STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	04/01/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on based on interview and document review, the facility failed to effectively identify, monitor, and administer pain medications as prescribed to maintain pain management for 1 of 3 residents (R1) reviewed for pain. Findings include: R1's Discharge Summary from a a geriatric psychiatric (geri-psych) unit dated 3/11/20, indicated R1 was admitted to their facility on 2/21/20, and discharged on [DATE]. R1 was admitted to their unit due to physical aggression in the context of dementia. During R1's stay at the geri-psych facility, R1 had been aggressive, combative, screamed out, was difficult to redirect, and required numerous as needed (prn) medications. R1's condition continued to decline, and she started to show signs of increased pain. [MEDICATION NAME] (narcotic pain medication) and [MEDICATION NAME] (antianxiety medication) were started 3/9/20, for comfort. Toward the end of R1's stay at the geri-psych unit, R1 appeared calmer, was no longer physically aggressive, was compliant with medication and cares, easier to redirected, and appeared less distressed. R1's discharge plan was to be referred to a long term care facility with recommended hospice services. R1's Medication Review Report dated 3/12/20, indicated R1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R1's care plan dated 3/11/20, indicated R1 was forgetful and confused, had a history of [REDACTED]. The care plan further indicated R1 had had pain or discomfort, and instructed staff to use the pain scale to determine her pain as applicable, and utilize a pain management plan. R1's medical record indicated a local hospice as the hospice provider, and listed contact numbers and names of the hospice care team. R1's medical record lacked hospice notes or a hospice care plan. R1's group sheet (nursing assistant care guide) dated 3/21/20, indicated R1 yelled out when in pain, and had chronic back and shoulder pain. R1's group sheet lacked indication she was on hospice. R1's Physician Note dated 3/12/20, indicated R1 was seen as a new admission transferred from a geri-psych hospital for terminal and hospice care. The note indicated R1 was agitated and restless. The note further indicated R1 would likely continue to have some central nervous system (CNS) bleeding, and may develop increased intracranial pressure (pressure in the brain) and increased agitation that may be related to additional [MEDICAL CONDITION] with subdural and subarachnoid bleed from January. R1's Pain Data Collection and Assessment completed on 3/17/20, indicated R1 was unable to articulate what caused, increased, or relieved her pain. Signs of pain exhibited by R1 were noted to be a grimaced/distorted face, tightly shut lips, perspiration, change in skin color, and clenched fist. R1's physician progress notes [REDACTED]. The note indicated R1 was admitted for end of life care, had vascular with behavioral disturbances as well as a [MEDICAL CONDITION]. The note indicated R1 was noted of having increased behavior of agitation and screaming out, and the facility was working closely with Essentia hospice on medication management to increase comfort. R1's medication record (MAR) for March directed the following scheduled medications: -[MEDICATION NAME] HCl (pain medication) 0.5 milligrams (mg) to be given by mouth two time a day for pain at 8:00 a.m. and 8:00 p.m. -[MEDICATION NAME] 1 mg to be given by mouth three times a day for agitation related to anxiety at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -[MEDICATION NAME] (antidepressant) 25 mg to be given by mouth two times a day for depression at 8:00 a.m. and 8:00 p.m. R1's MAR for March directed the following as needed (prn) medications: -[MEDICATION NAME] (pain medication) 2 mg to be given by mouth every hour as needed for mild pain. -[MEDICATION NAME] (antianxiety medication) 1 mg to be given by mouth every four hours as needed for agitation related to anxiety. -[MEDICATION NAME] ([MEDICATION NAME], an antipsychotic medication) 1 mg to be given by mouth every four hours as needed for [MEDICAL CONDITION] or hallucinations. -[MEDICATION NAME] solution to be given by injection intramuscularly (into the muscle) every 6 hours as needed for agitation from 3/21/20, through 3/24/20, then 5 mg injected subcutaneously (into the skin) every 6 hours as needed for agitation starting 3/24/20. On 3/11/20, a progress note indicated R1 was admitted