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 _____	03/05/2020

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 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to initiate timely cardio-pulmonary resuscitation (CPR) in accordance with resident wishes and physician orders [REDACTED]. This deficient practice resulted in an immediate jeopardy (IJ) when R4 was found with an absent pulse and respirations, timely CPR was not initiated, and R4 died . The IJ began on [DATE], when R4 was found with an absent pulse and respirations, timely CPR was not initiated, and R4 died . The administrator and director of nursing (DON) were made aware of the incident on [DATE], and immediately initiated corrective actions. The administrator and director of nursing (DON) were notified of the IJ on [DATE], at 3:14 p.m. The facility implemented corrective action on [DATE], prior to the onsite investigation, and the deficiency is being issued at past non-compliance. Findings include: R4's Face Sheet dated [DATE], indicated R4's [DIAGNOSES REDACTED]. R4's admission Minimum Data Set ((MDS) dated [DATE], identified R4 was cognitively intact. R4's Providers Order for Life Sustaining Treatment (POLST) dated [DATE], directed CPR/ATTEMPT RESUSCITATION and PROVIDE LIFE SUSTAINING TREATMENT. The POLST document was signed by R4's guardian on [DATE], and R4's physician on [DATE]. On [DATE], at 2:30 p.m. a progress note indicated R4's guardian requested CPR be performed, if needed. On [DATE], at 9:04 a.m. a progress note written by registered nurse (RN)-E indicated R4 died at 8:50 a.m. On [DATE], at 2:08 p.m. nursing assistant (NA)-A was interviewed. NA-A stated on [DATE], she had provided R4 a meal tray and changed the resident's incontinence product between 8:00 a.m. and 8:30 a.m. NA-A stated between 8:45 a.m. and 9:15 a.m. NA-B found R4 unresponsive, and informed her and RN-E. NA-A stated RN-E went to the nurses' station to look for R4's code status and then she saw him on the telephone. NA-A stated she was unaware if RN-E went into R4's room prior to going to the nurses' station. NA-A stated she then obtained supplies to perform post-mortem cares and placed the supplies in R4's room. NA-A stated she informed NA-C R4 had died , and then returned to R4's room. NA-A stated upon entering the room she asked NA-C how staff determined a resident's code status. NA-A stated NA-C responded you don't know, and instructed her to stay in the room and ran down a hallway towards the nurses' station. NA-A stated she then overheard a [NAME] (facility's [MEDICAL CONDITION] response team) called via an overhead page. NA-A stated the facility's nurse managers quickly came to R4's room and began CPR. NA-A estimated 15 minutes passed from when she was informed R4 had died , to when CPR was started. NA-A stated she heard R4's code status was supposed to be listed on a team sheet, but was not. On [DATE], at 2:26 p.m. NA-C was interviewed. NA-C stated she was in the unit dining room on [DATE], at approximately 9:00 a.m., when NA-A informed her post-mortem cares needed to be completed for R4. NA-C stated when she arrived to R4's room, the supplies were present. NA-C stated NA-A then asked her how to determine if a resident was a full-code or do-not-resuscitate. NA-C stated that made me think twice and she went to the nurses' station to look for R4's code status. NA-C stated she was unable to find R4's code status, and called a [NAME] via an overhead page. NA-C stated she saw RN-E at the nurses' station on the telephone and looking through a chart. NA-C stated staff came quickly once the [NAME] was called. NA-C stated she did not know when R4 was found unresponsive. On [DATE], at 2:49 p.m. NA-B was interviewed. NA-B stated R4 was not eating breakfast on [DATE], between 8:00 a.m. and 8:30 a.m., so she returned to R4's room at approximately 8:45 a.m. to offer her a popsicle. NA-B stated when she entered the room, R4 was lying in bed, her eyes were open, and the resident looked dead. NA-B stated she felt for a pulse on R4's neck for one minute and felt nothing. NA-B stated she then found RN-E within five minutes, and they went into R4's room together. NA-B stated RN-E checked R4's pulse and told her R4 had died . NA-B stated RN-E instructed her to clean up R4, and told her he would check for the resident's code status, and they left the room together. NA-B confirmed RN-E did not start CPR. NA-B stated she then left the room, and told NA-A R4 had died , and needed to be cleaned up. NA-B stated she saw RN-E at the nurses' station making telephone calls. NA-B stated approximately 15 to 20 minutes had passed from her finding R4 unresponsive until she overheard NA-C call a [NAME] via overhead page. On [DATE], at 8:59 a.m. RN-B was interviewed. RN-B stated she worked on [DATE], however, was not at the facility when R4 had died . RN-B stated the NAs reported RN-E failed to perform CPR when R4 was found unresponsive at approximately 9:00 a.m. RN-B stated RN-E had reported he started CPR and then stopped, however, this was