*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
September 15, 2022

Administrator
Jensen Health LLC
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: August 4, 2022

Dear Administrator:

On August 30, 2022, we notified you a remedy was imposed. On September 12, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 25, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 14, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 18, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

August 30, 2022

Administrator
Jensen Health LLC
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: August 4, 2022

Dear Administrator:

On August 18, 2022, we informed you that we may impose enforcement remedies.

On August 19, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

## REMOVAL OF IMMEDIATE JEOPARDY

On August 19, 2022, the situation of immediate jeopardy to potential health and safety cited at F 600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

## 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 14, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 14, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 14, 2022.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

## 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 $11,292, 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 August 19, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Jensen Health Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 19, 2022. 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.

## SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Jensen Health Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 19, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## 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" and/or an E tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

## 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 February 4, 2023 (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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161  Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc:  Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 30, 2022

Administrator
Jensen Health LLC
2501 Rice Lake Road
Duluth, MN 55811

Re: Event ID: OKQI11

Dear Administrator:

The above facility survey was completed on August 19, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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<br><br>On 8/16/22 through 8/19/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F600, when the facility failed to protect 3 of 3 residents (R2, R3, R5) from resident-to-resident abuse when the facility failed to mitigate abuse risks and implement individualized behavioral interventions to prevent future resident-to-resident incidents. The IJ began on 8/15/22, and the immediacy was removed on 8/19/22.<br><br>The above findings constituted substandard quality of care, and an extended survey was conducted on 8/19/22.<br><br>The following complaints were found to be SUBSTANTIATED:<br>H53663956C (MN00085907), with a deficiency cited at F600.<br>H53664293C (MN00085813), with a deficiency cited at F600.<br>H53664011C (MN00085504), with a deficiency cited at F600.<br>H53664029C (MN00084205), with a deficiency cited at F600.<br>H5366287C (MN00082727), with a deficiency cited at F600.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 09/01/2022 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 | Continued From page 1<br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 600<br>SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to protect 3 of 3 residents (R2, R3, R5) from ongoing resident-to-resident abuse when residents had multiple incidents of abuse and the facility failed to mitigate abuse risks and implement individualized behavioral interventions to prevent future resident-to-resident abuse incidents. This resulted in an immediate jeopardy for R2, R3 and R5. | F 600 | F600 Freedom form abuse and neglect<br>Alleged DOC: 8/25/20222<br><br>Corrective Action<br><br>• Resident 1 no longer resides at the Facility.<br>• Resident 2 continues to reside at the Facility.<br>• Resident 2 continues on a 1:1 that | 8/25/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 2<br><br>The immediate jeopardy began on 8/15/22 when the facility failed to implement interventions to protect residents from resident-to-resident physical and verbal abuse altercations which was identified on 8/18/22. The administrator and director of nursing were notified of the IJ at 11:17 a.m. on 8/18/22. The immediate jeopardy was removed on 8/19/22, but noncompliance remained at the lower severity level 2, and a lower scope level of a D/isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>R2's quarterly Minimum Data Set (MDS) dated 6/23/22, indicated R2 was severely cognitively impaired and displayed physical behaviors directed at others one to three days and other behavioral symptoms not directed at others one to three days. The MDS identified R2 had not displayed wandering behavior. R2's face sheet identified diagnosis of dementia was with behavioral disturbances.<br><br>R3's quarterly MDS dated 6/23/22, indicated R3 was severely cognitively impaired and was free of behaviors and wandering behavior. R3's diagnosis were listed as Alzheimer's disease and dementia. R3's face sheet identified the dementia was with behavioral disturbances.