DEPARTMENT OF HEALTH

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,

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

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

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:

Nursing Home Informal Dispute Process

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 12/10/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/9/20 and 12/10/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5366171C/MN00067845, with a deficiency cited at F760. The following complaint was found to be SUBSTANTIATED: H5366172C/MN00067552, with with no citation issued due to actions taken by the facility prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		1/6/21

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

Electronically Signed | 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.

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F 760	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), respiratory failure and dsypnea (shortness of breath). R1's admission Minimum Data Set (MDS) dated 11/19/20, included, R1 was cognitively intact and required extensive assistance with transfers and ambulation. R1's hospital Discharge Summary dated 11/12/20, indicated R1 was admitted to the hospital on 11/7/20, for acute respiratory failure related to COVID-19 (a contagious viral illness that attacks the respiratory system) and received an infectious disease consult while at the hospital that recommended continuation of R1's antiretroviral medication, (treatment used to reduce the amount of HIV virus and manage the disease) which included the antiretroviral medications Tivicay and Descovy. R1's hospital	F 760	Resident #1 no longer resides at the community; however, his medication was started, and the primary provider and pharmacy were updated on this medication omission. All residents admitted since 12/1/20 were reviewed to ensure all medications were available and proper follow up completed with primary provider and pharmacy if unavailable. Nursing administration team will be educated on proper process for medications that are not available on admission and requirements to contact provider and pharmacy when medication is not made available. DON/Designee will complete audits of all admissions for 90 days will be completed to ensure medications are available soon after admission. DON/designee will report findings of audits through QAPI process and continued changes will be made based on findings. Date of compliance is 1/6/2021	

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F 760	Continued From page 2	F 760		

Active Medications list indicated R1 was administered Tivicay and Descovy daily while hospitalized until discharge to the facility on 11/12/20.

R1's hospital discharge orders dated 11/12/20, included, Descovy 200-25 milligram (mg) tablet oral (by mouth) daily and Tivicay 50 mg tablet oral daily.

R1's facility contracted pharmacy communication notes entitled Omnicare Workflow Claims Census Clinical, sent from the pharmacy to the facility, dated 11/13/20, indicated Tivicay and Descovy were not dispensed. The communication included, under "action required," that the cost was greater than $500 and exceeded the maximum cost and under, "requested action," the facility was to obtain approved authorization prior to dispensing.

R1's Medication Administration Record (MAR) indicated, Descovy 200-25 mg give 1 tablet by mouth one time a day with the start date of 11/13/20 and Tivicay give 50 mg by mouth one time a day with the start date of 11/13/20. The MAR further indicated that the Descovy was not administered from 11/13/20 through 12/1/20 and was started daily on 12/2/20 and the Tivacay was not administered from 11/13/20 through 11/30/20 and was started daily on 12/1/20. On the days the Descovy and Tivicay were not administered as ordered there was a daily annotation of "9"' which indicated to, "see nursing notes."

R1's Progress Notes from 11/13/20 through 12/1/20, indicated the two medication were not administered due to not being available. Progress Notes during 11/13/20 through 11/30/20,

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F 760	Continued From page 3	F 760		

did not document communication with the provider or the pharmacy regarding the medication not being available or administered.

R1's Community Care Team Nursing SBAR (situation, background, assessment and recommendation note) dated 12/1/20, from registered nurse (RN)-A to R1's provider medical doctor (MD)-A documented, "Update on medication errors: He was to resume Descovey and tivicay [sic] (antiviral drugs) when arrived here on 11/12/2020. We did not get the medications until 3 days ago for tivicay [sic] and Descovy will be coming tonight."

R1's provider note dated 12/3/20, by nurse practitioner (NP)-B documented, "CJNH [Chris Jensen Nursing Home] did not have antiretroviral's until 11/28, so patient did not receive them during this time. This medication error has been reported."

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."

During interview on 12/9/20, at 12:02 p.m. NP-B stated R1 was not administered his Tivicay and Descovy for more than two weeks following admission to the facility and the provider was not notified of the medication being omitted until three days after they were restarted. NP-B stated the expectation is if a medication is ordered and not available the facility should contact the provider that day. NP-B stated she found the medication omission concerning but could not speak to if omission would affect R1's clinical course. NP-B stated the Infectious Disease specialist was

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F 760	Continued From page 4	F 760		

following R1 while at the facility and had been notified of the omission.

