, failed to no follow up with the p	nent is not met as evidenced v and document review, the sure 1 of 3 residents (R1) cation errors, was free of tion errors, when the facility e resident received two cordance with provider orders following admission to the tify the prescribing physician or oharmacy.		Corrected		
	admitted to the fac	ated 12/3/20, indicated R1 was ility on 11/12/20, with Medicaid nd with diagnoses including;				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00598	B. WING			C 12/10/2020		
IAME OF I	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE				
CHRIS J	ENSEN HEALTH & RE	HARII ITATION C	E LAKE ROAD , MN 55811)				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE		
21545	disease (caused by immune cells and d which left untreated respiratory failure a breath). R1's admission Min 11/19/20, included, required extensive ambulation. R1's hospital Disch 11/12/20, indicated hospital on 11/7/20, related to COVID-1 that attacks the res an infectious diseas that recommended antiretroviral medic reduce the amount disease) which inclu- medications Tivicay Active Medications administered Tivica hospitalized until dis 11/12/20. R1's hospital discha included, Descovy 2 oral (by mouth) dail daily. R1's facility contrac notes entitled Omni	ge 3 an immunodeficiency virus the HIV virus that invades lamages the immune system may become fatal), nd dsypnea (shortness of imum Data Set (MDS) dated R1 was cognitively intact and assistance with transfers and arge Summary dated R1 was admitted to the for acute respiratory failure 9 (a contagious viral illness piratory system) and received se consult while at the hospital continuation of R1's ation, (treatment used to of HIV virus and manage the uded the antiretroviral v and Descovy. R1's hospital list indicated R1 was y and Descovy daily while scharge to the facility on arge orders dated 11/12/20, 200-25 milligram (mg) tablet y and Tivicay 50 mg tablet ora ted pharmacy communication icare Workflow Claims Census he pharmacy to the facility,	I					

If continuation sheet 4 of 9

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	COMI	E SURVEY PLETED
		00598	B. WING		C 12/10/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
CHRIS J	ENSEN HEALTH & RE	FHABILITATION C	E LAKE ROAI , MN 55811	D		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
21545	Continued From pa	age 4	21545			
		under, "requested action," the n approved authorization prior				
	indicated, Descovy mouth one time a c 11/13/20 and Tivica time a day with the MAR further indicat administered from was started daily or not administered fro and was started dai the Descovy and Ti as ordered there was	Iministration Record (MAR) 200-25 mg give 1 tablet by lay with the start date of ay give 50 mg by mouth one start date of 11/13/20. The ted that the Descovy was not 11/13/20 through 12/1/20 and n 12/2/20 and the Tivacay was om 11/13/20 through 11/30/20 ily on 12/1/20. On the days ivicay were not administered as a daily annotation of "9" "see nursing notes."				
	12/1/20, indicated t administered due to Progress Notes due did not document c provider or the pha	es from 11/13/20 through he two medication were not o not being available. ring 11/13/20 through 11/30/20 communication with the rmacy regarding the ng available or administered.	,			
	(situation, backgrou recommendation no registered nurse (R doctor (MD)-A docu medication errors: and tivicay [sic] (an here on 11/12/2020	are Team Nursing SBAR und, assessment and ote) dated 12/1/20, from RN)-A to R1's provider medical umented, "Update on He was to resume Descovey tiviral drugs) when arrived 0. We did not get the days ago for tivicay [sic] and ming tonight."				
anosota D		dated 12/3/20, by nurse documented, "CJNH [Chris me] did not have				