<br><br>R5's significant change MDS dated 7/20/22, indicated R5 was severely cognitively impaired and was free of behaviors and wandering behavior. R5's diagnosis were listed as anxiety, alcohol abuse, cognitive communication deficit, | F 600 | started 8/18/2022 to monitor residents' daily behavior and effectiveness of interventions. As behaviors are understood removal of 1:1 will occur.<br>• Resident 2 behavior care plan was updated to include new interventions related to aggressive behaviors.<br>• Resident 3 continues to reside at the facility.<br>• Resident 3 behavior care plan was updated to include new interventions related to aggressive behaviors.<br>• Resident 3 continues on a 1:1 that started 8/18/2022 to monitor residents' daily behavior and effectiveness of interventions. As behaviors are understood removal of 1:1 will occur.<br>• Resident 4 continues to reside at the facility.<br>• Resident 4 behavior care plan was updated to include new interventions related to aggressive behaviors.<br>• Resident 5 continues to reside at the facility.<br>• Resident 5 behavior care plan was updated to include new interventions related to aggressive behaviors.<br><br>Identifying other residents<br>• Director of Nursing/Designee/IDT conducted an audit of all residents residing in the facility to identify resident specific behaviors and updated care plans to include appropriate interventions.<br>• IDT screened residents who reside on the secured memory are unit for any negative psychosocial affects from R2 and R3 actions. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 3<br>and disorientation.<br><br>R2, R3, and R5's Care Plans identified all three were at risk for abuse, wandered, and required the secured memory care unit. Interventions for all three directed staff to "Observe/Suspect abuse, remove resident from aggressor and relocate to safe location" and to "Observe and Provide Safe Environment."<br><br>Facility Risk Management - Physical reports, and medical records, identified the following resident-to-resident abuse events:<br>-4/15/22: At 6:30 a.m. the nurse was informed R3 "shoved [R2] into the wall, causing him to fall to the floor." R2's progress note, dated 4/15/22, at 6:10 a.m. identified R3, who was "totally unprovoked" shoved R2 into the wall as R2 ambulated by the nurse's station. R2 sustained a left outer eyebrow laceration and required medical attention (four sutures). R2 returned on 4/15/22, at 1:15 p.m. from the emergency room. R3 and R2 were immediately separated and R3 was placed on one-on-one supervision. R3's Resident 15 Minute Checks flow sheet identified R3 was on one-to-one checks on 4/15/22, from 6:30 a.m. until 10:15 a.m., 15 minute location checks from 10:15 a.m. to 6:30 a.m. on 4/16/22, and then on 4/16/22, from 6:30 a.m. to 10:30 a.m. R3's 15 minute location checks continued through 4/21/22, at 2:30 p.m.<br>-6/10/22: At 12:10 p.m. staff witnessed R3 turn and shove R2 after R2 grabbed R3's arm. R2 fell to his knees and was "visibly upset" based on his facial expression(s) and body language. R2 and R3 were placed on 15 minute location checks. Fifteen minute location check flow sheets, dated 6/10/22 through 6/16/22, identify R2 and R3 were provided 15 min checks; however, 6/11/22 - | F 600 | Systemic Changes<br>• DON/Designee shall educate staff regarding behavior management.<br>• DON/Designee shall educate staff regarding Abuse Policy.<br>• DON/Designee shall educate staff regarding Kardex.<br>• DON/Designee shall educate staff regarding Behavioral Monitoring Policy<br>• Interdisciplinary team shall meet weekly to discuss behavioral residents to determine the appropriateness of current interventions.<br>• Unit managers shall monitor behavior charting to ensure behaviors are care planned and interventions are in place.<br>Monitoring<br>• DON/Designee shall monitor behavior charting on 5 residents daily X 7 days then 5 times a week X2 weeks then weekly X 4 weeks or until sustained compliance is achieved.<br>• DON/Designee shall audit 5 behavior care plans to ensure appropriate interventions are in place daily X 7 days then 5 times a week X 2 weeks then weekly X 4 weeks or until sustained compliance is achieved.<br>• Audit results shall be submitted to QAPI to be addressed as appropriate. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 4<br>6/16/22 lacked numerous location entries each day.<br>-7/26/22: At 5:15 p.m. staff's attention was drawn by loud voices towards the [nurse's] desk while they served dinner and staff witnessed R3 "shoving" R2 in the shoulder. R2 stumbled, but did not fall, and R2 attempted to shove R3 in response. R3 stated, "He gets in my way! Fucking cunt." Staff separated them. Both were placed on 15 minute location checks. Fifteen minute location check flow sheets were provided. From 7/28/22 - 8/5/22 and then on 8/9/22, R3's location was monitored. Three undated flow sheets for R3 were provided. From 7/28/22 - 8/5/22, R2's location was monitored. One undated flow sheet for R2 was provided. The combined flow sheet lacked numerous location entries on most days and R2 and R3's 7/29/22 flow sheets were not provided.<br>-8/8/22: At 11:45 a.m. R2 stood up and "struck" R5 on the right shoulder/back three to five times while they waited for lunch. R5 conversed with other male residents prior to the incident. R2 was redirected to another area and R5 stated, "He didn't mean to hit me he was trying to tell me something." Fifteen minute location check flow sheet, dated 8/9/22 - 8/15/22, indicated R2's location was monitored; however, four days lacked multiple location entries. A flowsheet for 8/8/22 was not provided; however, the flow sheet dated 8/9/22, indicated location checks were performed on 8/8/22, from 10:30 p.m. - 12:00 a.m.