contrary to the NAs' report. RN-B stated she did not know what time a [NAME] was called, but confirmed CPR was not performed continuously when R4 was found unresponsive. RN-B stated the nurse managers performed CPR once the [NAME] was called, and did so continuously until emergency medical services (E[CONDITION]) arrived. RN-B stated she understood RN-E was having difficulty locating R4's POLST document. RN-B confirmed R4's code status was not documented on R4's team sheet on [DATE]. RN-B stated she personally placed a copy of R4's POLST in R4's medical record. RN-B stated R4's POLST was found at the nurses' station under paperwork RN-E had looked through. RN-B stated RN-E was immediately suspended pending investigation, and he was no longer employed at the facility. RN-B stated the facility expectation was to call a [NAME] if a resident's code status was unable to be determined. RN-B stated she instructed agency staff on the process of identifying residents' code status upon starting at the facility. RN-B stated the facility provided CPR education after the event occurred. On [DATE], at 9:11 a.m. RN-A stated she worked dayshift on [DATE]. RN-A stated she heard a [NAME] called at approximately 9:15 a.m., and licensed practical nurse (LPN)-C had an automated external defibrillator (AED) and was in the process of performing CPR when she arrived to the unit. RN-A stated she did not know what time R4 was found unresponsive. RN-A stated she called the ambulance and R4's guardian to let them know CPR was in progress when she arrived to the unit. RN-A stated she understood RN-E had difficulty locating R4's POLST document because the copy was made in white. RN-A stated the facility had made a process change and all POLST documents were now copied in gold. RN-A also stated all residents' team sheets were checked for accurate code statuses after the occurrence. On [DATE], at 9:21 a.m. LPN-C stated she worked dayshift on [DATE], and heard a [NAME] called sometime around 9:00 a.m. and grabbed an AED. LPN-C stated RN-E was near R4's room when she arrived to the unit, however, he was not performing CPR. LPN-C confirmed no CPR was in progress when she arrived to R4's room, and stated she was the first person to perform CPR. LPN-C stated she did not know what time R4 was found unresponsive. LPN-C stated since the occurrence, copies of POLST documents were to be made in gold. On [DATE], at 9:28 a.m. RN-F was interviewed and stated he worked dayshift on [DATE], and heard a [NAME] called between 9:15 a.m. and 9:20 a.m. RN-F stated when he arrived to R4's room, CPR was being performed by LPN-C. RN-F stated approximately five minutes after arriving to the unit, emergency medical services (E[CONDITION]) arrived. RN-F stated he did not know what time R4 was found unresponsive. RN-F stated since the occurrence, copies of the POLST were made in gold. On [DATE], at 9:42 a.m. the assistant director or nursing (ADON) was interviewed. The ADON stated she did not work on [DATE], however, was responsible for education regarding the occurrence which involved R4. The ADON stated code status education was provided to all nurses, and audits on resident code status were completed. The ADON stated R4 was found unresponsive, staff performed CPR, and after the [NAME] was called everything was conducted as it was supposed to be. The ADON was asked what if a resident's code status was unable to be identified, and responded the POLST should just be there

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

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The DON stated she interviewed RN-E, and he stated he performed CPR. The DON stated when she arrived to the unit RN-E was performing CPR. The DON stated she heard CPR was not performed timely, but she was only able to go by the fact R4 was provided CPR. The DON confirmed RN-E was suspended immediately following the occurrence to make sure everything was done. The DON confirmed it was not routine practice to suspend every nurse when a resident experienced a [MEDICAL CONDITION]. The DON stated proactive education was provided to all nursing staff. The DON stated copies of the POLST document were also to be made in orange moving forward. The DON stated the facility spent all weekend educating everybody. On [DATE], at 11:00 a.m. administrator was interviewed. The administrator stated she worked dayshift on [DATE], and was in morning meeting at approximately 9:15 a.m. when she heard a [NAME] called. The administrator stated all the nurses left the room at that time. The administrator stated she believed R4 was found unresponsive around 8:50 a.m., however, could only personally account for 9:15 a.m. The administrator stated she was made aware there was a concern CPR was not started timely when R4 was found unresponsive, and an investigation was started. The administrator stated RN-E was immediately suspended following the incident. The administrator stated RN-E reported he had started CPR and stopped. The administrator stated RN-E reported he was having difficulty