During interview on 12/10/20, at 12:30 p.m. consulting pharmacist (CP)-D stated the Descovy and Tivicay were not dispensed on 11/12/20, due to being withheld due to a high dollar limit agreed upon with the facility and the pharmacy did not have Medicaid as a payer sources until the following day. CP-D stated there was no documented communication from the facility following 11/12/20, that the medications were ordered but not available at the facility. CP-D stated the Tivacay was first sent to the facility on 11/28/20 and the Descovy was first sent to the facility on 12/1/20. CP-D stated there was no documentation of why they were released on those days and conjectured there may of been undocumented verbal communication with the facility at the time the two antiretroviral medication administration was started.

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 but there was no

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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's was on 12/1/20, after R1 had missed 19 days of the medication. DON stated the facility did not report this as a medication error due the facility knowing that the medication 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 communication with provider and contracted pharmacy if medications are ordered and not available had not been performed.

During interview on 12/9/20, at 1:28 p.m. RN-B stated, when a medication is ordered and not available the practice is to notify the pharmacy and the ordering provider and documentation those communications in the progress notes.

During interview on 12/10/20, at 11:00 a.m. RN-C stated, when a medication is ordered and not available the facility practice is to notify the pharmacy which is available 24/7 and notify the provider of the missed dose of medication and document both communications in the progress notes.

During interview on 12/10/20, at 7:53 a.m. NP-E stated the expectation is if an ordered medication is not available, the facility should notify the

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provider immediately and there is a provider on call 24/7 to address the issue.

During interview on 12/10/20, at 12:03 a.m. DON stated the expectation is that if a medication is ordered and not available the licensed staff working with the resident is to contact pharmacy informing them that the medication is not available and contact the provider with the same information and document that in the progress notes.

During interview on 12/10/20, at 11:51 a.m. medical director (MD)-F stated the procedure for when a resident is discharged from a hospital to a facility, the high dollar medications are disclosed to the facility prior to the discharge. MD-F further stated that once a resident is in a facility and has medication ordered that is not available, the facility is expected to notify the provider immediately and document the notification.

A facility procedure titled, Admission Orders, undated, included, "Upon admission there is a fax interagency cover sheet that is faxed to Omnicare. Any medications that are not here are obtained from Omnicell. If medication is unavailable in Omnicell, they are sent from local CVS for the first evening. Medications generally arrive in the evening of admission and are check [sic] in by nurse. Day after admission nurse manager reviews the chart and ensure [sic] follow up on missing items. New additions to process: The pharmacy will notify the DON and E.D. [Executive Director] if there are any medication is [sic] hold due to cost; unique features; etc. going forward."

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

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

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

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

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

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

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

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,

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

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

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

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

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

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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:

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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,

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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	C 12/10/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/9/20 and 12/10/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when	2 000		

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2 000	Continued From page 1 they will be completed. The following complaint was found to be SUBSTANTIATED: H5366171C - MN00067845, with a licensing order 1545 Medication Errors. The following complaint was found to be SUBSTANTIATED: H5366172C - MN00067552 , with with no order issued due to actions taken by the facility prior to survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single	21545		12/31/20

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21545	Continued From page 2 medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced 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;	21545	Corrected	

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21545	Continued From page 3	21545		

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), respiratory failure and dsypnea (shortness of breath).

R1's admission Minimum Data Set (MDS) dated 11/19/20, included, R1 was cognitively intact and required extensive assistance with transfers and ambulation.

R1's hospital Discharge Summary dated 11/12/20, indicated R1 was admitted to the hospital on 11/7/20, for acute respiratory failure related to COVID-19 (a contagious viral illness that attacks the respiratory system) and received an infectious disease consult while at the hospital that recommended continuation of R1's antiretroviral medication, (treatment used to reduce the amount of HIV virus and manage the disease) which included the antiretroviral medications Tivicay and Descovy. R1's hospital Active Medications list indicated R1 was administered Tivicay and Descovy daily while hospitalized until discharge to the facility on 11/12/20.

R1's hospital discharge orders dated 11/12/20, included, Descovy 200-25 milligram (mg) tablet oral (by mouth) daily and Tivicay 50 mg tablet oral daily.

R1's facility contracted pharmacy communication notes entitled Omnicare Workflow Claims Census Clinical, sent from the pharmacy to the facility, dated 11/13/20, indicated Tivicay and Descovy were not dispensed. The communication included, under "action required," that the cost was greater than $500 and exceeded the

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maximum cost and under, "requested action," the facility was to obtain approved authorization prior to dispensing.