to facility from a geriatric hospital and was accompanied by family. R1 was admitted with the [DIAGNOSES REDACTED]. On 3/12/20, at 12:38 p.m. a progress note indicated R1 had been screaming out profanity, and had refused all medications and meals. The note further indicated R1 was seen by a physician that day. At 1:03 p.m. a progress note indicated R1 had been yelling out on and off throughout the shift, was combative, and tried to get out of wheelchair on two separate occasions. R1 refused her 8:00 a.m. medication after three attempts were made, and took partial mediations that were scheduled between 12:00 p.m. and 2:00 p.m. R1's medical record lacked evidence of progress notes of R1's condition from 3/18/20, until 3/23/20. R1's physician orders [REDACTED]. May give prn medications for anxiety and pain, and to call hospice if the prn medications were not effective. Hospice would call in the a.m. 3/24/20, in regards to the above held scheduled medications. On 3/23/20, at 9:46 p.m. a progress note indicated R1 slept most of the day shift, and had unlabored shallow respiration at four to five breaths a minute. Afternoon medications were held due to R1 sleeping. Hospice and family were notified of R1's condition. The facility was unable to determine if R1 was transitioning towards end of life, or was in a deep sleep. Family had arrived in the evening, R1 had woken up and yelled out. On 3/23/20, at 10:50 p.m. a progress note indicated R1's bedtime [MEDICATION NAME] 5 mg, [MEDICATION NAME] 0.5 mg and trazadone 50 mg were put on hold due to her sedation and decreased respirations. On 3/24/20, R1's medical record lacked documentation of her condition. On 3/25/20, at 1:15 p.m. a progress note indicated licensed practical nurse (LPN)-A arrived for morning shift, and observed R1 screaming, and exhibiting signs of discomfort which include furrowed brow, restlessness, clenched fists, and resistive behaviors. Attempts were made to administer all oral scheduled medications, and R1 spit the medications out. The note further indicated staff offered oral prn medications for pain and restlessness which were ineffective. Facility staff contacted the hospice nurse, and the hospice nurse requested R1 to be admitted directly to the hospice house for an inpatient pain crisis. R1's family had agreed to the transfer. On 3/26/20, a progress note indicated staff called hospice house, and was informed R1 was actively dying and was comfortable. On 3/30/20, at 10:44 a.m. the hospice registered nurse (RN)-G was interviewed and stated R1 was admitted to the hospice program on 3/13/20, to assist with pain management. RN-G stated R1 had appeared restless, screamed out, became resistive with cares, and sometimes would spit out medications. RN-G stated R1 was prescribed medications by hospice to help with pain control, anxiety, aggression, and hallucinations. RN-G stated the facility staff would call hospice when R1's pain did not effectively respond to medications given, and medications adjustments were made. RN-G stated facility staff was instructed to administer R1's medications as prescribed in efforts to keep R1's pain under control, and R1's emotional status as stable as possible. RN-G stated at each visit, R1's MAR was reviewed, and he noted there were several times R1 went hours without being administered either scheduled or prn pain medications. RN-G stated he expressed his concerns to staff, telling them that when R1 went without her opioids and antianxiety medications for several hours, it would cause R1 extreme distress. RN-G stated the facility staff expressed concerns that they may be overmedicating R1, which would cause R1 to be sedated, and R1 had spit out the medications. RN-G stated facility staff was instructed to crush the medications and mix with 1 milliliter (ml) of liquid, and administer the medication to the inside of R1's cheek for quicker absorption, and to avoid R1 spitting out the medication. RN-G stated R1's family was updated on 3/24/20, with R1's change in condition, and the

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