locating R4's code status. The administrator stated R4's original POLST document was found in the physician's rounding folder, and an additional copy of R4's POLST was found at the nurses' station. The administrator confirmed a code stated was not listed on R4's team sheet on [DATE]. The administrator stated it was identified that further follow-up needed to be conducted with RN-E, however, he did not respond to further inquiries so his employment was terminated. The administrator confirmed CPR should have been started and not stopped until E[CONDITION] arrived. The administrator stated the facility completed CPR education with all licensed nursing staff. The administrator stated staff was instructed CPR was to be performed continuously unless the AED directed them to stop, no exceptions. The administrator stated the facility also reviewed employee files, had an ad hoc quality assurance meeting, and two audits were conducted of all residents team sheets and POLST documents on [DATE]. The administrator stated documentation showed education was completed on [DATE]. On [DATE], at 1:57 p.m. R4's guardian (G)-A was interviewed and stated he received a call from the facility on [DATE], between 9:05 a.m. and 9:10 a.m., and was informed R4 had died . G-A stated he had told the facility R4 was a full-code status, and was told the facility worked on R4 for a long time, and she died at 8:50 a.m. G-A stated he then told the facility which funeral home he preferred to use. G-A stated he then received another call from the facility at approximately 9:25 a.m., and was told the facility was in the process of performing CPR on R4. G-A stated approximately five minutes later he received another call from the facility and was told the R4 had died . The facility implemented corrective action to prevent recurrence by [DATE]. The facility audited resident team sheets and POLST documents to ensure accuracy on two occasions, the facility educated licensed nursing staff, conducted an ad hoc quality assurance meeting, reviewed employee files, and ensured POLST documents were printed on gold paper and placed in front of resident's charts. The corrective actions were verified by staff interview and review of resident records and education logs. The facility policy Cardiopulmonary Resuscitation (CPR) revised ,[DATE], directed, Personnel provide basic life support, including CPR, to a resident requiring such emergency care. Prior to the arrival of emergency medical services (E[CONDITION]), this community provides basic life support, including the initiation of CPR, to a resident who experiences [MEDICAL CONDITION] (cessation of respirations and/or pulse) in accordance with the resident's advance directives or in the absence of advance directives or Do Not Resuscitate (DNR) order. The facility policy Staff Competencies Policy revised ,[DATE], directed, It is the policy of Health Dimensions Group to assure staff have appropriate competencies and skills sets to provide nursing, food, nutrition, and related services to assure resident safety and attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident.
F 0684 **Level of harm -** 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 observation, interview, and document review, the facility failed to ensure a resident was able to complete his own wound care and dressing changes for 1 of 3 residents (R14) reviewed for skin conditions. This resulted in actual harm for R14 who had a worsening skin condition. Findings include: R14's Admission Record printed 3/4/20, indicated R14's [DIAGNOSES REDACTED]. R14's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R14 was cognitively intact, required assistance with bed mobility and transfers, and required assistance with dressing. R14's MDS indicated he had one Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister), two venous and arterial ulcers, [MEDICAL CONDITION](s), open lesion(s), and moisture associated skin damage. R14's care plan revised 2/20/20, indicated R14 was non-compliant with his plan of care. The care plan indicated staff were to observe for how often he was compliant with his care plan, and the reasons for non-compliance. R14 was identified to be at risk for impaired skin integrity and pressure related skin issues related to limited mobility, occasional incontinence, and [MEDICAL CONDITION]. The care plan also indicated staff were to follow the facility skin protocol, provide incontinence care with incontinent brief changes, provide medication and treatment as ordered, observe skin with morning and evening cares and with toileting for redness, rashes, open areas, pain, swelling, and report to team leader. The care plan also directed a weekly skin check, lotion to dry skin, review skin problems with physician, and treatment as ordered. An update to the care plan on 2/25/20, indicated R14 could perform self wound care. R14's care plan indicated he was at risk for deficit's with activities of daily living related to pain and neck pain, [MEDICAL CONDITION], and depression. He required