Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 27, 2024

Administrator
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, MN 55416

RE: CCN: 245460
Cycle Start Date: November 14, 2024

Dear Administrator:

On November 14, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 14, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 14, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
November 27, 2024

Administrator
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, MN 55416

Re: State Nursing Home Licensing Orders
Event ID: 43P411

Dear Administrator:

The above facility was surveyed on November 12, 2024 through November 14, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

(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
E 000	Initial Comments On 11/12/24 through 11/14/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/12/24 - 11/14/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H54601118C (MN106684) H54601117C (MN107274) H54601119C (MN107997 The following complaint was reviewed: H54601180C (MN107932) with a deficiency issued at F699. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 12/05/2024

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 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		12/23/24

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F 584	Continued From page 2 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a sanitary and homelike environment for 1 of 1 residents (R55) who had dried feeding tube-like substance on their feeding tube pole, dresser, bed, and floor. Findings include: R55's quarterly Minimum Data Set (MDS) dated 9/12/24, indicated R55 had intact cognition and depended on staff for assistance with dressing, transferring, and bed mobility. The MDS indicated R55 received over 50 percent of her total calories through a feeding tube. R55's medication administration record (MAR) dated 11/1/24 indicated received daily feedings from 9 p.m. to 11 a.m. During an observation on 11/12/24 at 11:20 a.m., R55 was observed lying in bed on the left side of the room with a feeding pump attached to a pole to her right. To the right of the pole was a dresser	F 584	F000 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. F 584 Safe/Clean Homelike Environment 1. Corrective Action: The substance on the floor was cleaned and sanitized in R55's room. The room sanitation policy was reviewed and remains current. Housekeeping and nursing staff will be	

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F 584	Continued From page 3 and in front of the pole was a bedside table. The dresser had splatters of a light brown/yellow substance scattered over the side and front of the dresser. The light brown/yellow substance was also observed scattered over the bottom one-fourth of the feeding pump pole, the carpet on the right side of the bed, and the right bed rail/frame of R55's bed. During an observation and interview on 11/13/24 at 11:02 a.m., the light brown/yellow substance was again observed in R55's room as described above. R55 stated she did not like that the brown substance was on her furniture and floor and at home she would have cleaned it up immediately. R55 stated she had family visit her at least a few days ago, and they noticed the brown substance on the furniture and floor, and it bothered her that her room was not clean especially when she had visitors. R55 stated she assumed the brown substance was tube feeding solution. R55 stated staff cleaned it up "whenever they feel like it" and most of her furniture hadn't been cleaned for several months. During an interview on 11/13/24 at 11:19 a.m., registered nurse (RN)-A stated she was the nurse in charge of R55's care and had stopped her tube feeding this morning. RN-A stated she was unsure how long the tube feeding had been on R55's furniture and floor. RN-A stated it should have been cleaned by either housekeeping or nursing staff but looked like it had not been. During an interview on 11/14/24 at 11:51 a.m., the unit nurse manager (RN)-B stated she expected nursing staff to clean the resident furniture and tube feeding pole as the spills occurred and housekeeping should have been called if nursing	F 584	re-educated on the Sanitary Environment policy. 2. Corrective Action as it applies to other residents: Other rooms have been audited to ensure sanitary and homelike environment. 3. Date of Completion: 12/23/24 4. Reoccurrence will be prevented by twice weekly audits of a minimum of 5 resident rooms for sanitary and homelike environment for 6 weeks. Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine if further action or auditing is necessary. 5. The Correction will be monitored by: Director of Environmental Services or designee.	

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F 584	Continued From page 4 staff was unable to clean the spill. RN-B stated staff should have cleaned the dried tube feeding to ensure R55's had a home-like environment and infection control measures were practiced. A policy regarding resident room cleaning was requested and not received.	F 584		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were followed and new interventions were implemented in a timely manner when resident pain goals were not met for 1 of 1 residents (R44) to ensure comfort and reduce the risk of complications. Findings include: R44's quarterly Minimum Data Set (MDS) dated 9/25/24, indicated R44 had intact cognition. The MDS indicated R44 was on a scheduled and as-needed (PRN) pain medication regimen and received non-pharmocological interventions for pain. The MDS indicated R44 had pain almost constantly over the past five days and it made it hard for R44 to sleep constantly and occasionally limited day-to-day activities.	F 697	F 697 -Pain Management 1. Corrective Action: R44's pain management care plan was reviewed and updated. The pain management policy has been reviewed and remains current. Licensed staff will be re-educated on the Pain assessment process. Licensed staff and Trained Medication Aides will receive re-education on the pain management and intervention policy. 2. Corrective Action as it applies to other residents: All other residents who have reported pain in their pain assessment have been reviewed to ensure proper follow up is occurring after pain medications are given and care plans are being followed. 3. Date of Completion: 12/23/24 4. Reoccurrence will be prevented by:	12/23/24

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F 697	Continued From page 5 R44's care plan dated 6/5/24, indicated R44 had pain related to multiple factors including lumbar spinal stenosis (narrowing of the spinal canal causing pressure on the nerves) with radiculopathy (a pinched nerve), osteoarthritis (a joint disease that can cause pain stiffness or swelling), osteoporosis (weak and brittle bones), and failed back surgery syndrome (pain following back surgery). The care plan indicated staff should give pain medications per schedule to maintain therapeutic levels, offer non-pharmacological interventions, and notify the provider of inadequate pain relief. R44's pain interview and evaluation dated 9/23/24, indicated R44 rated her pain at a seven out of ten and had non-verbal signs of pain such as moaning and grimacing. The assessment indicated R44's pain goal was zero out of ten. The assessment indicated R44's pain management plan included diclofenac gel (pain gel) and 1000 milligrams (mg) of Tylenol three times a day. R44's provider progress note dated 10/8/24, indicated R44 had a left arm fracture requiring surgery with ongoing discomfort to the left elbow area. The note indicated R44 currently had 50 mg of Tramadol (a narcotic pain medication) available every eight hours PRN but R44 stated her pain was not well-controlled with this schedule. The provider agreed to increase the medication to every six hours PRN. The note also indicated R44 had lumbar spinal stenosis (narrowing of the spinal canal causing pressure on the nerves) with radiculopathy (a pinched nerve). R44's medication administration record (MAR)	F 697	Weekly audits of a minimum of 5 residents will be conducted for 8 weeks to ensure proper follow up is completed for pain management. 5. The Correction will be monitored by: The Director of Nursing or Designee.	