<br><br>R2 and R3's progress notes lacked evidence of an analysis/evaluation for the discontinuation of the routine location checks after each incident. R2 and R3's progress notes, and Care Plans, lacked evidence of initiated and/or revised | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 5<br>interventions to mitigate/prevent similar resident-to-resident altercations. R2 and R3's medical records lacked evidence their behaviors were comprehensively assessed and/or the care plan interventions were evaluated for effectiveness.<br><br>Facility follow-up investigation reports forwarded to the State Agency (SA) identified the following event details:<br>-4/23/22: The report identified [on 4/15/22] R3 attempted to get around R2 and was "isolated" due to the nature of the event. The facility sent out a referral for R3 to Essentia psych/behavioral health and R3 was placed on a waiting list.<br>-6/17/22: The report identified [on 6/10/22] R2 attempted to ambulate with R3 by grabbing his arm. R2 was care planned for staff to offer him tactile items when he ambulated. R2 and R3 had a history of previous incidents.<br>-8/2/22: The report identified [on 7/26/22] R2 and R3 were observed with both hands on each other and R3 made contact with R2's shoulder with a closed hand. Headphones with cassettes were ordered for both to assist with comfort and distraction. In addition, the report identified R2 and R3 continued to gravitate towards one another.<br>-8/15/22: The report identified [on 8/8/22] R2 made contact with R5 with a closed fist and R2 had not shown prior physical aggression. Staff were educated to allow residents who wanted to calmly do something, to let them.<br><br>R2's progress note entry, dated 7/28/22, at 2:02 p.m. identified the following entry: "[R2] came up to writer, and said "Go [expletive] yourself," After initiating verbal aggression, [R2] attempted to initiate physical aggression towards staff, and | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 6<br>other residents. Staff immediately separated [R2] from others, and brought him to activity room for quiet environment. Behavior remained the same, and he came back to dining room ...[R2] is currently laying [sic] in bed. [R2] remains on 15 minute checks."<br><br>R2's Care Plan identified R2 displayed behavioral disturbances with paranoia, hallucinations, and delusions. Interventions directed staff to allow R2 to wander the unit, engage him with activities "as needed" and per his preference(s), and to remove stressors (noisy/overstimulating area or other residents in his personal space who are too close). In addition, the Care Plan intervention revised on 4/11/22 identified R2 "like[d] to hold hands while ambulating," and on 6/17/22, directed staff to "Offer tactile items while [R2 was] ambulating." R2's Care Plan lacked information R2 had a history of physical or verbal aggressive behaviors, was involved in resident-to-resident verbal/physical abuse episodes or that R2 and R3 adversely gravitated towards each other. In addition, the Care Plan lacked individualized behavioral interventions to safeguard R2 from resident-to-resident abuse.<br><br>R3's Care Plan identified R3 displayed behavioral disturbances with visual hallucinations and that "[R3] can act out physically towards others. [R3] has hit or struck out at others." Interventions directed staff to allow R3 to wander the unit, engage him with activities "as needed" and per his preference(s), and to remove stressors (noisy/overstimulating area or other residents in his personal space who are too close). R3's Care Plan lacked information R3 and R2 adversely gravitated towards each other and have a history of verbal and physical altercations. In addition, | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 7<br>the Care Plan lacked individualized behavioral interventions to safeguard R3 from resident-to-resident abuse.<br><br>R5's Care Plan lacked evidence R5 was involved in a resident-to-resident physical abuse encounter and lacked individualized behavioral interventions to safeguard from resident-to-resident abuse.<br><br>On 8/16/22, the following events were observed:<br>-At 11:09 a.m. R3 was brought to a unit activity and sat on R2's left side (within arm length). Shortly after, R5 propelled his wheelchair and sat next to R3's left side (within arms length). Staff did not separate R2, R3, and R5.<br>-At 11:40 a.m. R2, after he started to walk away from the activity, turned around and walked up to the back of a chair adjacent to R5 and just stood there (within arms length of R2). Staff did not separate R2 and R5.<br>-At 1:15 p.m. R3 approached R2 as he stood at the nurse's station and stood adjacent to R2's right side (within inches of each other). Nurse manager (RN)-A and registered nurse (RN)-B looked at R2 and R3 from behind the nurse's station desk and neither separated R2 and R3 or engaged them in conversation. Shortly after, both R2 and R3 moved at the same time: R2 moved to his right and R3 stepped back and to his left. Both were within inches of bumping into each other. R2 proceeded down the hall and walked up to another resident in the unit who stood approximately three-forths the way down the hallway. Nursing assistant (NA)-A came around the dining room corner, observed R2 and that resident together and called out "[R2]." She entered a non-resident room at the beginning of the hall and did not approach R2 or the other | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 8 | F 600 | | |