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING			C 12/10/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, ST	ATE, ZIP CODE		
יו פוסעי	ENSEN HEALTH & RE	ELABLI ITATION C 2501 RIC)		
		DULUTH	, 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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	ge 5	21545			
	antiretroviral's until	- 11/28, so patient did not g this time. This medication				
	During interview on 12/9/20, at 10:09 a.m. R1 stated that after he was admitted the facility, "They didn't have the expensive HIV medications, I went without them for a couple weeks."					
	stated R1 was not a Descovy for more that admission to the far notified of the medi days after they were expectation is if a n available the facility that day. NP-B state omission concernin omission would affer stated the Infectiou	12/9/20, at 12:02 p.m. NP-B administered his Tivicay and han two weeks following cility and the provider was not cation being omitted until three e restarted. NP-B stated the nedication is ordered and not v should contact the provider ed she found the medication ng but could not speak to if ect R1's clinical course. NP-B s Disease specialist was at the facility and had been sion.				
	consulting pharmace and Tivicay were not to being withheld du upon with the facilit have Medicaid as a following day. CP-E documented comm following 11/12/20, ordered but not avai stated the Tivacay v 11/28/20 and the De facility on 12/1/20. (documentation of w	12/10/20, at 12:30 p.m. cist (CP)-D stated the Descovy ot dispensed on 11/12/20, due ue to a high dollar limit agreed y and the pharmacy did not a payer sources until the D stated there was no unication from the facility that the medications were alable at the facility. CP-D was first sent to the facility on escovy was first sent to the CP-D stated there was no yhy they were released on alaction for may of been				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C C 00598 B. WING C C 12/10/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 55811 CMUID SUMMARY STATEMENT OF DEFICIENCY 2501 RICE LAKE ROAD DULUTH, MN 55811 CROSS-REFERENCED TO THE APPROPRIATE C CMUID SUMMARY STATEMENT OF DEFICIENCY DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE CO CHRIS JENSEN HEALTH & REHABILITATION C DULUTH, MN 55811 CROSS-REFERENCED TO THE APPROPRIATE CO 21545 Continued From page 6 21545 CROSS-REFERENCED TO THE APPROPRIATE CO 21545 Continued From page 6 indiministration was started. 21545 During interview on 12/9/20, at 215 p.m. RN-D Stated she worked with R1 during the time R1 Stated She worked with R1 during the time R1 Stated She worked with QS, I noticed they still weren't there. Then I filled out the SBAR Communication to St. Louis County Community Care on December 1st." During interview on 12/9/20, at 12:24 p.m. RN-E Stated the facility did not have documentation the facility da worked with the pharmacy or notified the provider regarding the medications. RN-E stated she beleiceved there was communications by hone or emai	Minnesc	ota Department of He	alth			FORM	APPROVED
00598 B. WING 12/10/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2501 RICE LAKE ROAD DULUTH, MN 5811 2501 RICE LAKE ROAD DULUTH, MN 5811 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) CONSTREET ADDRESS, CITY, STATE, ZIP CODE 21545 Continued From page 6 facility at the time the two antiretroviral medication administration was started. ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) CONSTREET ADDRESS, CITY, STATE, ZIP CODE 21545 Continued From page 6 facility at the time the two antiretroviral medication administration was started. ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) CONSTREET ADDRESS, CITY, STATE, ZIP CODE 21545 Continued From page 6 facility at the time the two antiretrovirals, RN-D stated she worked with R1 during the time R1 was not administered his antiretrovirals, RN-D stated fit for several days, I noticed they still weren't there. Then I filed out the SBAR communication to S1. Louis County Community Care on December 1st." During interview on 12/9/20, at 12:24 p.m. RN-E stated the facility did not have documentation the antiretroviral medications. RN-E stated she believed there was communication the pharmacy or notified the provider regarding R1 not receiving his oridered antiretroviral's was on 12/9/20, at 4:26 p.m. t	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CHRIS JENSEN HEALTH & REHABILITATION C 2501 RICE LAKE ROAD DULUTH, MN 55811 (YA)ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO 21545 Continued From page 6 facility at the time the two antiretroviral medication administration was started. 