an assist of one for hygiene. R14's orders from the Advanced Wound Care and Hyperbaric Center dated 2/28/20, indicated the following orders: Wound cleansing: may shower with wounds uncovered. Acetic acid (wound cleanser) washes prior to dressing changes. Abdominal fold needs to be washed and dried twice daily before antifungal and pillow case placed. Wound care for #45 and 46, change dressing Monday, Wednesday, and Friday. [MED] (ointment) to wound bed covered with [MEDICATION NAME] (dressing) secured with [MEDICATION NAME] (breathable) tape. Wound #52 and 53 change dressing twice a day. Cleanse and dry skin in abdominal fold then apply antifungal cream. Place a pillow case flat with tail exposed under the pannus (abdominal fold) and under breasts. On 2/28/20, a progress note from the wound clinic indicated R14 again with multiple open wounds to bilateral lower extremities, candidas (yeast infection) to the right groin and pannus, as well as under the right breast is significantly worse this week. Wound measurements in centimeters (cm) length by (x) width x depth taken from wound clinic provider progress notes dated [DATE], and 2/28/20, indicated progressive worsening of left lower leg anterior proximal, left lower leg anterior distal, and right lower leg midline anterior open areas. Wound #45 left lower leg anterior proximal measured on [DATE], was 2.5 centimeters (cm) length x 2 cm width x 0.1 cm depth. On 2/28/20, wound #45 measured 4.4 cm x 2.7 cm x 0.1 cm. Wound #46 left lower leg anterior distal measured on [DATE], was 4.4 cm x 4 cm x 0.1 cm. On 2/28/20, the wound measured 4 cm x 6.5 cm x 0.1 cm. Wound #51 right lower leg midline anterior measured on [DATE], was 0.2 cm x 0.2 cm x 0.1 cm. On 2/28/20, the wound measured 14 cm x 11.9 cm x 0.1 cm. On 2/25/20, a telephone order indicated R14 was okay to do his own wound care. The order was obtained by registered nurse (RN)-A from R14's regular physician, not from a provider at the wound clinic. On 3/3/20, at approximately 1:15 p.m. R14 was observed seated in a common area, his dressing was slipping off of his leg. On 3/4/20, at 11:38 a.m. R14 was seated in a common area, he pulled up his pant leg to show his dressing, it was clean, dry, and intact. R14 stated the nurse manager had completed his dressing change that morning. On 3/5/20, at 10:45 a.m. during a telephone interview with the nurse practitioner (NP)-B at R14's outside wound care clinic, NP-B stated she was not aware R14 was doing his own dressing changes. NP-B stated she did not believe R14 was capable of doing his own dressing changes. NP-B stated R14 was not making progress in wound healing on his legs. NP-B stated she had heard from other residents at the facility there was not enough staff, and they were not getting their dressing changes/treatments completed. On 3/5/20, at 1:06 p.m. R14 was observed changing his dressing. R14 made several statements that he would prefer the nursing staff to complete his dressing changes. R14 stated if they would be on it every other day, he would rather the nurses would do the dressing changes. R14

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) removed the sleeve dressing and threw it on the floor, then removed the old dressings throwing those into the waste basket. RN-A noted a new blister on R14's left leg mid-anterior which she measured. RN-A advised R14 not to pop the blister or place medication on the blister or on the open area that was caused by removing tape the day before. R14 did not wash his hands or use hand sanitizer after removing the old dressings. After washing his legs and allowing the area to dry, R14 used his finger to place the cream on his open skin areas, then wiped his finger on a towel. R14 opened the foam dressing, cut a piece to fit, taped over the foam dressing, and covered the blister. R14 continued to treat two other open areas, missing an open area below his knee. R14 stated he was done. R14 used his reacher to pick up the soiled sleeve dressing off the floor, and was stopped before he placed the soiled sleeve dressing onto the clean dressing. RN-A verified he should not use the dressing that had been on the floor, and left the room to obtain a clean dressing. R14 verified he had not washed his hands or sanitized his hands prior to the start of his wound care or at anytime during the process. R14 tossed the towel he had used to the floor in the corner of his room. An used washcloth was observed hanging off of his walker, the floor was littered with items that had missed the waste basket, he was observed to handle his urinal, and then put away his dressing supplies. R14 stated he had not completed his treatment for [REDACTED]. R14 stated he was unable to do the abdominal (pannus, groin, breast) wound care without help stating, I can't see it. On 3/5/20, at 10:31 a.m. RN-A was interviewed and stated she completed R14's wound measurements weekly. RN-A stated the wounds on R14's toes were healed. RN-A stated R14's wounds would start to heal, and then would start to look worse. RN-A stated