resident to separate. The hall was free of other staff. R2 continued to follow the resident and entered another resident's room after him. Both exited the room shortly after. A staff member exited a room closer to R2 and the other resident and initiated conversation with others (not R2). R2 passed the talking individuals and continued to walk back to the nurse's station.

On 8/17/22, the following events were observed:
-At 7:30 a.m. R2 sat on a bench at the end of the hall with his head down. At 7:33 a.m. R3 walked down the hall towards R3. On his way, he entered a resident's room. A staff member exited a resident room, walked by him, and kept on down the hall. Shortly after, R3 exited the room and continued toward R2. When R3 was about half way down the hall, another staff member exited a room and asked R3 how he was doing. The staff did not cue him to return to the dining room area before she walked away from him. R3 continued a few steps towards R2; however, turned around and went back to the dining room. Once R3 returned to the dining room, staff at the medication cart kept their back turned towards the residents.

On 8/18/22, the following events were observed:
-At 9:18 a.m. R2 walked past R3 on his way to the main dining room. Both were within arms-reach. A staff member walked by R2 and did not initiate conversation or direct him away from R3. R2 walked to the end of the dining room and turned around and walked back toward R3; however, this time he passed him within approximately a couple feet. Staff were in the area; however, their backs were turned.
-At 9:22 a.m. Staff approached R3's table where he sat with another resident and removed a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 9<br>coffee cup. After the staff walked away, R3 stated, "This is bullshit!" got up and walked to the coffee pot. Staff approached him and stated she would go fill the coffee pot. R3 stood there with his hands on his hips as the staff member walked off of the unit. His mouth was down-turned and his brows were furrowed. No other staff were in the area.<br>-At 9:28 a.m. R2 was brought to a different table adjacent to R3 and sat down. Their backs were within arms-length. From 9:33 a.m. to 9:35 a.m. (approximately two minutes), R2, R3, and the residents in their vicinity were unsupervised as the nurse at the medication cart continued to keep their back turned.<br><br>During unit observations on 8/16/22, 8/17/22, and 8/18/22, R2 and R3 were observed numerous times to wander throughout the unit, either alone or directly past other residents. Both R2 and R3 were assisted to sit at tables for the noon meal, snacks, activities, and wandering rest breaks, which put them within arm's reach of each other and many other residents. At times one or both were unsupervised as staff either assisted other residents, there were no staff in the area, and/or the nurse was at the medication cart with their back turned towards them. R2 was not observed to hold tactile items and neither R2 nor R3 were observed to have headphones on.<br><br>During interview on 8/16/22, at 10:57 a.m. R3 was asked if he felt safe in the facility and if he was ever physically or verbally abused by any one at the facility in which he stated, "I would knock the day lights out of them if they did." He denied he had ever had to knock the day lights out of someone at the facility. | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 10<br>When interviewed on 8/16/22, at 1:20 p.m. nursing assistant (NA)-A "about a couple weeks ago" she witnessed R2 push R3 on the left shoulder and chest area. When she attempted to separate them, R3 almost punched her. She denied that R3 hit R2 in response. She alerted the director of nursing (DON) and RN-A. She could not remember if new behavior/safety interventions were implemented to protect R2 or R3 after the incident. "When [R2] and [R3] act up a little bit and once you get them out of the situation they are fine for a week ...something has to irritate them for them to get angry." R2 would "get really aggressive" if something triggered him or if he did not take his medications in which he took it out on "whoever is in front of him." R2 and R3 often acted out with each other as R3 often went up to R2 and explained "when they walk, they walk by each other" as both gravitate towards the nurse's station. When R2 and R3 appeared angry, staff attempted to keep them away from each other. When R3 first admitted to the unit, he and R2 were best friends and then R3 started acting out and "he would always go after [R2]:" now it was "a hit and miss. Sometimes they will talk and it will go good and then it can start to go badly ...depends on the day with them." She did not witness R2 and R5's event; however, she explained she heard R2 stood up and hit R5 about five times: "[R2] was agitated. He wanted to walk around and someone kept telling him to sit down so he was ready for lunch. He was just irritated at that and took it out on [R5]."<br><br>During interview on 8/16/22, at 1:52 p.m. NA-B stated the memory care unit was not her primary scheduled wing and the resident Kardex's did not contain enough information on behaviors and behavioral interventions: "There could be more | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 11 | F 600 | | |