21545 During interview on 12/9/20, at 2:15 p.m. RN-D stated she worked with R1 during the time R1 was not administered his antiretrovirals, RN-D stated, "I brought this to the attention of my manager, RN-E, then when I came back to work after being off for several days, I noticed they still weren't there. Then I filled out the SBAR communication to St. Louis County Community Care on December 1st." During interview on 12/9/20, at 12:24 p.m. RN-E stated the facility did not have documentation the facility had worked with the pharmacy or notified the provider regarding R1 not receiving the antiretroviral medications. RN-E stated she believed there was communication by phone or email regarding the medications. BN-E stated she believed there first documentation of those communications. During interview on 12/9/20, at 4:26 p.m. the director of nursing (DON) confirmed the first documented communication with the provider that indicated R1 was not receiving his ordered antiretroviral was of 12/1/20, after R1 had missed 19 days of the medication. DON stated the facility did not report this as a medication <th colspan="2">00598</th> <th>00598</th> <th>B. WING</th> <th></th> <th></th> <th></th>	00598		00598	B. WING			
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was not available. DON stated Medicaid would cover payment for the antiretroviral medications and conjectured the medications were started on 12/1/20 as a result of telephone communication that was not documented. DON confirmed Infectious Disease had been notified of the antiretrovirals not being administered. DON stated that staff education regarding		director of nursing (documented comm that indicated R1 w antiretroviral's was missed 19 days of t the facility did not re error due the facility was not available. cover payment for t and conjectured the 12/1/20 as a result that was not docum Infectious Disease antiretrovirals not b stated that staff edu	(DON) confirmed the first unication with the provider as not receiving his ordered on 12/1/20, after R1 had the medication. DON stated eport this as a medication y knowing that the medication DON stated Medicaid would the antiretroviral medications e medications were started on of telephone communication nented. DON confirmed had been notified of the eing administered. DON ucation regarding				
communication with provider and contracted pharmacy if medications are ordered and not		communication with	n provider and contracted				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00598		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING			C 12/10/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CHRIS JI	ENSEN HEALTH & RE	FHARILITATION C	E LAKE ROAD , MN 55811)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21545	Continued From pa	ige 7	21545			
	available had not be	een performed.				
	stated, when a med available the practic and the ordering pr those communication During interview on stated, when a med available the facility pharmacy which is provider of the miss document both com notes. During interview on stated the expectat	12/9/20, at 1:28 p.m. RN-B dication is ordered and not ce is to notify the pharmacy ovider and documentation ons in the progress notes. 12/10/20, at 11:00 a.m. RN-C dication is ordered and not y practice is to notify the available 24/7 and notify the sed dose of medication and nmunications in the progress 12/10/20, at 7:53 a.m. NP-E ion is if an ordered medication facility should notify the				
	provider immediate call 24/7 to address During interview on stated the expectat	ly and there is a provider on				
	working with the re- informing them that available and conta	sident is to contact pharmacy t the medication is not act the provider with the same cument that in the progress				
	medical director (M when a resident is a facility, the high dol to the facility prior to stated that once a r	12/10/20, at 11:51 a.m. D)-F stated the procedure for discharged from a hospital to a lar medications are disclosed o the discharge. MD-F further resident is in a facility and has I that is not available, the				
		to notify the provider ocument the notification.				

If continuation sheet 8 of 9

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00598		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		B. WING		C 12/10/2020		
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		2501 RIC	E LAKE ROAL			
	ENSEN HEALTH & RI	DULUTH	, MN 55811			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
21545	Continued From pa	age 8	21545			
		titled, Admission Orders,				
		"Upon admission there is a fax sheet that is faxed to	<			
	Omnicare. Any me	dications that are not here are				
		nicell. If medication is				
		nicell, they are sent from local vening. Medications generally				
		ig of admission and are check				
	[sic] in by nurse. D	ay after admission nurse				
		he chart and ensure [sic] follow	/			
		s. New additions to process: notify the DON and E.D.				
] if there are any medication is				
	[sic] hold due to co	st; unique features; etc. going				
	forward."					
	SUGGESTED MET	THOD OF CORRECTION:				
	The director of nurs	sing (DON) or designee could				
		policies and procedures for				
		The director of nursing or	F			
		velop a system to educate stafi hitoring system to ensure				
		prrectly received from the				
		ninistered. The quality				
	assurance commit measures to ensur	tee could monitor these				
		e compliance. R CORRECTION: Twenty One				
	(21) days					

If continuation sheet 9 of 9