R1's Medication Administration Record (MAR) indicated, Descovy 200-25 mg give 1 tablet by mouth one time a day with the start date of 11/13/20 and Tivicay give 50 mg by mouth one time a day with the start date of 11/13/20. The MAR further indicated that the Descovy was not administered from 11/13/20 through 12/1/20 and was started daily on 12/2/20 and the Tivacay was not administered from 11/13/20 through 11/30/20 and was started daily on 12/1/20. On the days the Descovy and Tivicay were not administered as ordered there was a daily annotation of "9"' which indicated to, "see nursing notes."

R1's Progress Notes from 11/13/20 through 12/1/20, indicated the two medication were not administered due to not being available. Progress Notes during 11/13/20 through 11/30/20, did not document communication with the provider or the pharmacy regarding the medication not being available or administered.

R1's Community Care Team Nursing SBAR (situation, background, assessment and recommendation note) dated 12/1/20, from registered nurse (RN)-A to R1's provider medical doctor (MD)-A documented, "Update on medication errors: He was to resume Descovey and tivicay [sic] (antiviral drugs) when arrived here on 11/12/2020. We did not get the medications until 3 days ago for tivicay [sic] and Descovy will be coming tonight."

R1's provider note dated 12/3/20, by nurse practitioner (NP)-B documented, "CJNH [Chris Jensen Nursing Home] did not have

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antiretroviral's until 11/28, so patient did not receive them during this time. This medication error has been reported."

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."

During interview on 12/9/20, at 12:02 p.m. NP-B stated R1 was not administered his Tivicay and Descovy for more than two weeks following admission to the facility and the provider was not notified of the medication being omitted until three days after they were restarted. NP-B stated the expectation is if a medication is ordered and not available the facility should contact the provider that day. NP-B stated she found the medication omission concerning but could not speak to if omission would affect R1's clinical course. NP-B stated the Infectious Disease specialist was following R1 while at the facility and had been notified of the omission.

During interview on 12/10/20, at 12:30 p.m. consulting pharmacist (CP)-D stated the Descovy and Tivicay were not dispensed on 11/12/20, due to being withheld due to a high dollar limit agreed upon with the facility and the pharmacy did not have Medicaid as a payer sources until the following day. CP-D stated there was no documented communication from the facility following 11/12/20, that the medications were ordered but not available at the facility. CP-D stated the Tivacay was first sent to the facility on 11/28/20 and the Descovy was first sent to the facility on 12/1/20. CP-D stated there was no documentation of why they were released on those days and conjectured there may of been undocumented verbal communication with the

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facility at the time the two antiretroviral medication administration was started.

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 but there was no 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's was on 12/1/20, after R1 had missed 19 days of the medication. DON stated the facility did not report this as a medication error due the facility knowing that the medication 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 communication with provider and contracted pharmacy if medications are ordered and not

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21545	Continued From page 7 available had not been performed. During interview on 12/9/20, at 1:28 p.m. RN-B stated, when a medication is ordered and not available the practice is to notify the pharmacy and the ordering provider and documentation those communications in the progress notes. During interview on 12/10/20, at 11:00 a.m. RN-C stated, when a medication is ordered and not available the facility practice is to notify the pharmacy which is available 24/7 and notify the provider of the missed dose of medication and document both communications in the progress notes. During interview on 12/10/20, at 7:53 a.m. NP-E stated the expectation is if an ordered medication is not available, the facility should notify the provider immediately and there is a provider on call 24/7 to address the issue. During interview on 12/10/20, at 12:03 a.m. DON stated the expectation is that if a medication is ordered and not available the licensed staff working with the resident is to contact pharmacy informing them that the medication is not available and contact the provider with the same information and document that in the progress notes. During interview on 12/10/20, at 11:51 a.m. medical director (MD)-F stated the procedure for when a resident is discharged from a hospital to a facility, the high dollar medications are disclosed to the facility prior to the discharge. MD-F further stated that once a resident is in a facility and has medication ordered that is not available, the facility is expected to notify the provider immediately and document the notification.	21545		

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21545	Continued From page 8 A facility procedure titled, Admission Orders, undated, included, "Upon admission there is a fax interagency cover sheet that is faxed to Omnicare. Any medications that are not here are obtained from Omnicell. If medication is unavailable in Omnicell, they are sent from local CVS for the first evening. Medications generally arrive in the evening of admission and are check [sic] in by nurse. Day after admission nurse manager reviews the chart and ensure [sic] follow up on missing items. New additions to process: The pharmacy will notify the DON and E.D. [Executive Director] if there are any medication is [sic] hold due to cost; unique features; etc. going forward." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly received from the pharmacy and administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		