[information]." She had not witnessed resident-to-resident events with R2, R3, or R5. R2 required a lot of redirection and she had never seen him aggressive. Additionally, she had never seen R3 with behaviors. She was unaware of issues between R2 and R3 and acknowledged she was never informed she needed to keep a closer eye on them when they are within proximity of each other. If R2, R3, or R5 showed behaviors, she would try to keep them separated and keep them busy.

When interviewed on 8/16/22, at 2:20 p.m. NA-C stated resident-to-resident behaviors occurred "pretty often especially on this unit as the boys like to fight ...they are like lions." Because of this, she watched the residents close for signs, such as body language, which cued her to potential issues. She then utilized distraction, activities, food, etc. to help decrease stressors. She stated she reviewed the care plan for behaviors and behavioral interventions; however, the Kardex's "could have a little more in there" or be "more specific" to assist with behaviors on the unit. She stated R2 "just wanders" and she is unsure as to what triggered him to become angry and R3 appeared to get "super overwhelmed when there is too much going on around him." R2 and R3 needed closer supervision when they were closer to each other; however, staff did not keep them from talking to each other as they did get along at times. NA-C stated R2 and R3 were currently on 15 minute checks in order to make sure they were okay and staff knew where they were.

During interview on 8/17/22, at 9:00 a.m. R2's family member (FM)-B stated the facility updated her related to the R2 and R5's altercation and she explained the incident did not seem like a big

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 12 | F 600 | | |

deal. She stated R2 was not an aggressive person; however, she mentioned "maybe in the beginning when they did not have his medications adjusted" and he displayed verbal aggression. She added that she knew R2 was aggressive in which she believed staff "just separated them." She was unaware of any other interventions to help decrease the risk of R2 being involved in resident-to-resident altercations.

When interviewed on 8/17/22, at 11:33 a.m. NA-D stated [on 4/15/22] she heard R2 and R3 arguing at the nurse's desk and when she exited the room she was in, she witnessed R3 push R2 into the wall "with two hands full force" on his "chest and shoulder" areas." She heard R3 call R2 "all sorts of b words ...calling him an asshole." She stated it was reported to her from the evening shift that R3 was "moody" and "antsy" and "to watch out for him." NA-D acknowledged she was unable to remember if any new interventions were implemented to protect them from each other.

During interview on 8/17/22, at 2:45 p.m. RN-B stated she witnessed R3 push R2 in the shoulder on [7/26/22] and she was unable to reach them in time after she heard their raised voices. She was able to stop R2 from hitting R3 after R2 made motions as if he was going to hit R3. She stated, "On this shift, when you hear loud voices you react immediately." RN-B confirmed she did not update R2 or R3's care plans with information related to the altercation nor did she update or implement any new interventions in the care plans. She denied R2 or R3 required current 15 minute checks.