R14 was not good about keeping his legs elevated, and stated he consumed unhealthy snacks (high carbohydrate content) and sugar drinks. RN- A verified on R14's February TAR that he had 13 missing treatments for cleansing his wounds (legs). R14's stated the order did not make sense to cleanse his legs every shift when the dressing change was ordered on Monday, Wednesday, and Friday. RN-A verified she would expect staff to question an order that did not make sense, and for most of February the wound cleansing was documented as completed every shift. RN-A was not able to explain how this could be possible with only Monday, Wednesday, and Friday dressing changes. R14's February TAR had missing documentation for seven missed wound care/dressing changes for his right and left abdominal folds. RN-A verified the missing treatments. On 3/5/20, at 1:59 p.m. RN-A stated, It looks like he is having a harder time doing the dressing change. RN-A stated it had been a few weeks since she had last observed R14 complete his dressing change. RN-A verified R14 did not wash or sanitize his hands at any point during the procedure, and he was going to use the sleeve dressing after picking it up off of the floor. RN-A stated she had obtained an order for [REDACTED]. the time. When she was asked if there was enough staff to complete all of the ordered dressing changes RN-A stated, Honestly, no. On 3/5/20, at 2:48 p.m. the director of nursing (DON) and the administrator were interviewed. The DON stated she would expect the nurse manager (NM) to determine a resident's ability to complete their own dressing changes by observing them. The DON stated, You can't stop someone from doing their own dressing change even if they aren't competent. The DON stated she would expect a resident's competency would be assessed quarterly or with a significant change. The DON stated if the resident's wound was getting worse, she would expect the NM to re-educate the resident, and if the resident was not competent, staff should offer to do the dressing change. The DON and administrator stated the nurse working on the medication cart was the person responsible for completing wound care and dressing changes. Both stated audits on wound care were completed, and they did not find any residents who had missed treatments or dressing changes. Both stated there was enough staff scheduled to complete wound care and dressing changes. The facility policy Pressure Injury/Skin Integrity Wound Management dated 11/16, directed staff to complete wound assessments upon admission, weekly, quarterly, re-admission or with a significant change in condition, and annually. The policy further directed staff to have the care plan reflect resistance or refusals to interventions, and to document alternatives, as well as education to the resident regarding the risks. The facility policy Infection Prevention and Control dated 11/16, directed there was a system in place for when and how isolation should be used, and on standard and transmission based precautions. A policy on enhanced barrier precautions was requested, a one page handout was provided. The untitled handout directed everyone to clean their hands upon entering and exiting the room, to wear gloves and gowns for high-contact resident care activities including wound care (defined as any skin opening requiring a dressing).
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure dressing changes were completed according to physician orders [REDACTED]. This resulted in actual harm for R13 whose pressure ulcer worsened. Findings include: Pressure ulcer stages from the National Pressure Ulcer Advisory Panel (NPUAP): Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. R13's Face Sheet printed 3/5/20, identified [DIAGNOSES REDACTED]. R13's annual Minimum Data Set ((MDS) dated [DATE], indicated R13 was cognitively intact, and required assistance of staff with bed mobility, transfers, personal hygiene, and set up for toileting. The MDS also identified R13 was at risk for the development of pressure ulcers, and currently had one Stage 2 pressure ulcer. The MDS also indicated R13 had a pressure reducing device for in the bed and the chair, and had nutrition or hydration inventions to manage skin problems. R13's care plan dated [DATE]5/19, indicated R13 was at risk for impaired skin integrity and pressure related to the need for assistance with activities of daily living (ADLs). R13's goal was for skin to remain clean, dry and intact, and have decreased potential for development of pressure injuries. R13's care plan directed the use of pressure reducing cushions in wheelchair and on bed, medications, labs, and treatments as ordered. On 1/24/20, R13's Advanced Wound Care and Hyperbaric Center visit noted indicated R13's left heel continued to show areas of pressure and significant macerated peri-wound. The note further indicated R13 had arrived again with a soaked dressing that had not been changed from R13's shower earlier that day at the facility. The note further indicated R13 had arrived