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) family stated they would rather R1 be sedated and comfortable than to be in extreme distress. RN-G stated when a patient was at the end of life and became restless and confused, no one knew if it was manifested by emotional or physical trauma, and advised to use both an opioid to treat pain and shortness of breath (sob), and use the antianxiety medication for restlessness, and agitation. RN-G stated administering both medications would promote both physical and emotional comfort. RN-G stated when he asked staff why R1 went over 24 hours without pain medications, staff reported R1 was sedated on 3/23/20, and medications were held and then R1 refused. RN-G stated after review of R1's MAR, R1 had been given prn [MEDICATION NAME] and [MEDICATION NAME] during R1's reported state of sedation. RN-G stated at the time the [MEDICATION NAME] and [MEDICATION NAME] were administered, there was an opportunity of administering pain medication along with the antianxiety medications, and it was a missed opportunity. RN-G stated staff was not able to keep R1's pain managed and ultimately, R1 was admitted to the hospice house for pain management. On 3/30/20, at 3:32 p.m. the director of nursing (DON) was interviewed and stated R1 was admitted to the facility from a geriatric psychiatric facility where R1's behaviors were being managed by antipsychotic medications administered intravenously (IV, directly into to the bloodstream). The DON stated R1's antipsychotic IV medications were discontinued before R1 was admitted to the facility. The DON stated staff contacted hospice when scheduled and prn medications were not effective, and several medication adjustments were made throughout R1's admission. The DON stated staff tried to manage R1's pain with the least effective dosing, while trying to make sure the resident remained comfortable. The DON stated R1 would spit out her medications, and had prn medications ordered by injection. The DON stated R1 would become resistive and combative, and it was not facility practice to hold down a resident that was being resistive, and force the injection. The DON stated it had been difficult to keep R1 comfortable and manage R1's pain day since admission, and the staff did everything they could. ON 3/31/20, at 11:52 a.m. LPN-A was interviewed and stated R1 would yell out, become agitated, and she would resist cares and spit out medications. Interventions used by staff were offering snacks, toileting, offloading, and administering prescribed [MEDICATION NAME], and [MEDICATION NAME]. LPN-A stated she believed a lot of R1's yelling and screaming out were due to pain. LPN-A stated R1 was unable communicate reasons for her restlessness and agitation, so staff had to use their best judgement when administering prn mediations. LPN-A stated some newer staff or staff that were unfamiliar with hospice, were uncomfortable administering prn pain medications fearing they would over sedate R1. LPN-A stated on 3/23/20, R1 slept most of the day shift, and later that evening R1 had respirations of four to five per minute. LPN-A stated it was difficult to determine if R1 was transitioning to end of life, or if she was sedated. Hospice was called and ordered scheduled [MEDICATION NAME], and trazadone to be held that evening due to sedation, and to administer prn pain and antianxiety medications as needed. LPN-A stated according to R1's MAR, R1 had not received pain medications from 8:00 a.m. 3/23/20, until 10:06 a.m. 3/25/20. LPN-A further stated during that 50 hour period, R1's pain medications were held due to sedation or R1 refused. LPN-A verified R1's MAR indicated during the times R1's pain medications were not given due to staff documentation that indicated R1 was sedated or refused, R1 was administered prn [MEDICATION NAME] and [MEDICATION NAME]. LPN-N stated R1 could have been administered prn pain medications during that time if staff felt administering the medications were appropriate. LPN-A stated R1 was prescribed [MEDICATION NAME] for agitation and [MEDICATION NAME] for [MEDICAL CONDITION] and hallucinations. LPN-A stated it was possible R1's yelling out and agitation was a result of R1 being in pain. LPN-A reviewed R1's progress notes, and verified R1's medical record lacked documentation why R1 was given the prn [MEDICATION NAME] and [MEDICATION NAME] between 3/23/20, p.m. to the a.m. on 3/25/20. LPN-A stated the hospice nurse instructed staff to utilize all medications as prescribed to keep up on R1's pain control. LPN-A stated R1's family wishes were for R1 to be comfortable, and that is why R1 was admitted to the hospice house on 3/25/20. On 3/31/20, at 4:20 p.m. family member (FM)-D was interviewed and stated R1 would yell out in pain, and felt R1's prn pain medication was not given as hospice directed. FM-D stated when R1 arrived at the facility, R1 was sleepy and rested for the evening, and by the next day staff reported R1 had been yelling and hollering out. FM-D stated when R1 was admitted to the hospice house, R1 appeared to be comfortable, and was not agitated or yelling out in pain. On 3/31/20, at 4:44 p.m. FM-E was interviewed and stated R1 had not been at the facility very long, and during R1's entire stay staff had struggled to regulate R1's pain without feeling they were overdosing R1. FM-E stated she had told staff and RN-G that family would rather R1 be in a sedated state than to be distressed. FM-E stated it seemed staff waited too long to give the breakthrough pain medications (prn medications), and should have been giving them as they were ordered, and maybe R1 would have not been screaming out and restless. FM-E stated staff crushed R1's mediations and mixed into pudding, and R1 would spit it out. FM-E stated R1 was not getting all of her medications to manage her pain, and should have given the medication. FM-E stated family called RN-G and expressed their concerns. FM-E stated during R1's stay at the geriatric psychiatric hospital, it took awhile, but the staff was able to get R1's pain and behaviors under control. FM-G stated staff called the family on 3/23/20, and was informed R1 might be approaching end of life, and family was recommended to come to the facility. FM-E stated on 3/25/20, they received a call from RN-G that the staff was unable to manage R1's pain, and recommended R1 be admitted to the hospice house for pain management. FM-E stated she visited R1 at the hospice house, R1 was not aggressive or hollering out, and R1 appeared comfortable. On 4/1/20, at 12:05 p.m. trained medication aide (TMA)-A was interviewed and stated R1 yelled, screamed out, was resistive with cares, and tried to crawl out of bed. TMA-A stated it was difficult to know if R1 yelled due to pain, or if it was a behavior due to dementia, and thy had to use their best judgement. TMA-A further stated R1 was like no other resident with dementia, it was a special case. TMA-A stated R1 was prescribed medications for pain and medications for behaviors, and they administered medications according the orders. TMA-A stated R1 spent a lot of time in the wheelchair at the nurse's station, because R1 would crawl out of the bed. TMA-A stated R1 was either screaming out or sleeping, and her behaviors went from zero to ten. TMA-A stated he worked the night shift on 3/24/20, and administered medications to R1 during his shift. TMA-A stated he administered R1's antipsychotic and antianxiety medications instead of pain medications, because R1 was restless, tried to get out of bed, and was being resistive. TMA-A stated his best judgement was used, and he believed those were signs of behavior. TMA-A was unable to identify licensed nurse working that night. On 4/1/20, at 12:10 p.m. nursing assistant (NA)-C was interviewed and stated R1 was restless, and screamed out a lot since her admission to the facility. NA-C stated R1 was unable to verbally communicate her needs, so it was difficult to know if R1 was in pain, or if her behaviors were from dementia. NA-C stated R1 spent most of the time in her chair near the nurses station because R1 would try to crawl out of bed. NA-C stated she would sit with R1, hold her hand, and offer ice cream to try and comfort her to calm her down, which had a short term effect. NA-C stated R1 did not appear sedated during the night shift from 3/24/20, to 3/25/20. NA-C stated R1 slept some that night, and was restless and screaming out. NA-C stated she reported R1's symptoms to TMA-A , and asked him if R1 could have something for pain. NA-C stated TMA-A told her R1 had already received medications, and could not have anything else for four hours. The facility policy Pain Management revised 11/16, directed residents to be screened for pain regularly though observing the resident during daily care, and/or for signs and symptoms of pain. For residents with advanced dementia, either the pain assessment in advanced dementia form or the assessment for pain in cognitively impaired would be completed. For residents who had difficulty communicating physical signs such as grimacing, restlessness, moaning/groaning, vital sign changes, or behavioral changes would be monitored. The policy further directed to document the reason for PRN (as needed) pain medications administered, as well as effectiveness of the administration, will be recorded on the medication administration record (MAR).
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure staff performed hand hygiene when removing and changing gloves, failed to ensure staff assisted a resident with handwashing after handling a used brief, and failed to ensure residents were spaced six feet apart. This had the potential to affect all 145 residents in the facility. Findings include: On 3/30/20, at 8:44 a.m. on the Cedar unit, activity aide (AA)-A was observed measuring vital signs for the residents. AA-A did not perform hand hygiene after removing her gloves and re-gloving prior to measuring the next resident's temperature, oxygen saturation, and heart rate. At 9:13 a.m. AA-A stated she had been educated to use hand sanitizer or to wash her hands after removing gloves. AA-A stated she forgot, because there wasn't any hand sanitizer in the equipment basket. Several pocket size bottles of hand sanitizer were observed at the nurse's station desk. On 3/30/20, at 10:15 a.m. on the Willows unit, nursing assistant (NA)-A was observed standing in the doorway of a resident's room holding soiled bed linen in his arms. The soiled bed linen was touching his uniform from chest to ankles. At 10:24 a.m. NA-A verified the linen he was holding was dirty linen, and it was not good practice to hold soiled linen against his uniform. At 10:36 a.m. registered nurse (RN)-E was interviewed and stated she would expect staff to place soiled linen in a

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) bag, and to not allow linen to touch their uniform. RN-E stated staff should perform hand hygiene after removing or changing gloves. RN-E stated all staff had recent training on hand hygiene and on using personal protective equipment (PPE). On 3/30/20, at 2:42 p.m. RN-F was interviewed and stated staff had been educated on using hand sanitizer or washing their hands after glove removal. On 3/31/20, at 1:05 p.m. the director of nursing (DON) was interviewed. She stated all staff had been recently educated on hand hygiene and she would expect staff to wash or use hand sanitizer after removing gloves. R4's Admission Record printed 4/1/20, indicated R4 had [DIAGNOSES REDACTED]. R4's quarterly Minimum Data Set (MDS) assessment note dated 3/5/20, indicated R4 had a severe cognition deficit. The note further indicated R4 had a pattern of changing her own incontinent brief and bringing the dirty brief to the desk claiming someone left it in her room. On 3/30/20, at 1:13 p.m. on the Willows unit, R4 walked past the nurse's desk carrying a soiled incontinent brief. R4 stated she didn't want it (the soiled brief) in her room. R4 walked past RN-D who was standing at the medication cart. RN-D did not intervene. A housekeeper who was standing in front of the dirty utility room took the soiled brief. R4 started walking back to her room. When asked RN-D if he was going to assist R4 to wash her hands, RN-D stated R4 would go back to her room and wash her hands. R4 turned and walked back to the nurse's station and asked what time the next meal would be. RN-D then went to R4 and squirted a large amount of hand sanitizer into her hands, and told her to wash her hands. RN-D verified he did not intervene immediately. On 3/31/20, at 9:43 a.m. RN-E stated she would expect a staff member to intervene immediately if they saw a resident carrying a soiled incontinent brief. On 3/31/20, at 10:05 am. RN-D was interviewed and stated he thought it was the nursing assistant's job to intervene when the resident was carrying a soiled incontinent brief. On 3/31/20, at 9:13 a.m. on the Birch unit, three residents were observed eating breakfast. Two were seated at a table along with two staff members who were assisting them with eating; a third resident was seated at a second table alone. One of the residents seated at the table being fed was coughing periodically. At 9:17 a.m. NA-B stated she did not know if the table had been measured to ensure residents were six feet apart. NA-B stated she did not believe the residents seated across from each other were six feet apart. NA-B then moved one resident to a chair and pulled an overbed table in front of the resident, ensuring the residents were now six feet apart, and proceeded to finish assisting the resident with their meal. At 10:18 a.m. RN-F stated two residents should not be seated at the same table for meals. The facility policy Hand Washing dated 4/1/08, directed staff were to wash their hands after each direct resident contact. The facilty policy Gloves, Non-Sterile dated 4/1/08, directed staff were to wash hands upon removal of gloves. The facility policy Infection Prevention and Control (General) dated 11/2016, directed staff were to follow hand hygiene procedures for direct contact with residents.