During interview on 8/17/22, at 7:51 a.m. trained medication aide (TMA)-A stated he was expected

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 13<br>to follow the resident's Kardex (nursing assistant care plans) to help with behaviors and interventions. He confirmed the Kardex often lacked behavioral information and he stated, "I think they should put more stuff on there and gave examples such as activity preferences, spare time enjoyments, likes when younger, etc. TMA-A stated he had witnessed events where R2 and R3 were physically aggressive with other residents and he explained R2 and R3 appeared as if they were in a relationship where they were best friends one moment and then the next one was upset with the other. R2 and R3 were allowed to wander the unit together; however, he attempted to watch them as "it is hard to keep them separated" and the unit had "too many residents with behaviors at times," which was harder to manage when the "core staff" were not scheduled on the unit. In addition, there were "too much male hormones over here" and it was like the residents were in grade school again and because of all the different behaviors, they clashed. He confirmed R2 and R3 were not on 15 minute checks or one-on-one supervision; however, he stated R2 and R3 required one-on-one supervision to keep them safe.<br><br>When interviewed on 8/17/22, at 10:16 a.m. RN-C stated when a resident-to-resident altercation occurred, staff separated the involved residents, ensured their needs were met, and provided them with distraction/activities at least "for the rest of the shift." He explained 15 minute checks were often initiated. He denied any residents were on one-to-one supervision at that time and he felt R2 and R3 were on 15 minute checks; however, he was not certain as he had not seen the 15 minute check flow sheet on the clip board that morning and it was not reported off | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 14<br>in the shift report. RN-C stated he was unsure as to the process of determining when 15 minute checks were discontinued as that was a role for the DON and RN-A. He stated when R2 grabbed his arm and twisted it, or when R3 started to raise his voice, they required increased supervision. At the start of the shift, he would first determined where R2 and R3 were and he observed them. If neither showed any signs of concerns, both R2 and R3 "are good to wander" and he did not keep a close eye on them. R2 and R3 used to be "buddies and walked the hallways always together ...that changed and I am not sure what happened." Since then, both required increased supervision and staff tried to keep them separated. In addition, he explained if R2 was seen "fiddling with his fingers he has to go to the bathroom" and if staff "spend time with [R3] on one-to-ones and give him focus and attention, that helps him feel grounded and not so anxious." He also stated R3 was very protective of the other residents and "was ready to defend someone's honor" if he felt the need. RN-C was unsure if such information was present in R2 or R3's care plans and acknowledged the unit needed "to have someone out in that area and by the nurse's desk and have eyes out on the floor ...that is the most important thing to help prevent a problem."<br><br>During interview on 8/17/22, at 10:54 a.m. hospice nurse (RN)-D stated she witnessed that R2 kept standing up and staff kept directing him to sit down as lunch would be there soon. After this direction, R2 stood up and "started hitting [R5] on the back about five times with a closed fist ...it was more than a pat." RN-D stated, "I think [R2] was overstimulated. There was a lot going on around him." such as ring toss, popcorn, and resident conversations. | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 15<br><br>When interviewed on 8/17/22, at 1:49 p.m. RN-A stated staff were expected to review the resident Kardex's. R2 and R3's Kardex's were reviewed and she confirmed both Kardex's lacked specific behavioral signs/symptoms or that either had a history of physical or verbal aggression. In addition, she stated all Kardex's on the secured unit lacked such information. She explained such information should be on the Kardex, along with individualized interventions so staff watched for specific behaviors and "being on top of it ...instead of just watching for behaviors in general." She stated if staff were not updated on behaviors or interventions, staff may not spot them or pay closer attention to particular residents. Overall, she did not change behavior care plans as "they still seem to be effective;" however, recently she lacked sufficient time to make sure the care plans were accurate and acknowledged this process needed to be completed. Fifteen minute checks were a frequently used intervention and staff were expected to review a designated clip board for the flow sheets to identify the checked residents. She was unsure if any of the resident's currently required routine checks. Fifteen minute checks were not put on the Kardex or in the main Care Plan and when 15 minute checks were implemented, she was unsure of the interventions used to protect R1, R2, R3, R4, and R5 in between the check times for each incident reviewed. Fifteen minute checks were discontinued when an intervention was put into place and determined to be effective. She explained R2 was setup to assist/offer tactile items while ambulating and she expected staff to follow the care plan/Kardex interventions. She confirmed R2 should have a tactile item in his | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 16<br>hands when he walked and when she was updated this was not observed, she commented she should have removed that and tried something different as staff attempted it and it did not work: "He does not hold onto anything for very long." RN-A stated she "ordered [the cassette players] maybe a week ago" which had not yet arrived [documentation indicated they were ordered as of 8/2/22]. She did not implement a replacement intervention until the cassette players arrived. RN-A indicated R2 was not an aggressive resident and she did not believe R2 hit R5 to be mean, just to get his attention. R2 did not like stimulation and she stated R5 and another resident were talking loudly by R2. RN-A confirmed R3 no longer followed psych services as she wanted to have Essentia psych follow him versus Mille Lacs psych services, in which R3 was removed from Mille Lacs services and placed on a waiting list for Essentia. She indicated R3 was last seen by psych possibly sometime in April of this year [facility provided psych visit notes indicated 4/15/22 was the last visit]. She confirmed she had not contacted Essentia psych to communicate with them related to R3's wait time for psych services since he was placed on the waiting list.