at the Advances Wound Care Center with soaked dressings in the past despite calls to the facility which instructed R13's dressing to be removed prior to shower, and gauze placed over wound until R13's wound appointment. Left heel ulcer measured 0.9 centimeters (cm) x 0.5 cm x 0.2 cm. On 1/31/20, the Advanced Wound Care and Hyperbaric Center visit noted indicated R13's left heel ulcer had significantly improved from last week. R13 did not arrive with a wet dressing, and maceration to left heal showed improvement. Left heel ulcer measured 0.9 cm x 0.3 cm x 0.2 cm. On 2/10/20, R13's Wound Assessment Flow Sheet indicated R13's left heel wound ulcer measured 0.9 cm x 0.7 cm x 0.1 cm. On 2/17/20, R13's Wound Assessment Flow Sheet indicated R13's left heel wound ulcer measured in 0.9 cm x 0.6 cm x 0.1 cm. On 2/18/20, the Advanced Wound Care and Hyperbaric Center visit note indicated R13's left heel ulcer looked good and was heading in the correct direction. Left heel ulcer measured 0.4 cm x 0.2 cm x 0.2 cm. On [DATE], a progress note indicated R13 complained of left ankle pain, was offered [MEDICATION NAME] (narcotic pain medication) but declined. The note further indicated R13 called 911 and Emergency Medical Services (E[CONDITION]) arrived and transported R13 to St. Luke's. On [DATE], emergency department (ED) summary indicated R13 was seen at the ED for left heel infection with increased pain. R13's preliminary x-ray results were negative for [CONDITION], and R13 was started on [MEDICATION NAME] (antibiotic), returned to the facility, and was instructed to have a follow up appointment that week. On 2/25/20, a progress note indicated R13 left at 10:00 a.m. for his wound care appointment. The Advanced Wound Care and Hyperbaric Center called the facility and stated R13 would be admitted to the hospital due to [DIAGNOSES REDACTED]. On 2/25/20, the Advanced Wound Care and Hyperbaric Center visit note indicated R13's left heel ulcer had worsened from last week's visit, and started to get some tissue necrosis (tissue death). Due to the worsened appearance and deterioration of the wound, R13 was admitted to the hospital for IV antibiotics and evaluation to make sure wound did not turn into a necrotizing type of infection and to rule out [CONDITION] (bone infection). R13's pressure ulcer measured 3.6 cm x 3.4 cm x 0.4 cm. The note further indicated a registered nurse (RN) from the wound clinic spoke with RN-B at the facility to update of R13's admission, and was told there were issues to address with staff but would not elaborate. On 2/28/20, R13's hospital discharge summary indicated R13 was admitted on [DATE], from the wound care clinic for [MEDICAL CONDITION], left heel ulcer which was reddened, sore, and tender. R13 had a computed tomography (CT) scan (a medical imaging procedure allowing the user to see inside the object without cutting) showed no deep space infection or [CONDITION]. R13 received a broad spectrum antibiotic intravenously with some improvement, and was seen by infectious disease. Discharge instructions to left heel wound instructed: Cleanse and dry with saline and gauze. Use skin prep to skin about the bound bed and allow to dry. Lotion to remainder of both feet and legs. Cover with [MEDICATION NAME] foam 4 x 4 and [MED]. Use heel boots at all time to both feet when sitting or in bed, and follow up with Wound Care as scheduled. On 3/2/20, R13's Wound Assessment Flow Sheet indicated R13's left heel wound ulcer measured in 0.5 cm x 0.4 cm x 0.1 cm. On 3/4/20, at 1:40 p.m. R13 was interviewed and stated staff at the facility were not changing the dressing to his left heel ulcer. R13 stated he started to experience more pain in his left heel so he told RN-B that he was going to call E[CONDITION] to go the ED to be evaluated. R13 stated

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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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) when E[CONDITION] arrived, R13 was asked why he needed to go to the ED, and R13 stated he told E[CONDITION] no one had been changing his left heel dressing, and it was getting worse and painful. R13 was observed to have his left boot protector on, cushion was on the wheelchair, and pressure relief mattress was on the bed. On 3/4/20, at 1:55 p.m. RN-C was interviewed and stated she did not change R13's left heel dressing on 02/13, 2/19, 2/20, and 2/25. RN-C stated R13's dressing were not changed because there was not enough time in the work day to get it done. RN-C stated there had been a lot of staff turnovers, and an increase in resident care levels on R13's unit, so treatments were not being done including R13's left heel ulcer. RN-C stated R13 went to the ED on [DATE], due to increased left foot pain. RN-C stated R13's left heel ulcer had been improving prior to R13's hospitalization . RN-C stated R13's daily wound care to his left heel ulcer not being completed for several days contributed to his foot pain, deterioration of R13's heel ulcer, and hospitalization . On 3/4/20, at 2:40 p.m. RN-B was interviewed. RN-B stated on [DATE], R13 called E[CONDITION] for left foot pain, and she was alerted by R13 at that time his left heel dressing changes were not being completed. RN-B stated she completed a review of dressing changes for February, and determined there were blanks spaces on R13's treatment administration record (TAR) from 2/19/20, through [DATE], indicating R13 did not receive daily dressing changes to left heel ulcer as ordered. RN-B stated she had spoken with RN-C, and RN-C admitted she did not complete R13's dressing changes on 2/13, 2/19, 2/20, and 2/25, because it was too busy, and there was not enough time to get all the work done on the her shift. RN-B stated calls were made to the other nursing staff that worked the remaining days R13's dressing changes were not signed off as being completed, and she has had no return calls. RN-B stated she would expect staff to notify her if they were unable to get their work done during their shift, and it was unacceptable to not do the work. RN-B verified R13's medical record lacked documentation R13's dressing changes to his left heel ulcer were completed on 2/11, 2/13, 2/15, 2/16, and 2/21-2/24. RN-B stated R13 was seen at the wound clinic on 2/18/20, and his wound had been improving. RN-B stated R13's missed wound care contributed to R13's hospitalization and worsening of R13's wound. On 3/4/20, at 3:45 p.m. the director of nursing (DON) and administrator were interviewed. The DON stated R13 did not have an infection in his left heel prior to his hospitalization on [DATE], and further stated R13's left heel ulcer had been healing. The DON would only confirm 4 out of the 8 dressing changes were not completed. The DON further stated interviews with the other nurses who were involved needed to be completed to determine why R13's chart lacked documentation that R13's wound care was not completed. The DON stated if R13's dressing changes were completed daily, the nurses would have noticed any changes to R13's left heel ulcer. On 3/5/20, at 9:26 a.m. the DON and administrator provided documentation of telephone conversations between the DON, RN-D, and licensed practical nurse (LPN)-B regarding R13's missed dressing changes. The DON stated she spoke with LPN-B on the phone 3/4/20. LPN-B stated she did not change R13's left heel dressing on 2/21/20, because she did not have time, and she failed to report it to the next shift. The DON stated she spoke with RN-D on the phone 3/4/20. RN-D stated she did not have enough time to complete R13's left heel dressing change on 2/22/20, and failed to report to the next shift that R13's dressing change was not completed. The DON stated education was provided to RN-D and LPN-B on reporting to the charge nurse or DON if work was unable to be completed. The administrator stated a time study would be completed to determine why the nurses were unable to complete their workload. The facility policy Pressure Injury/Skin Integrity/Wound Management dated 11/16, directed residents with pressure injuries will received treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure injuries form developing.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure sufficient staff was available for 2 of 3 residents (R13, R14) reviewed for pressure ulcers/skin conditions. The practice had the potential to affect all 10 residents (R15, R16, R17, R18, R19, R21, R22, R23, R24, and R25) who received scheduled dressing changes at the facility. Findings include: See F684: The facility failed to ensure 1 of 1 resident (R14) was competent to perform his own wound care and dressing changes. See F686: The facility failed to ensure dressing changes were completed according to physician orders [REDACTED]. On 3/5/20, at 10:45 a.m. nurse practitioner (NP)-B was interviewed. NP-B stated she was the NP who treated R14 at the wound care clinic. NP-B stated she was not aware R14 was doing his own dressing changes, and she did not believe he was capable of doing his own dressing changes. NP-B stated R14 was not making progress with wound healing on his legs. NP-B stated she had heard from other residents at the facility there was not enough staff, and they are not getting their dressing changes or treatments completed. On 3/5/20, at 1:12 p.m. prior to beginning his dressing change R14 made several statements that he would prefer the nursing staff to complete his dressing changes. R14 stated if the nurses would be on it every other day, he would rather they would do the dressing changes. On 3/5/20, at 2:48 p.m. the director of nursing (DON) and the administrator were interviewed. The DON stated she would expect the nurse manager (NM) to determine a resident's ability to complete their own dressing changes by observing them. The DON stated, You can't stop someone from doing their own dressing change even if they aren't competent. The DON stated she would expect a resident's competency would be assessed quarterly or with a significant change. The DON stated if the resident's wound was getting worse, she would expect the NM to re-educate the resident, and if the resident was not competent, staff should offer to do the dressing change. The DON and administrator stated the nurse working on the medication cart was the person responsible for completing wound care and dressing changes. Both stated audits on wound care were completed, and they did not find any residents who had missed treatments or dressing changes. Both stated there was enough staff scheduled to complete wound care and dressing changes. On 3/5/20, at 3:40 p.m. employee (E)-A was interviewed. E-A stated they didn't want to get fired for talking with someone from the state. E-A stated there was not enough staff to care for residents in the facility, and staff missed breaks and meals in order to complete cares for residents. E-A stated it had been rough the last eight months,and there was not enough time to provide the care the residents required. E-A stated the care for residents has gotten heavier due to more residents with behaviors, homelessness, detoxing, and really sick people. E-A was fearful of losing their employment if they spoke up to administration, stating staff are stressed and concerned about being suspended or fired. On 3/4/20, at 1:40 p.m. R13 was interviewed and stated staff at the facility were not changing the dressing to his left heel ulcer. R13 stated he started to experience more pain in his left heel so he told registered nurse (RN)-B that he was going to call emergency medical services (E[CONDITION]) to go the emergency department (ED) to be evaluated. R13 stated when E[CONDITION] arrived, R13 was asked why he needed to go to the ED, and R13 stated he told E[CONDITION] no one had been changing his left heel dressing, and it was getting worse and painful. R13 was observed to have his left boot protector on, cushion was on the wheelchair, and pressure relief mattress was on the bed. On 3/4/20, at 1:55 p.m. RN-C was interviewed and stated she did not change R13's left heel dressing on 02/13, 2/19, 2/20, and 2/25. RN-C stated R13's dressing were not changed because there was not enough time in the work day to get it done. RN-C stated there had been a lot of staff turnovers, and an increase in resident care levels on R13's unit, so treatments were not being done including R13's left heel ulcer. RN-C stated R13 went to the ED on [DATE], due to increased left foot pain. RN-C stated R13's left heel ulcer had been improving prior to R13's hospitalization . 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RN-B stated calls were made to the other nursing staff that worked the remaining days R13's dressing changes were not signed off as being completed, and she has had no return calls. RN-B stated she would expect staff to notify her if they were unable to get their work done during their shift, and it was unacceptable to not do the work. RN-B verified R13's medical record lacked documentation R13's dressing changes to his left heel ulcer were completed on 2/11, 2/13, 2/15, 2/16, and 2/21-2/24. RN-B stated R13 was seen at the wound clinic on 2/18/20, and his wound had been improving. RN-B stated R13's missed wound care contributed to R13's hospitalization and worsening of R13's wound. On 3/4/20, at 3:45 p.m. the director of nursing (DON) and administrator were interviewed. The DON stated R13 did not have an infection in his left heel prior to his hospitalization on [DATE], and further stated R13's left heel ulcer had been healing. 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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) further stated interviews with the other nurses who were involved needed to be completed to determine why R13's chart lacked documentation that R13's wound care was not completed. The DON stated if R13's dressing changes were completed daily, the nurses would have noticed any changes to R13's left heel ulcer. On 3/5/20, at 9:26 a.m. the DON and administrator provided documentation of telephone conversations between the DON, RN-D, and licensed practical nurse (LPN)-B regarding R13's missed dressing changes. The DON stated she spoke with LPN-B on the phone 3/4/20. LPN-B stated she did not change R13's left heel dressing on 2/21/20, because she did not have time, and she failed to report it to the next shift. The DON stated she spoke with RN-D on the phone 3/4/20. RN-D stated she did not have enough time to complete R13's left heel dressing change on 2/22/20, and failed to report to the next shift that R13's dressing change was not completed. The DON stated education was provided to RN-D and LPN-B on reporting to the charge nurse or DON if work was unable to be completed. The administrator stated a time study would be completed to determine why the nurses were unable to complete their workload. The Facility Assessment Tool dated 1/29/20, directed there must be sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of reach resident, as determined by resident assessments and individual plans of care and considering the number, acuity and [DIAGNOSES REDACTED].