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F 697	Continued From page 6 dated 10/1/24 through 11/11/24, indicated R44 had orders for the following medications: - 1000 mg of Tylenol three times a day dated 1/15/24 - 400 mg of gabapentin daily at bedtime dated 5/3/24 - two lidocaine patches (pain patch) daily dated 7/23/24 - 100 mg of gabapentin (medication used for nerve pain) two times a day dated 8/15/24 - one percent diclofenac gel available every eight hours PRN dated 8/26/24 - 0.2596 mg total daily dose of hydromorphone (narcotic pain medication) through an implanted pain pump dated 9/3/24 - 50 mg of PRN tramadol available every eight hours dated 9/17/24 through 10/8/24 - 50 mg of PRN tramadol available every six hours dated 10/8/24. - 30 mg daily (10/19/24-10/24/24), 20 mg daily (10/25/24-10/27/24), and 10 mg (10/28/24-10/30/24) of prednisone (a steroid) ordered for gout (a form of arthritis that can cause severe pain, swelling, and joint tenderness) R44's progress notes, order administration notes, pain scores, and MAR dated 10/27/24 through 11/11/24 were reviewed and indicated: - On 10/27/24 at 2:24 a.m., tramadol was given for six out of ten pain. A follow-up pain score was assessed at 7:01 a.m., an eight out of ten and the medication was documented as being "ineffective". The note did not include what new pain interventions were implemented and if needed, the provider was notified. - On 10/27/24 at 10:13 a.m., tramadol was given for eight out of ten pain. At 12:43 p.m., left elbow elevation, and a cold compress were applied to the left elbow for swelling, pain, and slight	F 697		

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F 697	Continued From page 7 warmth. The note indicated this information would be reported to the oncoming nurse. A follow-up pain score was assessed at 1:17 p.m., at eight out of ten and the medication was documented as being "ineffective". The note did not include what further pain interventions were completed at that time or if the provider had been notified. - On 10/27/24 at 4:36 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 5:19 p.m., at seven out of ten and the medication was documented as being "effective". - On 10/28/24 at 1:24 p.m., tramadol was given for seven out of ten left elbow pain. A follow-up pain score was assessed at 2:07 p.m., at five out of ten and the medication was documented as being "effective". - On 10/29/24 at 9:56 a.m., R44 requested a physical therapy evaluation as she thought that might help with her pain, so the nurse left a message for the nurse practitioner. At 10:58 a.m., the nurse left a message for nurse practitioner who was in the building, but the note did not indicate what the message was regarding. - On 10/30/24 at 8:03 a.m., tramadol was given for six out of ten left leg pain. A follow-up pain score was assessed at 1:01 p.m., at eight out of ten and the medication was documented as being "ineffective". The note did not include what further pain interventions were completed at that time or if the provider had been notified. - On 10/30/24 at 8:06 p.m.,tramadol was given for eight out of ten left leg pain. A follow-up pain score was not documented. - On 11/1/24 at 9:19 a.m., tramadol was given for eight out of ten left elbow pain. A follow-up pain score was assessed at 10:12 a.m., at four out of ten and the medication was documented as being "effective".	F 697		

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F 697	Continued From page 8 - On 11/2/24 at 8:58 a.m., tramadol was given for eight out of ten left elbow pain. A follow-up pain score was assessed at 9:40 a.m., at four out of ten and the medication was documented as being "effective". - On 11/4/24 at 9:30 p.m., tramadol was given for seven out of ten pain. A follow-up pain score was not documented. - On 11/6/24 at 2:04 p.m., the nurse stated she had talked to the nurse practitioner, and she was working on "the order". - On 11/8/24 at 7:43 a.m., tramadol was given for seven out of ten pain. A follow-up pain score was not assessed until 12:55 p.m., and was seven out of ten and the medication was documented as being "ineffective". - On 11/8/24 at 1:12 p.m., tramadol was given for seven out of ten pain. A follow-up pain score was assessed at 3:22 p.m., at six out of ten and the medication was documented as being "effective". - On 11/9/24 at 6:09 a.m., tramadol was given for eight out of ten pain. A follow-up pain score was not assessed until 1:16 p.m., and was eight out of ten and the medication was documented as being "ineffective". - On 11/9/24 at 1:16 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 7:28 p.m., at six out of ten and the medication was documented as being "effective". - On 11/9/24 at 7:28 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 8:39 p.m., at six out of ten and the medication was documented as being "effective". - On 11/10/24 at 8:00 a.m., tramadol was given for eight out of ten pain. A follow-up pain score was not assessed until 12:55 p.m., and was seven out of ten and the medication was documented as being "ineffective". The note indicated the resident stated this medication "	F 697		

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F 697	Continued From page 9 only helps a bit". - On 11/10/24 at 4:43 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 7:09 p.m., at six out of ten and the medication was documented as being "effective". - On 11/11/24 at 8:23 a.m., tramadol was given for eight out of ten in the left elbow pain. A follow-up pain score was assessed at 10:09 a.m., and was five out of ten. The medication was documented as being "ineffective" and an ice pack was offered. The note did not indicate if a pain follow-up assessment was completed to ensure the non-pharmacological intervention was effective. During an interview on 11/14/24 at 8:51 a.m., nurse practitioner (NP)-A stated she was R44's primary care provider and managed her pain plan. NP-A stated R44 had pain related to a broken elbow that did not heal correctly and chronic back pain. NP-A stated she had not gotten any reports in the last few weeks from nursing staff indicating the current pain plan was not effectively managing her pain. NP-A stated she had gotten a report and had worked on orders regarding getting R44 physical therapy per her request but R44 had not qualified for this. NP-A stated if she had gotten a report from nursing staff indicating R44's pain was inadequately managed, she would have followed up with R44 to evaluate possible interventions but stated she doubted her pain would ever be under a seven out of ten. During an interview on 11/14/24 at 10:21 a.m., R44 stated she did not feel like her pain was well controlled and would like her pain at a maximum of 3 out of 10. R44 stated her pain was usually in	F 697		

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F 697	Continued From page 10 her back or her left elbow and lately had been sitting at a seven or eight out of ten. R44 stated she did not feel like the staff believed her pain was as bad as it felt to her and were not providing adequate pain interventions even when she was telling them her pain was still higher than what was tolerable for her. R44 stated she feels like the facility does not listen to her when she tells them she still has pain and the pain interventions that have been attempted didn't help. During an interview on 11/14/24 at 10:28 a.m., registered nurse (RN)-C stated the trained medication aides (TMA) were responsible for asking residents what their pain levels were and then following up later to ensure the medication was effective. RN-C stated he thought R44's pain goal was zero out of ten. RN-C stated if a resident did not meet their pain goal after a PRN medication was given, then the TMA would offer a non-pharmacological intervention. RN-C stated he expected the TMA to complete this follow up assessment to determine if the residents pain goal was met after administering PRN pain medications or non-pharmacological interventions. RN-C stated if the pain goal was not met, he expected to be notified and then he would call the NP to determine what further interventions could be attempted and then that would be documented in the progress notes. During an interview on 11/14/24 at 10:58 a.m., RN-D, the unit nurse manager, stated she would expect the TMA to alert the nurse if the resident is reporting pain so the nurse could assess the resident and determine appropriate interventions. RN-D stated she would expect the nurse to follow up with the resident to determine if the resident's pain goal had been met after the pain intervention	F 697		

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F 697	Continued From page 11 had been implemented. RN-D stated if they had already attempted the PRN medications available as well as non-pharmacological interventions she would expect nursing staff to notify the NP that the resident's pain goal was not being met so they can see if pain medication regimen needs to be updated, such as scheduling pain medications, ensuring they are using the right medication and it is being dosed effectively. RN-D stated she was unsure what the expectation was for how long after a pain medication was given, nursing staff should re-evaluate pain levels, but thought it would be around an hour. A policy regarding resident pain management was requested and not received.	F 697		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess past trauma and develop a comprehensive person-centered care plan with goals and interventions utilizing a trauma-informed approach including monitoring of post traumatic stress disorder (PTSD) for 1 of 1 residents (R79) reviewed for trauma-informed care.	F 699	F 699 – Trauma Informed Care 1. Corrective Action: R79's care plan was updated immediately to reflect trauma and appropriate interventions related to trauma informed care. The Trauma Informed Care Policy was reviewed and remains current. Social Services and Nursing staff will be re-educated on the	12/23/24

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F 699	Continued From page 12 Findings include: R79's quarterly Minimum Data Set (MDS) dated 9/24/24, indicated R79 was 80 years old, was cognitively intact and the MDS further indicated R79 was widowed, suffered from feelings of depression or hopelessness several days a week, and always socially isolated. R79's diagnoses sheet, dated 11/13/24, indicated the following diagnoses: post-polio syndrome (a condition that causes gradual muscle weakness and atrophy), hypertension (high blood pressure), hemiplegia (paralysis or weakness on one side of the body), and schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly) and altered mental status. An Associated Clinic of Psychology (ACP) progress note dated 6/24/24, indicated R79's social history included an alcoholic father, had lost two siblings, had suffered the loss two sons who died as infants, and was the victim of an abusive partner. It further indicated R79 suffered from flashbacks of her traumatic experiences. ACP progress note dated 9/13/24, indicated R79 exhibited behavioral and emotional symptoms that affect functioning, was paranoid and lacked trust in others. R79's facility Psychosocial/History assessment dated 6/24/24, indicated resident had experienced life threatening or traumatic events that included: polio as a child, her first husband died at age 35, her second husband committed suicide, loss of two children in infancy, and had history of a stroke. The assessment further indicated R79 had been intimidated, hurt,	F 699	Trauma Informed Care Policy and Procedures. 2. Corrective Action as it applies to other residents: All resident care plans have been reviewed to ensure previous trauma has been reflected in the resident's care plan. 3. Date of Completion: 12/23/24 4. Reoccurrence will be prevented by: All residents in facility will be reviewed. Newly admitted residents will be audited upon the first 14 days of admission to ensure Trauma Informed Care is included in the care plan if necessary. Audits will be completed weekly for 8 weeks. Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine if further action or auditing is necessary. 5. The Correction will be monitored by: The Director of Social Services or Designee.	

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F 699	Continued From page 13 manipulated, or controlled by her second husband who was verbally and physically abusive towards her. R79's care plan printed 11/13/24, at 12:05 p.m. lacked any information on trauma informed care or trauma triggers. A care plan printed on 11/13/24, at 2:15 p.m. indicated R79's care plan had been updated to include trauma informed care with an initiation date of 11/13/24, three days after survey entrance. During interview on 11/13/24, at 1:09 p.m. certified nursing assistant (CNA)-A stated he was familar with R79 and worked with her frequently. CNA-A stated he did not now if R79 was a trauma survivor but did have behavioral issues. CNA-A stated he did some online education for trauma-based care but nothing specific to R79. During interview on 11/13/24, at 1:21 p.m. registered nurse (RN)-F stated she was familiar with R79 and worked with her frequently. RN-F stated she would occasionally take R79 outside if she was exhibiting behavioral issues but could not identify any specific trauma informed care-based interventions for R79. During interview on 11/13/24 at 1:35 p.m. transitional care unit charge nurse (TCU-CN) stated when a resident is assessed by social workers the information is shared with staff, used to create the plan of care, and discussed in interdisciplinary meetings. TCU-CN went on to say the facility meets with ACP providers weekly to discuss resident care and will reach out to them for instruction, assistance, or guidance on how to treat residents with history of trauma.	F 699		

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F 699	Continued From page 14 During interview on 11/13/24 at 2:40 p.m. director of nursing (DON), stated she was familiar with R79, and she required total care and assistance. DON stated R79 had trauma history including emotional and physical abuse, death of children and dealing with law enforcement. She went on to say R79 would frequently isolate herself, exhibited fear of the government and it was difficult to identify what was trauma and what was delusion. DON stated she would expect any resident who had experienced trauma would have trauma informed care addressed on their care plan and it should identify what the trauma was and how to minimize risk of retraumatizing. DON confirmed R79's care plan did not previously include trauma informed care, did not include trauma triggers or interventions but had been updated on 11/13/24, three days after survey entrance, to include trauma informed care, triggers and interventions. DON stated it was important to know and understand a residents trauma history to avoid re-traumatization.	F 699		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		12/23/24

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F 758	Continued From page 15 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure orders for PRN (as needed) psychotropic medication (mood altering medications) were time limited to 14 days. In	F 758	F758 □ Unnecessary Medications Corrective Action: A medication review was completed for R79 and R40. Changes were made the orders of these	

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F 758	Continued From page 16 addition, the facility failed to ensure provider assessment and documentation of rationale and duration of continuation of a psychotropic PRN medication beyond 14 days occurred for two of six residents (R70 and R40) reviewed for PRN psychotropic medication use. The facility further failed to ensure an indication for use was present for one of six residents (R40) reviewed for psychotropic medication. Findings include: R70 R70's significant change Minimum Data Set (MDS) dated 9/13/24, indicated R70 was moderately cognitively impaired with the diagnoses of cancer. Section O. indicated R70 was receiving hospice services at the facility. The Current Order Summary dated November 2024, included the order: lorazepam (medication which act on the brain and nerves to produce a calming effect) oral concentrate 2 milligrams per milliliter (mg/ml) Give 0.5 mg by mouth every 2 hours as needed for anxiety, sleep, severe nausea. The stop date was listed as indefinite. R70's provider order for lorazepam documented, lorazepam oral concentrate mg/ml, give 0.5 mg by mouth every 2 hours as needed for anxiety, sleep, severe nausea. provider order did not document it was time limited to 14 days or less. R70's medication administration record showed that R70 had not received a dose of the ordered lorazepam between the dates of 9/6/24 to 11/13/24.	F 758	medications to ensure the appropriate rationale for use is provided and psychotropic medications have a 14 day review period. The Psychopharmacologic drug use policy was reviewed and remains current. Corrective Action: All residents in house will be reviewed to ensure medications have appropriate rationale and the appropriate review dates are in place and medications are discontinued if not being used. Providers, nurse managers, and Health Unit Coordinators will be educated the Psychopharmacologic drug use policy to ensure the correct systems are in place. Date of Completion: 12/23/24 Reoccurrence will be prevented by audits of a minimum of 4 residents will be completed once per week for 6 weeks to ensure compliance. Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to determine if further correction is necessary. The Correction will be monitored by: The DON or designee.	

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F 758	Continued From page 17 Provider notes between 9/1/24 and 11/14/24 lacked evidence to show a provider had reviewed R70's lorazepam order for discontinuation or order renewal every 14 days. The Consultant Pharmacist's Medication Review dated 9/17/24, identified R70 had been prescribed lorazepam since "9/3/20" [error lorazapam was started ordered on 9/6/24] and indicated: there was not a stop date or duration listed in the order. Written review included: "Per updated CMS regulations, all new prn psychotropic medications orders must be re-evaluated within 14 days of initiation and then at routine intervals thereafter. Provider note must specify rationale for renewal of medication." During an interview on 11/14/24 at 12:17 p.m., the director of nursing (DON) stated all the prn antipsychotic/psychotropic medications such as lorazepam ordered as a PRN medication should be reviewed and evaluated every 14 days for renewal or discontinuation and they should not be ordered with a stop date of indefinitely. The Policy Psychopharmacologic Drug use dated 7/8/2024, number 11. As needed (PRN) orders subpart b. included: PRN orders for psychotropic drugs are limited to 14 days except if the provider or prescribing practitioner believes the order period should be extended. They must document in the medical record the duration of and the rationale for extension of the order. The provider must directly examine the resident to determine if the PRN is still needed. R40's quarterly MDS, dated 10/1/24, indicated R40 was admitted to the care facility on 2/6/23 and was cognitively intact.	F 758		

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F 758	Continued From page 18 R40's diagnoses list, printed 11/14/24, indicated R40 had several medical diagnoses including bipolar disorder, anxiety disorder, depression, and insomnia. R40's Physician Orders contained an order, dated 10/23/24, for Compazine (an antipsychotic medication) 5 milligrams (mg) by mouth every 8 hours as needed for nausea. The order however lacked an end date or a rationale of why the medication should be continued beyond 14 days. R40's Physician Orders also contained an order, dated 6/19/24, for Trazadone (an antidepressant and sedative medication) 25 mg by mouth at bedtime. The order however lacked an indication for use (i.e. depression or insomnia). During an interview on 11/14/24 at 8:22 a.m., licensed practical nurse (LPN)-B was unable to confirm if R40 received Trazodone for depression or insomnia, stating it was for "bedtime." During an interview on 11/14/24 at 9:13 a.m., assistant nurse manager and registered nurse (RN)-E stated it would be expected that an indication for use would be noted on R40's Trazodone order to ensure staff knew why they were giving the medication, stating she was usually notified when a medication was missing an indication for use. During an interview on 11/14/24 at 1:42 p.m., the director of nursing (DON) confirmed all antipsychotics should "always" have a 14-day end date. The DON further stated it would be expected the Trazodone order had an indication of use, stating if staff did not know what they were giving the medication for they would not be able	F 758		

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(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 758	Continued From page 19 to assess the medication's effectiveness.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to test the levels of chemicals used on the three compartments sink to sanitize the pots used for meal preparation; failed to ensure dry goods removed from original packaging were stored in a manner to reduce the risk for cross contamination; and failed to properly monitor food temperatures before serving food to residents. These findings had the potential to affect all 102 residents, staff, and visitors, who consumed food prepared from the main production kitchen.	F 812	F 812 - Food Procurement, Store/Prepare/Serve 1. Corrective Action: The Food Sanitation and Storage Policy has been reviewed and remains current. The flour scoop was removed immediately from the flour container upon discovery, a process was put in place to consistently log food temperatures, and to monitor chemicals in the three compartment sinks. 2. Corrective Action as it applies to other residents: All Culinary Staff will be	12/23/24

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	245460	A. BUILDING _____ B. WING _____	C 11/14/2024

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F 812	Continued From page 20 Findings include: During observation and interview on 11/12/24 at 8:20 a.m., an initial kitchen tour was completed with culinary coordinator (CC) and the following items were identified: 1. A series of two white colored plastic bins were on the floor (wheeled) adjacent to the baking area. These were labeled for flour and sugar. However, the bin labeled for flour was approximately half full and a plastic, blue-colored scoop was present inside the bin and touching the flour. The handle was pointed upward from the product. CC opened the flour container and stated, "that shouldn't be there." 2. The three compartments sink was filled with water. The water in two of the compartments was clear, and the third one was tinted blue. A testing log of the chemical used on this sink was not available upon request. During interview on 11/13/24 at 10:25 a.m., CC and company regional kitchen manager (RKM) confirmed the facility used a chemical sanitization process for cleaning pot and pans and stated the staff had not been testing the chemical levels used in the three-compartment sink. CC stated the pots used to prepared food were washed in the three compartments sink and the pots were never washed in the dishwasher. RKM stated a testing log was implemented that morning. During observation on 11/13/24 at 11:36 a.m., dietary staff were dishing food from a steam located next to the main cooking area. A black binder was on top of the steam table and contained daily temperature logs for the month of	F 812	re-educated on how to use the three-compartment sink, monitor and document food temperatures prior to service, and ensure where to appropriately place utensils including the flour scoop within the kitchen to be in compliance with state and federal regulations. 3. Date of Completion: 12/23/24 4. Reoccurrence will be prevented by: Kitchen Sanitation Audits will be completed 2 Times per week for 8 weeks to ensure compliance. Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine if further action or auditing is necessary. 5. The Correction will be monitored by: The Culinary Director or designee.	

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F 812	Continued From page 21 November. Daily logs included breakfast, lunch, and dinner. Temperature documentation of meals were as follows: 11/01/24 - Breakfast and dinner temperatures were documented. 11/02/24 - No temperatures were documented 11/03/24 - Breakfast and dinner temperatures were documented. 11/04/24 - Breakfast, lunch, and dinner temperatures were documented 11/05/24 - Breakfast and dinner temperatures were documented. 11/06/24 - Breakfast and lunch temperatures were documented. 11/07/24 - Breakfast and dinner temperatures were documented. 11/08/24 - Breakfast and lunch temperatures were documented. 11/09/24 - Breakfast and lunch temperatures were documented. 11/10/24 - Breakfast and lunch temperatures were documented. 11/11/24 - Breakfast, lunch, and dinner temperatures were documented 11/12/24 - Breakfast and lunch temperatures were documented. 11/13/24 - Breakfast and lunch temperatures were documented. During interview on 11/13/24 at 12:20 p.m., CC and RKM verified the daily temperature logs for the steam table were incomplete. CC stated the cooks used a blue colored binder to document the food temperatures when they were preparing the food, and before the food was transferred to the kitchen's steam table. CC was unable to locate the cook's binder used to log temperatures	F 812		

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F 812	Continued From page 22 at the point of food preparation and stated she was going to contact the weekend cook and ask where the binder was. During interview on 11/14/24 at 7:20 a.m., CC stated the binder used by the cooks to document the food temperature was not found. During interview on 11/14/24 at 7:25 a.m., cook (CA) stated he did not temp or document the breakfast or lunch temperatures on 11/12 or 11/13 before he transferred the food from the kitchen to the steam table because the dietary aide checks the food temperature at the steam table. During interview on 11/14/24 at 8:32 a.m., RKM stated having two binders to document temperatures was not functional, and probably the cook and the kitchen aid were relying on each other to check the temperature. RKM stated starting immediately a single temperature log will be used by the kitchen staff. RKM stated the food temperatures needed to be monitored to assure the quality of the food, meet regulations, and prevent foodborne illnesses. Further, RKM stated leaving a scoop inside a container was a concern for cross contamination, and the chemical levels of the three-compartments sink should be tested to assure pots are properly sanitized. During interview on 11/14/24 at 1:58 p.m., the administrator stated the expectation was to check the temperature of food before it's served, scoops are not left inside food containers to prevent cross contamination, and testing of the chemicals used to sanitize kitchen equipment was done to assure proper sanitation.	F 812		

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F 812	Continued From page 23 Facility Policy titled Meal Program, dated 03/2023, indicated the purpose of this policy was to offer a comprehensive and attractive meal program that meets the United States Department of Agriculture guidelines for the nutritional needs of the elderly and ensures compliance with 144G.41 and 144G.91. Policy also indicated the food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. Further, policy indicated temperatures will be taken by cook after transfer any item to the steam table prior to beginning of service and logged. Facility Policy titled Food Labeling and Storage dated 11/2023 indicated the director of food and nutrition services will be responsible for providing safe foods for all individuals and knows to store food to prevent cross contamination. Facility Policy titled Food Safety and Sanitation dated 05/2024 indicated the staff will complete all necessary tasks regarding regulations for service and preparation in healthcare environment. Policy included the proper procedure to set up three-compartment sink and test water for PPM ((200-4500) for quart and (500-700) for sink and surface, record and initial in log.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		12/23/24

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F 883	Continued From page 24 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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F 883	Continued From page 25 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents (R25, R85) were offered, educated and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC), who were reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R25's annual Minimum Data Set (MDS) dated 9/10/24 indicated R25 was 91 years old, was admitted to the facility on 12/5/2019, was severely cognitively impaired, and had the following diagnoses: peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), hypertension (high blood	F 883	F 883 – Influenza and Pneumococcal Immunizations 1. Corrective Action: R25 was offered Pneumococcal vaccine and resident representative refused, education on risks were provided. R85 received pneumococcal vaccine. Influenza and Pneumococcal policies were reviewed and remain current. 2. Corrective Action as it applies to other residents: Other residents have been reviewed and proper follow up has occurred to ensure compliance with 3. Date of Completion: 12/23/24 4. Reoccurrence will be prevented by: Audits of new admissions will be completed weekly for 8 weeks. Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine if further action or auditing is necessary. 5. The Correction will be monitored by: DON or Designee.	

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F 883	Continued From page 26 pressure), Alzheimer's disease, and dementia. R25's Point Click Care Immunization, updated 11/14/24, indicated R25 had received pneumococcal vaccine (PCV23) on 4/26/17. The record did not indicate a refusal or if R25 had been offered/educated on the benefit of receiving an additional pneumococcal vaccinations. R85's quarterly MDS dated 10/22/24 indicated R85 was 87 years old, admitted on 5/27/23, was severely cognitively impaired, and had the following diagnoses: heart failure, diabetes mellitus (a chronic disease where the body is unable to properly regulate blood sugar levels), hyperlipidemia (high blood lipid levels), Alzheimer's disease, and dementia. R85's Point Click Care Immunization tab, updated 11/24/24, indicated R85 received PCV13 on 7/13/15 and PCV23 on 01/11/07. The record did not indicate a refusal of PCV20, or if if R85 had been offered/educated on the benefit of receiving an additional pneumococcal vaccinations. During interview on 11/14/24, at 1:40 p.m. infection preventionist (IP) stated she used the Minnesota Immunization Information Connection (MIIC) and admission paperwork to determine residents' vaccination status. IP stated R25, and R85's medical records lacked documentation of receiving the PCV20 vaccination. During interview on 11/14/24, at 1:44 p.m. director of nursing (DON) stated R25 and R85 were eligible to receive the PCV20 vaccination. DON confirmed R25 and R85 had not been offered nor had they received the PCV20 vaccination. DON stated her expectation was all residents would be	F 883		

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F 883	Continued From page 27 educated on the risks and benefits of receiving vaccinations, as well as offered any eligible vaccinations. DON stated it is important to receive vaccinations to promote good health. A vaccination policy was requested but not provided.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff	F 887		12/23/24

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F 887	Continued From page 28 member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Coronavirus Disease (COVID-19) vaccination was offered and/or provided to reduce the risk of severe illness to 1 of 5 residents (R58) reviewed for immunizations. Findings include: Center of Disease Control and Prevention (CDC) "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States"	F 887	F 887- COVID-19 Immunizations 1. Corrective Action: Reviewed Covid Vaccine R58 refused covid vaccine. The refusal and education have been documented in the resident's record. COVID-19 Immunization policy was reviewed and revised. Re-education will be completed with nurse managers to ensure proper offering and tracking of vaccines per state and federal	

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F 887	Continued From page 29 reviewed 4/4/24, directed the following guidance: For people 12 years or older who are not moderately or severely immunocompromised: -unvaccinated= 1 dose of an updated (2023-2024 Formula) mRNA COVID-19 vaccine OR 2 doses of updated Novavax vaccine. -Previously received 1 or more Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of Original monovalent Novavax vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of Janssen vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine or Original monovalent Novavax doses= 1 dose of any updated COVID-19 vaccine. -Special situation for people ages 65 years and order= People ages 65 year and older should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months following the previous dose of updated COVID-19 vaccine. For initial vaccination with updated Novavax COVID-19 vaccine, the 2-dose series should be completed before administration of the additional dose. For people 12 years or older who are moderately or severely immunocompromised: -Unvaccinated= 3 homologous (i.e., from the same manufacturer) updated (2023-2024 Formula) mRNA vaccine doses OR 2 updated Novavax vaccine doses. -Previously received 1 or 2 Original monovalent or bivalent mRNA vaccine doses= Complete the 3-dose series with 2 or 1 homologous updated	F 887	requirements. 2. Corrective Action as it applies to other residents: All other residents in facility have been reviewed to ensure they have been offered the COVID vaccine. 3. Date of Completion: 12/23/24 4. Reoccurrence will be prevented by: Audits of new admissions will be completed weekly for 8 weeks. Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to determine if further action or auditing is necessary. 5. The Correction will be monitored by: DON or Designee.	

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F 887	Continued From page 30 mRNA vaccine doses, respectively. -Previously received a combined total of 3 or more Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more Original monovalent Novavax vaccine doses, alone or in combination with any Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of Janssen vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine or Original monovalent Novavax doses= 1 dose of any updated COVID-19 vaccine. -People ages 12-64 year may receive 1 or more additional doses of any updated COVID-19 vaccine. -People ages 65 years and older should receive 1 additional dose and may receive further additional doses of any updated COVID-19 vaccine. R58's quarterly Minimum Data Set (MDS) dated 10/24/24, indicated R58 was admitted on 7/23/24, was cognitively intact, and had the following diagnoses: anemia (low red blood cells and hemoglobin in blood), hypertension (high blood pressure), hyperlipidemia (high levels of fat in the blood) and anxiety disorder(a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). R58's Point Click Care Immunizations tab lacked any documentation for COVID 19 vaccination. During an interview on 11/14/24, at 1:40 p.m. infection preventionist (IP) stated she had reviewed R58's admission medical record and the	F 887		

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F 887	Continued From page 31 Minnesota Immunization Information Connection (MIIC) website to obtain R58's vaccination status. IP stated R58 was eligible to receive the COVID-19 vaccination but had not been offered, nor had she refused the vaccination. During an interview on 11/14/24, at 1:44 p.m. director of nursing (DON) confirmed R58 had not been offered nor received the COVID 19 vaccination. DON stated her expectation was all residents would be educated on the risks and benefits of receiving vaccinations, as well as offered any eligible vaccinations. DON stated it is important to receive vaccinations to promote good health. A vaccination policy was requested but not provided.	F 887		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/12/24 - 11/14/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 11/14/2024

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued: H54601118C (MN106684) H54601117C (MN107274) H54601119C (MN107997 H54601180C (MN107932) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to test the levels of chemicals used on the three compartments sink to sanitize the pots used for meal preparation; failed to ensure dry goods removed from original packaging were stored in a manner to reduce the risk for cross contamination; and failed to properly monitor food temperatures before serving food to residents. These findings had the potential to affect all 102 residents, staff, and visitors, who consumed food prepared from the main production kitchen. Findings include:	21025	Corrected	12/23/24

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21025	Continued From page 3 During observation and interview on 11/12/24 at 8:20 a.m., an initial kitchen tour was completed with culinary coordinator (CC) and the following items were identified: 1. A series of two white colored plastic bins were on the floor (wheeled) adjacent to the baking area. These were labeled for flour and sugar. However, the bin labeled for flour was approximately half full and a plastic, blue-colored scoop was present inside the bin and touching the flour. The handle was pointed upward from the product. CC opened the flour container and stated, "that shouldn't be there." 2. The three compartments sink was filled with water. The water in two of the compartments was clear, and the third one was tinted blue. A testing log of the chemical used on this sink was not available upon request. During interview on 11/13/24 at 10:25 a.m., CC and company regional kitchen manager (RKM) confirmed the facility used a chemical sanitization process for cleaning pot and pans and stated the staff had not been testing the chemical levels used in the three-compartment sink. CC stated the pots used to prepared food were washed in the three compartments sink and the pots were never washed in the dishwasher. RKM stated a testing log was implemented that morning. During observation on 11/13/24 at 11:36 a.m., dietary staff were dishing food from a steam located next to the main cooking area. A black binder was on top of the steam table and contained daily temperature logs for the month of November. Daily logs included breakfast, lunch, and dinner. Temperature documentation of meals	21025		

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21025	Continued From page 4 were as follows: 11/01/24 - Breakfast and dinner temperatures were documented. 11/02/24 - No temperatures were documented 11/03/24 - Breakfast and dinner temperatures were documented. 11/04/24 - Breakfast, lunch, and dinner temperatures were documented 11/05/24 - Breakfast and dinner temperatures were documented. 11/06/24 - Breakfast and lunch temperatures were documented. 11/07/24 - Breakfast and dinner temperatures were documented. 11/08/24 - Breakfast and lunch temperatures were documented. 11/09/24 - Breakfast and lunch temperatures were documented. 11/10/24 - Breakfast and lunch temperatures were documented. 11/11/24 - Breakfast, lunch, and dinner temperatures were documented 11/12/24 - Breakfast and lunch temperatures were documented. 11/13/24 - Breakfast and lunch temperatures were documented. During interview on 11/13/24 at 12:20 p.m., CC and RKM verified the daily temperature logs for the steam table were incomplete. CC stated the cooks used a blue colored binder to document the food temperatures when they were preparing the food, and before the food was transferred to the kitchen's steam table. CC was unable to locate the cook's binder used to log temperatures at the point of food preparation and stated she was going to contact the weekend cook and ask where the binder was.	21025		

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21025	Continued From page 5 During interview on 11/14/24 at 7:20 a.m., CC stated the binder used by the cooks to document the food temperature was not found. During interview on 11/14/24 at 7:25 a.m., cook (CA) stated he did not temp or document the breakfast or lunch temperatures on 11/12 or 11/13 before he transferred the food from the kitchen to the steam table because the dietary aide checks the food temperature at the steam table. During interview on 11/14/24 at 8:32 a.m., RKM stated having two binders to document temperatures was not functional, and probably the cook and the kitchen aid were relying on each other to check the temperature. RKM stated starting immediately a single temperature log will be used by the kitchen staff. RKM stated the food temperatures needed to be monitored to assure the quality of the food, meet regulations, and prevent foodborne illnesses. Further, RKM stated leaving a scoop inside a container was a concern for cross contamination, and the chemical levels of the three-compartments sink should be tested to assure pots are properly sanitized. During interview on 11/14/24 at 1:58 p.m., the administrator stated the expectation was to check the temperature of food before it's served, scoops are not left inside food containers to prevent cross contamination, and testing of the chemicals used to sanitize kitchen equipment was done to assure proper sanitation. Facility Policy titled Meal Program, dated 03/2023, indicated the purpose of this policy was to offer a comprehensive and attractive meal program that meets the United States	21025		

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21025	Continued From page 6 Department of Agriculture guidelines for the nutritional needs of the elderly and ensures compliance with 144G.41 and 144G.91. Policy also indicated the food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. Further, policy indicated temperatures will be taken by cook after transfer any item to the steam table prior to beginning of service and logged. Facility Policy titled Food Labeling and Storage dated 11/2023 indicated the director of food and nutrition services will be responsible for providing safe foods for all individuals and knows to store food to prevent cross contamination. Facility Policy titled Food Safety and Sanitation dated 05/2024 indicated the staff will complete all necessary tasks regarding regulations for service and preparation in healthcare environment. Policy included the proper procedure to set up three-compartment sink and test water for PPM ((200-4500) for quart and (500-700) for sink and surface, record and initial in log. SUGGESTED METHOD OF CORRECTION: The facility could develop education for staff responsible to serve food that includes the proper process to evaluate temperature of food prior to serving. Education on safe food handling and danger zone for time/ temperature control for safety (TCS) food could be provided. The facility could replace current steamtable or evaluate opportunity to fix current steamtable to maintain safe tempoerature of food. The Director of Food and Nutrition, Certified Dietary Manager, Registered Dietitican, or Chef could provide close oversight and documentation of temperaure monitoring of foods prior to serving to residents.	21025		

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21025	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21025		
21180	MN Rule 4658.0680 Subp. 2 Manual Cleaning&Sanitizing;Three Compart.sink Subp. 2. Three compartment sink. For manual washing, rinsing, and sanitizing of utensils and equipment, a sink with at least three compartments must be provided and be used. Sink compartments must accommodate food preparation equipment and utensils, and each compartment of the sink must be supplied with hot and cold potable running water. Fixed equipment and utensils and equipment too large to be cleaned in sink compartments must be washed manually or cleaned through pressure spray methods. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to test the levels of chemicals used on the three compartments sink to sanitize the pots used for meal preparation; failed to ensure dry goods removed from original packaging were stored in a manner to reduce the risk for cross contamination; and failed to properly monitor food temperatures before serving food to residents. These findings had the potential to affect all 102 residents, staff, and visitors, who consumed food prepared from the main production kitchen. Findings include: During observation and interview on 11/12/24 at 8:20 a.m., an initial kitchen tour was completed	21180	Corrected	12/23/24

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21180	Continued From page 8 with culinary coordinator (CC) and the following items were identified: 1. A series of two white colored plastic bins were on the floor (wheeled) adjacent to the baking area. These were labeled for flour and sugar. However, the bin labeled for flour was approximately half full and a plastic, blue-colored scoop was present inside the bin and touching the flour. The handle was pointed upward from the product. CC opened the flour container and stated, "that shouldn't be there." 2. The three compartments sink was filled with water. The water in two of the compartments was clear, and the third one was tinted blue. A testing log of the chemical used on this sink was not available upon request. During interview on 11/13/24 at 10:25 a.m., CC and company regional kitchen manager (RKM) confirmed the facility used a chemical sanitization process for cleaning pot and pans and stated the staff had not been testing the chemical levels used in the three-compartment sink. CC stated the pots used to prepared food were washed in the three compartments sink and the pots were never washed in the dishwasher. RKM stated a testing log was implemented that morning. During observation on 11/13/24 at 11:36 a.m., dietary staff were dishing food from a steam located next to the main cooking area. A black binder was on top of the steam table and contained daily temperature logs for the month of November. Daily logs included breakfast, lunch, and dinner. Temperature documentation of meals were as follows: 11/01/24 - Breakfast and dinner temperatures	21180		

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21180	Continued From page 9 were documented. 11/02/24 - No temperatures were documented 11/03/24 - Breakfast and dinner temperatures were documented. 11/04/24 - Breakfast, lunch, and dinner temperatures were documented 11/05/24 - Breakfast and dinner temperatures were documented. 11/06/24 - Breakfast and lunch temperatures were documented. 11/07/24 - Breakfast and dinner temperatures were documented. 11/08/24 - Breakfast and lunch temperatures were documented. 11/09/24 - Breakfast and lunch temperatures were documented. 11/10/24 - Breakfast and lunch temperatures were documented. 11/11/24 - Breakfast, lunch, and dinner temperatures were documented 11/12/24 - Breakfast and lunch temperatures were documented. 11/13/24 - Breakfast and lunch temperatures were documented. During interview on 11/13/24 at 12:20 p.m., CC and RKM verified the daily temperature logs for the steam table were incomplete. CC stated the cooks used a blue colored binder to document the food temperatures when they were preparing the food, and before the food was transferred to the kitchen's steam table. CC was unable to locate the cook's binder used to log temperatures at the point of food preparation and stated she was going to contact the weekend cook and ask where the binder was. During interview on 11/14/24 at 7:20 a.m., CC stated the binder used by the cooks to document	21180		

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21180	Continued From page 10 the food temperature was not found. During interview on 11/14/24 at 7:25 a.m., cook (CA) stated he did not temp or document the breakfast or lunch temperatures on 11/12 or 11/13 before he transferred the food from the kitchen to the steam table because the dietary aide checks the food temperature at the steam table. During interview on 11/14/24 at 8:32 a.m., RKM stated having two binders to document temperatures was not functional, and probably the cook and the kitchen aid were relying on each other to check the temperature. RKM stated starting immediately a single temperature log will be used by the kitchen staff. RKM stated the food temperatures needed to be monitored to assure the quality of the food, meet regulations, and prevent foodborne illnesses. Further, RKM stated leaving a scoop inside a container was a concern for cross contamination, and the chemical levels of the three-compartments sink should be tested to assure pots are properly sanitized. During interview on 11/14/24 at 1:58 p.m., the administrator stated the expectation was to check the temperature of food before it's served, scoops are not left inside food containers to prevent cross contamination, and testing of the chemicals used to sanitize kitchen equipment was done to assure proper sanitation. Facility Policy titled Meal Program, dated 03/2023, indicated the purpose of this policy was to offer a comprehensive and attractive meal program that meets the United States Department of Agriculture guidelines for the nutritional needs of the elderly and ensures compliance with 144G.41 and 144G.91. Policy	21180		

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21180	Continued From page 11 also indicated the food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. Further, policy indicated temperatures will be taken by cook after transfer any item to the steam table prior to beginning of service and logged. Facility Policy titled Food Labeling and Storage dated 11/2023 indicated the director of food and nutrition services will be responsible for providing safe foods for all individuals and knows to store food to prevent cross contamination. Facility Policy titled Food Safety and Sanitation dated 05/2024 indicated the staff will complete all necessary tasks regarding regulations for service and preparation in healthcare environment. Policy included the proper procedure to set up three-compartment sink and test water for PPM ((200-4500) for quart and (500-700) for sink and surface, record and initial in log. SUGGESTED METHOD OF CORRECTION: The Director of Culinary services, or designee will ensure the dietary staff follows the proper procedures to set up the three-compartment sink and test water for PPM (200-450) for quart and (500-700) for sink and surface, record and initial in log.The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21180		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance	21695		12/23/24

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21695	Continued From page 12 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a sanitary and homelike environment for 1 of 1 residents (R55) who had dried feeding tube-like substance on their feeding tube pole, dresser, bed, and floor. Findings include: R55's quarterly Minimum Data Set (MDS) dated 9/12/24, indicated R55 had intact cognition and depended on staff for assistance with dressing, transferring, and bed mobility. The MDS indicated R55 received over 50 percent of her total calories through a feeding tube. R55's medication administration record (MAR) dated 11/1/24 indicated received daily feedings from 9 p.m. to 11 a.m. During an observation on 11/12/24 at 11:20 a.m., R55 was observed lying in bed on the left side of the room with a feeding pump attached to a pole to her right. To the right of the pole was a dresser and in front of the pole was a bedside table. The dresser had splatters of a light brown/yellow substance scattered over the side and front of the dresser. The light brown/yellow substance was also observed scattered over the bottom one-fourth of the feeding pump pole, the carpet on the right side of the bed, and the right bed	21695	Corrected	

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21695	Continued From page 13 rail/frame of R55's bed. During an observation and interview on 11/13/24 at 11:02 a.m., the light brown/yellow substance was again observed in R55's room as described above. R55 stated she did not like that the brown substance was on her furniture and floor and at home she would have cleaned it up immediately. R55 stated she had family visit her at least a few days ago, and they noticed the brown substance on the furniture and floor, and it bothered her that her room was not clean especially when she had visitors. R55 stated she assumed the brown substance was tube feeding solution. R55 stated staff cleaned it up "whenever they feel like it" and most of her furniture hadn't been cleaned for several months. During an interview on 11/13/24 at 11:19 a.m., registered nurse (RN)-A stated she was the nurse in charge of R55's care and had stopped her tube feeding this morning. RN-A stated she was unsure how long the tube feeding had been on R55's furniture and floor. RN-A stated it should have been cleaned by either housekeeping or nursing staff but looked like it had not been. During an interview on 11/14/24 at 11:51 a.m., the unit nurse manager (RN)-B stated she expected nursing staff to clean the resident furniture and tube feeding pole as the spills occurred and housekeeping should have been called if nursing staff was unable to clean the spill. RN-B stated staff should have cleaned the dried tube feeding to ensure R55's had a home-like environment and infection control measures were practiced. A policy regarding resident room cleaning was requested and not received.	21695		

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JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

(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
21695	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The director of housekeeping with the director of nursing could ensure appropriate policies were current, and staff responsible would receive training. Audits could be conducted, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

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	245460	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/13/2024**

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JONES HARRISON RESIDENCE	**3700 CEDAR LAKE AVENUE** **MINNEAPOLIS, MN 55416**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on November 13, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Jones Harrison Residence, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/06/2024

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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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Jones Harrison Residence is located in a 4-story building with a full basement that was built in in 1979 was determined to be of Type II(222) construction. In 1991, an addition was built that was determined to be of Type II(222) construction. The 4th floor of this facility is dedicated as an assisted living occupancy that is separated by a	K 000		

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K 000	Continued From page 2 2-hour fire rated floor. There is also an assisted living occupancy to the West that is separated by a 2-hour fire rated wall. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with complete smoke detection that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 98 at the time of the survey.	K 000		
K 311 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). These deficient findings could have a widespread impact on the residents within the facility.	K 311	K311 Vertical Openings Corrective Action: The ceiling tiles have been replaced. Date of Completion:¿12/23/24	12/23/24

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K 311	Continued From page 3 Findings Include: On 11/13/2024, between 9:30 AM and 1:00 PM, observations and staff interview revealed that there were ceiling tiles missing in the kitchen above the dishwasher and in the storage room in the basement. This condition can delay the activation of the sprinkler system. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 311	Reoccurrence will be prevented by: Training was provided to maintenance staff on 12/3/2024 to ensure replacement of tiles after removal. The EVS Director will monitor storage spaces and work zones weekly for three months for compliance. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary. The EVS director or designee is responsible for compliance.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install the fire	K 341	K341 Fire Alarm System – Installation	12/23/24

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K 341	Continued From page 4 alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.3, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 17.14.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/13/2024 between 09:30 AM and 1:00 PM, it was revealed by observation that The fire alarm manual pull stations located in the corridor of the TCU Foyer and in the Copy room were obstructed. An interview with the Director of Environmental Services verified thesed deficient findings at the time of discovery.	K 341	Corrective Action: Furniture was removed from areas blocking pull stations. Date of Completion: 12/23/2024 Recurrence will be prevented by: Training was provided to leadership on 11/18/2024 about placing furniture within three feet of pull stations. All staff will received education on clear pathways to fire alarms. Audits will be completed 3 times per week for 6 weeks to ensure compliance. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary. The EVS director or designee is responsible for compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.3.4.1, 9.6, and NFPA 72 (2010 edition), National Fire	K 345	K345 Fire Alarm System – Testing and Maintenance Corrective Action: The Director of EVS reviewed the Fire Alarm system testing	1/2/25

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K 345	Continued From page 5 Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/13/2024 between 9:30 AM and 1:00 PM, it was revealed during a review of available documentation that a detailed sensitivity report was not available for review. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 345	and maintenance policy. Date of Completion:¿1/2/25 Reoccurrence will be prevented by: The fire alarm system testing has been added to the preventative maintenance log. Annual audits will be completed to ensure all appropriate testing is completed by regulation. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary. The EVS director or designee is responsible for compliance.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5,	K 351		1/2/25

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K 351	Continued From page 6 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/13/2024 between 9:30 AM and 1:00 PM, it was revealed by observation that there was conduit in contact with the sprinkler system above the ceiling near Room 321 and Insulation from duct work in contact with the sprinkler system above the ceiling near Stair D. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 351	K351 Sprinkler System – Installation Corrective Action: An outside vendor will be relocating the conduit to prevent contact with the sprinkler system. Date of Completion: 1/2/2025. Recurrence will be prevented by: EVS Director will inspect after the contractor completes tasks to ensure the conduit does not have contact with the sprinkler system. Weekly audits of sprinkler systems above ceiling tiles in random locations will be completed for 6 weeks. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary. The EVS director or designee is responsible for compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		12/23/24

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K 353	Continued From page 7 _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a widespread impact on the residents within the facility. Findings include: On 11/13/2024 between 09:00 AM and 1:00 PM, it was revealed by observation that storage materials had been placed within 18" of the sprinkler system in the following locations: a. Basement Storage Room b. Medical Records Storage Closets An interview with the Director of Environmental Servicesverified these deficient findings at the time of discovery.	K 353	K 353 – Maintenance and Testing Corrective Action: The Fire Prevention Policy was reviewed, there are no necessary changes. Items with medical records have been removed from the storage rooms. Staff using this office were trained on 11/25/24. Date of Completion:¿12/23/2024 Recurrence will be prevented by: All staff will be trained on fire prevention policy, placing shelves within 18” of fire sprinklers. In addition, the EVS Director will complete audits 2 times per week for 6 weeks to ensure sustainable compliance. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary. The EVS director or designee is responsible for compliance.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101	K 363		2/1/25

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K 363	Continued From page 8 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363		

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K 363	Continued From page 9 Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/13/2024 between 9:30 AM and 1:00 PM, it was revealed by observation that the 1 hour fire rated doors at the dock were damaged and failed to proplery latch when tested. 2. On 11/13/2024 between 9:30 AM and 1:00 PM, it was revealed by observation that the Kitchen Storage Room Door, Housekeeping Storage Room and the Nursing Storage Room were being blocked open. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 363	K363 (1) – Corridor- Doors Corrective Action: New Doors have been ordered and will be installed upon arrival. Doors have been ordered and will take eight weeks for delivery. Date of Completion:¿2/1/2025 Recurrence will be prevented by the EVS Director, along with maintenance staff, who will do annual door inspections. Inspections will be added to the preventative maintenance plan which is reviewed by the Safety Committee. The EVS director or designee is responsible for compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and	K 521	K521 HVAC	1/5/25

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K 521	Continued From page 10 staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 19.7.6, 4.6.12, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/13/2024, between 9:30 AM and 1:00 PM, it was revealed by a review of available documentation that the Mechanical Fire Dampers were not being properly tested to ensure functionality in the event of a fire. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 521	Corrective Action: An outside contractor will carry out a complete inspection of the Mechanical Fire Dampers to ensure functionality. EVS Director has been re-educated on Fire Prevention policies. Damper testing has been added to the preventative maintenance schedule. Date of Completion:¿1/5/25 Recurrence will be prevented by the outside contractor being tasked with doing an annual inspection of the system. Results of the damper testing will be reviewed by the Safety Committee to deter if further actions are necessary. The EVS director or designee is responsible for compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months	K 918		12/23/24

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JONES HARRISON RESIDENCE	**3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416**

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K 918	Continued From page 11 for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/13/2024 between 9:30 AM and 1:00 PM, it was revealed by a review of available documentation of the emergency generator maintenance and testing, that there were gaps in the weekly inspections for October and November	K 918	K363 (2) Doorstops Corrective Action: Fire prevention policy was reviewed and there are no necessary changes. Doorstops have been removed from all fire doors. Date of Completion:¿ 12/23/24 Recurrence will be prevented by: Staff will be educated on fire door policy and the EVS Director or designee will complete audits 2 times per week for 6 weeks to ensure sustainable compliance. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES HARRISON RESIDENCE	**3700 CEDAR LAKE AVENUE** **MINNEAPOLIS, MN 55416**

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K 918	Continued From page 12 2024. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 918	necessary. The EVS director or designee is responsible for compliance K918 – Electrical Systems Corrective Action: Weekly generator tasks will be assigned weekly inspections, and a notification will go to the EVS Director through TELS work requests. The maintenance team was re-educated on the generator maintenance and testing policy. Date of Completion:¿ 12/23/2024 Recurrence will be prevented by: The EVS Director or designee will complete weekly audits for 6 weeks to ensure sustainable compliance. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary. The EVS director or designee is responsible for compliance.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for	K 920		12/23/24

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	245460	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/13/2024**

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K 920	Continued From page 13 non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/13/2024 between 9:30 AM and 1:00 PM, it was revealed by observation that there were several electrical appliances plugged power-strips in the following areas: 1. In the 3rd floor telecommunication closet, there were power strips and extension cords daisy chained supplying power to equipment. 2. In the Barber Shop, there were power strips	K 920	K920 – Electrical Equipment Corrective Action: The power strips in the Barber Shop, as well as the power strips and extension cords daisy chained together in the 3rd-floor closet, will be removed, and extra outlets will be added to handle the electrical support. The Beauty salon manager will be re-educated on the electrical equipment policy. Date of Completion:¿ 12/23/24 Recurrence weekly audits for 6 weeks will be completed in random locations throughout the facility to ensure sustainable compliance. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary.	

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K 920	Continued From page 14 being used to supply power to curling irons and hair dryers in place of permanent electrical outlets. An interview with the Director of Environmental Servicesverified these deficient findings at the time of discovery.	K 920	The EVS director or designee is responsible for compliance.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/13/2024, between 9:30 AM and 1:00 PM, it was revealed by observations that the necessary PPE for oxygen transfilling were not preset for staff protection. An interview with the Director of Environmental Services verified this deficient finding at the time of	K 926	K926 Corrective Action: The oxygen transfilling policy was reviewed and revised. Staff have been educated on the transfilling oxygen policy Date of Completion:¿12/23/24 Recurrence weekly audits for 6 weeks will be completed in random locations throughout the facility to ensure sustainable compliance. Audits will be reviewed by the safety committee to ensure sustainable compliance and determine if further changes are necessary.	12/23/24

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K 926	Continued From page 15 discovery.	K 926	The DON or designee is responsible for compliance.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 5, 2025

Administrator
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, MN 55416

RE: CCN: 245460
Cycle Start Date: November 14, 2024

Dear Administrator:

On January 23, 2025, we notified you a remedy was imposed. On January 31, 2025 the Minnesota Departments of Health and Public Safety 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 January 31, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 14, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 23, 2025, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 14, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 31, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiency cited under K0363 at the time of the November 14, 2024 survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of February 28, 2025, has been forwarded to the the Centers for Medicare and Medicaid Services (CMS) Location for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 5, 2025

Administrator
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, MN 55416

Re: Reinspection Results
Event ID: 43P412

Dear Administrator:

On December 27, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 14, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us