<br><br>During interview on 8/17/22, at 3:18 p.m. the DON stated she expected immediate intervention(s) to be implemented, care planned, and followed to ensure the resident(s) remained safe, even if the intervention was a "simple" intervention, in order to prevent further incidence altercations. The DON stated routine review of interventions was important to ensure they were effective as interventions at times may no longer be well suited for that resident. She felt many of the resident-to-resident altercations the facility | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 17<br>experienced recently were due to residents needing increased activity and more supervision. The facility recently hired more activity staff, adjusted available activities, and worked on camera placement on the secured unit. The DON expressed she felt R2 and R5's altercation was not a true resident-to-resident abuse situation. For R1 and R4, she stated his family came in and he left the building for a few hours and he appeared calm when he returned: "Fifteen minute checks were good for him." For R2 and R3, she explained, "Ever since day one, they have been friends and they gravitate towards each other." She stated initially when R2 and R3 started to have altercations, both families were talked to and family did not want them segregated. She identified R2 liked to be next to someone and that R3 "did better in a less male setting" and the facility attempted to keep the male census on the unit as low as they were able. The DON stated behavioral reviews with the consulting pharmacist stopped due to new ownership; however, these reviews would again start in September and until that time would be performed as needed with the IDT.<br><br>A policy Altercation-Resident to Resident, revised 3/1/14, identified if was a policy to protect resident(s) and intervene on behalf of the residents to prevent further aggression. The policy directed staff to take prompt action to mediate the aggression and separate the residents. Preliminary prevention interventions were to be taken and the care plans were to be revised as needed and all appropriate staff were to be updated of any care plan changes and/or interventions. In addition, the policy directed the administrator was to seek guidance from the DON, the resident's physician, and the medical | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 18<br>director to review the appropriateness of retention of the aggressor within the facility.<br><br>A policy Freedom from Abuse, Neglect, and Exploitation, revised 5/2020, identified it was a policy of the facility to take appropriate steps to prevent the occurrence of abuse and defined resident-to-resident altercations as an incident that involved a resident who willfully inflicts injury upon another resident. The policy defined willful as the resident must have acted deliberately, not that they must have intended to inflict injury or harm. The policy directed if the suspected perpetrator was another resident, the staff separated the residents so they did not have access to each other until the circumstances of the alleged incident were determined.<br><br>A policy Behavior Monitoring Policy, dated 6/8/22, directed the interdisciplinary team (IDT) to evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies were to be implemented immediately if necessary to protect the resident and others from harm. In addition, the policy directed that interventions would be individualized and part of the overall care environment that supports physical, functional and psychological needs, and strives to understand, prevent or relieve the residents distress or loss of abilities. The policy lacked evidence of how often the IDT was to review behavioral symptoms.<br><br>The immediate jeopardy that began on 8/15/22, was removed on 8/19/22 at 2:40 p.m., when the facility updated R2 and R3's care plan, to include a behavioral intervention of one-on-one | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245366 | A. BUILDING _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 600 | Continued From page 19<br>supervision to monitor/observe daily habits until further appropriate interventions were identified and implemented according to their needs. In addition, R2 and R3's Kardex's were updated to reflect behavioral signs and interventions, IDT and nursing staff were educated on the updated interventions as well as Kardex use and processes, the updated abuse policy and the updated Behavior Monitoring policy; however, noncompliance remained at a lower scope and severity level of an E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00598 | A. BUILDING: _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 8/16/22 through 8/19/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure.<br><br>The following complaints were found to be | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00598 | A. BUILDING: _____ B. WING _____ | C 08/19/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JENSEN HEALTH LLC | 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 | Continued From page 1<br><br>SUBSTANTIATED with no licensing orders issued.<br>H53663956C (MN00085907),<br>H53664293C (MN00085813),<br>H53664011C (MN00085504),<br>H53664029C (MN00084205),<br>H5366287C (MN00082727).<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |