DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8O28

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00216

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245460**
2.STATE VENDOR OR MEDICAID NO.
(L2) **461242600**

3. NAME AND ADDRESS OF FACILITY
(L3) **JONES HARRISON RESIDENCE**
(L4) **3700 CEDAR LAKE AVENUE**
(L5) **MINNEAPOLIS, MN** (L6) **55416**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/25/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **130** (L18)
13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Brandon Martfeld, HFE NE II — 04/20/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 04/29/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted

March 17, 2021

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

RE: CCN: 245460
Cycle Start Date: February 25, 2021

Dear Administrator:

On February 25, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 24, 2021, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 1, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 1, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 1, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 25, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be

notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Jones Harrison Residence is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 25, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 25, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this

letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

DIRECTED PLAN OF CORRECTION - Personal Protective Equipment (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, with Governing Body oversight must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. Information regarding RCAs is available in the Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care..

- Develop and implement a policy and procedure for source cotrol masks.

- Develop and implement a policy and procedure for proper use of gowns.

- Review policies regarding standard and transmission-based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

- The training must include competency testing of staff and this must be documented.

- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.

- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

RESOURCES:

Superior Health Quality Alliance:
https://www.superiorhealthqa.org/
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/ Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html
Strategies for Optimizing the Supply of N95 Respirators:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
Strategies for Optimizing the Supply of Facemasks
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html
Using Personal Protective Equipment PPE:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
ShapeMDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF):
https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.

- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors, and residents.

- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.

- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on proper use of gowns to ensure PPE is in use.

- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter.

To successfully complete the DPOC, the facility must provide documentation to support evidence the DPOC was completed.

- Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

- A revisit will not be completed prior to receipt of documentation confirming the DPOC was completed.

- Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

EPOC:

The ePOC system is programmed, so the facility cannot upload additional documents after MDH formally accepts the Plan of Correction through the EPOC system.

To resolve this, after the POC is received, and meets all the required POC components. The supervisor will reject the POC for F880 in the system, BUT will identify in the comment section, "POC accepted but waiting additional documents complete DPOC process."

By completing this process the ePOC portal opens for the facility to upload the final DPOC documents for review.

If additional information is required for the POC, the supervisor will identify this in the comment section.

Adding attachments DPOC:

When adding DPOC attachments, the software does not have a limit to the number of attachments, but each attachments cannot be greater than 4MB. If this occurs, the attachment will not upload in the ePOC system.

ASPEN web ePOC guide for providers:
https://qtso.cms.gov/system/files/qtso/ePOC-Fac_PG_11.9.4.2_FINAL.pdf

Training videos for ePOC provider: https://qtso.cms.gov/training-materials/epoc-providers

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and interventions/correction action plan, reviewed with QA committee and Governing Body President with confirmation this was completed.
2	Documentation that the interventions or corrective actions plan that resulted form the RCA was fully implemented.
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training.
4	Names and positions of all staff that attended trainings, include sign-in sheet.
5	Summary of staff training post-test results, if applicable and include any follow up in response to failed tests.
6	Documentation of completed audit forms and any follow up action taken from failed audits.

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 02/25/2021

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 A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on February 22, 2021 through February 25, 2021, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 037	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their	E 037		4/10/21

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

Electronically Signed | 03/26/2021

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 02/25/2021

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
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expected roles.

(ii) Demonstrate staff knowledge of emergency procedures.

(iii) Provide emergency preparedness training at least every 2 years.

(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

(v) Maintain documentation of all emergency preparedness training.

(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) After initial training, provide emergency preparedness training every 2 years.

(iii) Demonstrate staff knowledge of emergency procedures.

(iv) Maintain documentation of all emergency preparedness training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the

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following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of all emergency preparedness training.

(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

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E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to provide annual training for staff, individuals providing services under arrangement, and volunteers regarding the facility emergency preparedness plan (EPP), and corresponding policies and procedures. This had the potential to	E 037	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is	

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E 037	Continued From page 4 affect all 96 residents in the facility. Findings include: When interviewed on 2/24/21, at 9:54 a.m. the administrator stated the facility had not provided staff with annual education on the facility's emergency preparedness policies and procedures during 2020. When interviewed on 2/24/21, at 10:02 a.m. the director of nursing (DON) stated facility-specific training on emergency preparedness was not completed in 2020. The DON stated, "With COVID, I don't recall training." When interviewed on 2/25/21, at 9:07 a.m. nursing assistant (NA)-C stated she had not received annual facility-specific training on the facility's emergency preparedness policy and procedures. When interviewed on 2/25/21, at 9:14 a.m. licensed practical nurse (LPN)-G stated she had not received annual facility-specific training on the facility's emergency preparedness policy and procedure. The Residence Emergency Operations Plan updated 5/7/20, indicated employees would be trained upon hire and annually to this plan, the means of evacuating the residents, use of fire extinguishers and to the location of alarms and extinguishers. The facility's Emergency Operations policy dated 11/2017, indicated the facility would develop a training and testing program that must be reviewed and updated at least annually and would	E 037	submitted to meet state and federal requirements. 1. The Administrator will review Jones-Harrison's emergency operations plan and update / revise as necessary. The finalized process will be provided to the quality assurance committee for review and approval. 2. The Administrator, or designee, will train all staff on Jones-Harrison's emergency operations plan consistent with their respective role(s). 3. The HR Director, or designee, will retain copies of training documentation including attendance and proof of learning. 4. The Director of Quality and Education will audit new hire training and annual training each month to ensure staff continue to receive training on Jones-Harrison's emergency operations plan. The audit results will be brought to the quality assurance committee for review on a quarterly basis. Substantial Compliance will be achieved by April 10, 2021.	

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E 037	Continued From page 5 do all the following: a. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. b. provide emergency preparedness training at least annually. c. Maintain documentation of the training and d. Demonstrate staff knowledge of emergency procedures.	E 037		
E 039	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of	E 039		4/10/21

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this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,

clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of

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this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop led

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by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that

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is led by a facilitator and includes a group discussion, using a narrated,

clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion,

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E 039	Continued From page 10 using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E 039		

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E 039	Continued From page 11 prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure two emergency preparedness exercises, including both a community-based or a full-scale exercise or documented response to an actual emergency event and analysis of the response and another full-scale community-based exercise or a tabletop exercise were completed annually to test their emergency preparedness plan. This had the potential to affect all 96 residents currently	E 039	1. The Administrator instituted the organization's emergency preparedness plan in March of 2020 in response to the COVID-19 pandemic; however, formal documentation is not complete. The Administrator will record in the Quality Meeting minutes, at the next quality meeting, the date the emergency preparedness plan as activated. 2. The Administrator will complete an	

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E 039	Continued From page 12 residing in the building. Findings include: When interviewed on 2/24/21, at 9:54 a.m. the administrator stated she was counting the facility's response to the COVID-19 pandemic as the community based exercise, however the administrator was unable to provide documentation to show the facility activated their emergency preparedness plan in response to this real-life event. The administrator added the after action report was "in-progress," but not yet completed. The administrator stated no other emergency preparedness exercise was held in 2020. The facility's Residence Emergency Operations Plan policy updated 5/7/20, indicated the facility would participate in a Table Top and a Full-Scale Community Exercise if available, annually. If a Full-Scale Community Exercise was not available or feasible, the facility would document this and conduct a facility-based exercise instead to test specific aspects of their emergency operations plan (EOP) and identify areas for improvement. Both exercises would follow a formal exercise plan with objectives and a scenario designed to meet those objectives. An After Action Report (AAR) would be completed following these exercises with identified areas for improvement, and a plan for the improvement activities to be completed in a specific time frame. Documentation of these exercise would include sign-in sheets and would be available for review. If the facility experienced an actual emergency event that resulted in an activation of their EOP, this may suffice for one of the exercises, and an AAR would be completed in a timely manner	E 039	after-action report regarding the emergency preparedness response to the pandemic to date. 3. The Administrator will schedule an emergency preparedness tabletop exercise for staff. The tabletop exercise and all appropriate documentation will be completed. 4. The Administrator will review Jones-Harrison's emergency operations plan and update / revise as necessary. The finalized process will be provided to the quality assurance committee for review and approval by the quality committee. Substantial Compliance will be achieved by April 10, 2021.	

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E 039	Continued From page 13 following the event. The facilitiy's Emergency Operations policy dated 11/2017, indicated the facility would also conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The facility would: a. Participate in a full-scale exercise that was community-based or when a community-based exercise was not accessible, an individual, facility-based. If the facility had an actual natural or man-made emergency that required activation of the emergency plan, this occurrence would exempt the facility from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset for the actual event. b. Conduct an additional exercise that could include, but was not limited to the following: i. A second full-scale exercise that was community-based or individual, facility-based. ii. A tabletop exercise that included a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. c. Analyze the facility response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the Emergency Operations Plan, as needed.	E 039		
F 000	INITIAL COMMENTS On 2/22/2021, through 2/25/2021, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and	F 000		

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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 000	Continued From page 14	F 000		

Requirements for Long Term Care Facilities.

The survey resulted in an Immediate Jeopardy (IJ) at F678 when the facilited failed to ensure resident code statas was verified before beginning cardiopulmonary resuscitation (CPR) and failed to ensure the electronic medical record included a resident's code status. The IJ began on 2/23/21, at 6:25 p.m. and was removed on 2/24/21, at 3:08 p.m.

The above findings constituted substandard quality of care, and an extended survey was conducted from 2/23/21, to 2/25/21.

At the time of the recertification survey, onsite investigations were completed and the following complaints were found to be unsubstantiated:

H5460069C- MN63408

H5460070C- MN67518

H5460071C- MN67719

H5460073C- MN69761

At the time of the recertification survey, onsite investigations were completed and the following complaints were found to be substantiated:

H5460072C- MN68273 with a deficiency at F657, and F689.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567

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	245460	A. BUILDING _____ B. WING _____	C 02/25/2021

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F 000	Continued From page 15 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		4/10/21

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F 550	Continued From page 16 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to provide dignified assistance with dining for 6 of 6 residents (R93, R48, R17, R11, R29, and R50) reviewed for dignified dining. Findings include: R93's quarterly Minimum Data Set (MDS) dated 2/12/21, indicated severely impaired cognition and she needed physical assistance of one staff member when eating. R93's diagnosis included Alzheimer's disease. R93's care plan revised on 2/16/21, included, "At risk for decreased intakes r/t [related to] cognitive decline and disease progression of dx [diagnosis] dementia." R48's annual MDS dated 1/1/21, indicated severely impaired cognition and she needed physical assistance of one staff member when eating. R48's diagnosis included Alzheimer's disease.	F 550	1. The Director of Nursing, or designee, will review the policy and procedure Mealtimes & Assisting Residents and complete revisions as needed. 2. The Director of Nursing, or designee, will train all staff responsible for assisting residents with meals on how to appropriately assist residents during mealtimes. 3. The Director of Nursing or designee will complete audits of random second floor dining rooms x 14 days, then 3x/week x 8 weeks to ensure all staff are adhering to the policy on assisting residents appropriately during mealtimes. 4.Audits will be brought to the quality committee for review. Substantial Compliance will be achieved by April 10, 2021.	

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F 550	Continued From page 17	F 550		

R48's care plan revised on 10/5/20, included, "I am able to feed myself with use of adaptive equipment. Nsg [nursing] to provide me with assistance with food being cut up, and supervision/cueing PRN [as needed]."

R17's quarterly MDS dated 12/11/20, indicated moderately impaired cognition and she needed physical assistance of one staff member when eating. R17's diagnosis included unspecified dementia with behavioral disturbances.

R11's annual MDS dated 11/27/20, indicated severely impaired cognition and she needed physical assistance of one staff member when eating. R11's diagnosis included Alzheimer's disease with early onset.

R11's care plan initiated 11/30/20, included, "I require limited assistance with meals."

R29's quarterly MDS dated 12/25/20, indicated severely impaired cognition and she needed physical assistance of one staff member when eating. R29's diagnosis included Alzheimer's disease.

R29's care plan initiated 12/28/20, included, "I require limited assistance with meals."

R50's annual MDS dated 1/8/21, indicated severely impaired cognition and she needed physical assistance of one staff member when eating. R50's diagnosis included Alzheimer's disease.

R50's care plan initiated on 10/8/20, included, "Staff anticipate my needs and assist me."

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F 550	Continued From page 18	F 550		

On 2/22/21, at 4:49 p.m. nursing assistant (NA)-A was observed standing next to the dining room table while cutting R48's food. R48 was sitting in her wheelchair at the table. NA-A then walked over and stood next to the table where R29 was seated. While still standing, NA-A assisted R29 with eating one spoonful of food. NA-A then walked to another table to cut up food for R93. NA-A remained standing while she provided assistance to R93, while R93 remained seated in her wheelchair. NA-A then walked over to R50 and assisted with buttering bread. R50 was seated in her wheelchair while NA-A remained standing while providing assistance.

On 2/22/21, at 5:07 p.m. NA-A was observed standing next to R17, who is seated in a wheelchair, as she assisted with cutting up R17's food.

On 2/22/21, at 5:12 p.m. NA-A was observed standing at the table assisting R11 to eat while R11 remained seated. NA-A eventually used the seat on R11's walker which was placed next to the table to sit down while continuing to assist R11 with her meal. NA-A got up and stood next to R29 while assisting her to eat her meal. R29 was seated in her wheelchair. NA-A returned to R11 and sat back down on R11's walker.

On 2/22/21, at 5:16 p.m. NA-E had another resident's tray in his hand, stood next to R19, and assisted her in eating her pudding while standing

On 2/22/21, at 5:33 p.m. NA-A stood next to R11, who remained seated, while assisting her with cleaning her hands and drinking additional fluids. NA-A stood next to R17 while providing assistance as R17 finished eating her meal.

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F 550	Continued From page 19 When interviewed on 2/23/21, at 1:26 p.m. NA-B stated the expectation was "You sit with them [residents] when helping them eat." When interviewed on 2/23/21, at 1:40 p.m. licensed practical nurse (LPN)-A stated, "We sit down to help them eat. I wouldn't want someone helping me, standing over me." When interviewed on 2/23/21, at 1:53 p.m. NA-C stated, "You encourage them [residents] to eat. You ask if you can help them. You go where you are needed. You sit down. You don't sit on a walker. You sit on a chair." The facility policy Mealtimes & Assisting Residents revised Feburary 2021, indicated, "Staff feeding residents will sit in chair next to resident. Staff may feed one or two residents. But during COVID all residents will be assisted by one staff person."	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		3/30/21

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F 657	Continued From page 20 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to update the plan of care for 1 of 2 residents (R103) who were reviewed for care planning. Findings include: R103's diagnosis report dated 2/25/21, incidated R103 had pneumonitis due to inhalation of food and vomit, acute respiratory failiure with hyposia, and dementia. R103's quarterly Minimum Data Set dated 10/9/20, indicdated R103 did not have any swallowing disorders. R103's Speech Therapy Discharge Instructions dated 11/20/20, indicated caregivers were trained on diet texture, recommendations for cueing small bites, slow pace and to provide direct supervision at meals to safely consume mechanical soft texture.	F 657	1. The Director of Nursing, or designee, will review the policy Comprehensive Baseline Care Planning and update if needed. 2. R103 has passed away, care plan can not be revised. 3. The Director of Nursing, or designee, will review all current resident therapy information for all residents in speech therapy and update the resident's plans of care as needed. 4. The Director of Nursing, or designee, will audit all resident charts who were discharged from ST in the last 30 days and ensure the plans of care are up to date and current regarding ST recommendations. Results of the audit will be brought to the quality committee for review. 5. The Interdisciplinary Team will discuss and determine how speech therapy recommendations are brought to the team for review including how education on	

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F 657	Continued From page 21 R103's speech therapy progress and discharge summery dated 11/20/20, indicated R103 discharged from therapy on a mechanical soft diet with thin liquids and recommendations for cueing to take small bites, slow pace and direct supervision at meals to safely consume mechanical soft textures. R103's care plan dated 12/17/20, indicated R103 had choking episodes on 10/11/20, and on 12/16/20, which required the Heimlich maneuver performed and emergency services intervention. R103's care plan indicated the goal was to not choke on food items. Staff were directed to monitor R103 as needed for any signs or symptoms of dysphagia (difficulty in swallowing). The care plan indicated R103 could feed himself but staff were to anticipate his needs and assist. R103's care plan did not include updates from the Speech Language Pathologist (SLP) recommendations made on 11/30/20. During an interview on 2/25/21, at 9:02 a.m. the Speech Language Pathologist (SLP) stated she evaluated R103 after he returned from the hospital from a chocking incident in October 2020. The SLP stated R103's wife wanted R103 to upgrade to a diet that the SLP did not recommend as being safe. Since the SLP did not feel the upgraded diet was safe for R103 she recommended and educated staff to directly supervise, sit next to R103 and cue him as he was impulsive and ate fast. During an interview on 2/25/21, at 10:30 a.m. the director of rehabiliation stated therapists educated whoever they can and report to that department. It is the responsibility of that department to pass information on to others.	F 657	recommendations will occur and how plans of care will be updated. 6. The Director of Nursing, or designee, will ensure review of speech therapy and speech therapy recommendations is added to the Interdisciplinary Team Meeting agenda and all residents on speech therapy are discussed. 7. The Director of Nursing, or designee, will train nursing staff who are responsible for care plan updates on the process for speech therapy recommendations and how to update plans of care. Substantial Compliance will be achieved by March 30, 2021.	

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F 657	Continued From page 22 When the SLP told the nursing staff her recommendations she educated those she could. It was the responsibility of the nursing department to inform their staff. During an interview on 2/25/21, at approximately 3:35 p.m. the director of nursing (DON) verified it was her expectation that care plans to be updated with recommendations and changes. The DON verifed R103's care plan should have been updated. On 3/4/2021, at 11:58 a.m. the administator replied by email that a care plan was updated after each assessment or as needed with any changes in interventions, goals or focuses. Care plans include information necessary to meet residents goals, preferences, strengths, needs, and problems. The facility policy Comprehensive and Baseline Care Planning dated 9/2020, had no indication on when a care plan was to be updated.	F 657		
F 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a system for consistent verification of code status before they implemented cardiopulmonary resiscitation (CPR)	F 678	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions	4/10/21

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F 678	Continued From page 23 for 6 out of 7 residents (R85, R26, R91, R96, R94, and R46) who were reviewed who did not want resuscitation. This resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ began on 2/23/21, at 6:25 p.m. when it was determined the facility failed to assure a resident's code status was verified before beginning cardiopulmonary resuscitation (CPR) nor did they ensure that the electronic medical record was accurate as identified by the resident or their representative. The administrator, administrator in training, and director of nursing (DON) were notified of the IJ on 2/23/21 at 6:25 p.m. The IJ was removed on 2/24/21, at 3:08 p.m. but noncompliance remained at a lower scope and severity level of E which indicated no actual harm but potential for more than minimal harm that is not immediate jeopardy. Findings include: R85's face sheet dated 2/25/21, indicated R85 had diagnoses that included late onset Alzheimer's disease and Parkinson's disease. R85's paper medical record included a Provider Orders for Life-Sustaining Treatment (POLST), dated 2/10/20, that indicated R85 wanted to be allowed a natural death and not have cardiopulmonary resuscitation (CPR) performed should his heart stop or he stop breathing. The POLST was signed by his representative and physician. R85's electronic medical record orders, dated 2/23/21, indicated R85 was on hospice and had a do not resuscitate (DNR) order. R85's electronic medical record's "banner" was blank space for	F 678	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. To ensure no current or future residents are suffering or are likely to suffer serious injury, serious harm, serious impairment or death, Jones-Harrison has taken the following steps related to code status: 1. The facility policy & procedure titled Advance Care Directive has been reviewed and revised on 02/23/2021 to include that staff must verify code status by checking Point Click Care before providing life sustaining measures. 2. All staff will be trained on their role related to facility code status policy. Licensed nurses and other CPR certified staff will be trained on the revised policy as well as where to find each resident's code status in the medical record to ensure they will follow residents wishes regarding code status consistently. Training and understanding will be documented. 3. Facilities code status policy will be reviewed with all new hires during day one of general orientation. 4. On 2/23/2021, all facility residents including R85's had their code status reviewed to ensure what is in the electronic health record reflects their wishes.	

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F 678	Continued From page 24 code status. The "banner" appears on the first screen of a resident's electronic medical record and code status (DNR or CPR) is visible here once a resident's status order is entered. During an interview on 2/23/21, at 2:00 p.m.TMA-A stated she would look on phone (opened up electronic medical record on her phone and showed R85's banner, which was blank in the code status section). TMA-A stated if the code status was blank "you start CPR" because a blank banner means there was not a do-not-resuscitate (DNR) order. TMA-A stated if she found R85 without a pulse or not breathing, she imiplement cardiopulmonary resuscitation (CPR) as directed by the blank banner. TMA-A stated she never checked the paper medical record because they were told to use their phones to check the electronic medical record for care direction. TMA-A stated she always had her phone with her, so she didn't have to go to the nurses station. TMA-A again stated she would always start CPR first if a resident did not have a pulse or was not breathing because CPR should not be delayed. During an interview on 2/23/21, at 2:19 p.m. LPN-D stated he would start CPR if a resident was found without a pulse or was not breathing because he would not want to wait to find the resident's code status and someone else could check the code status. During an interview on 2/23/21, at 3:10 p.m., LPN-C stated he would first start CPR if a resident was found without a pulse or was not breathing. LPN-C also stated staff could look in the paper medical record or the electronic medical record to find the resident's code status,	F 678	5. Jones-Harrison will conduct quarterly code-status drills to ensure ongoing understanding. Results of these drills will be brought to QAPI for review. 6. The Director of Nursing, or designee, will interview two staff each week x 12 weeks to audit for understanding of code status. Interviews will be documented and tracked. Results of the audit will be brought to the quality meeting for review. 7. Code status audits will be completed monthly, and results provided to the quality committee to ensure monitoring of continued success in entering code status into the medical record. 8. Jones-Harrison will complete the above re-education of all staff on the schedule by 02/24/2021 or before start of next shift ensure the likelihood for serious harm to any recipient no longer exists. Trainings will be completed in person, via phone, or email as able. Substantial Compliance will be achieved by April 10, 2021.	

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F 678	Continued From page 25	F 678		

whichever was closet.

Review of additional records identified the following:

R26's face sheet dated 2/26/21, indicated R26 had diagnoses that included dementia.

R26's paper medical record included a POLST, dated 1/28/21, that indicated R26 was a DNR, with selective treatment. R26's POLST was signed by the provider.

R26's electronic medical record lacked an order for code status and as a result the "banner" in the electronic medical record was blank. R26's electronic medical record also lacked evidence of code status in her care plan.

R91's face sheet dated 2/25/21, indicated R91 had a diagnosis of colon cancer.

R91's paper medical record included a POLST dated 11/9/21, that indicated R91 wanted DNR status, and comfort focused treatment (allow a natural death). R91's POLST was signed by the physician.

R91's electronic medical record lacked an order for code status, and as a result the "banner" in the electronic medical record was blank.

R96's face sheet dated 2/26/21, indicated R96 had diagnoses that included Alzheimer's Disease and diabetes.

R96's POLST was not found in the paper medical

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record.

R96's electronic medical record lacked an order for code status and as a result the "banner" in the electronic medical record was blank.

R94's face sheet dated 2/26/21, indicated R94 had diagnoses of generalized weakness, repeated falls, and blood clots in his lungs.

R94's paper medical record lacked a POLST but did include a Code Status form dated 1/29/21, that indicated R94 wanted to be a Full Code (resuscitated if he stopped breathing or his heart stopped). The Code Status form was signed by a witness but had not been signed by a physician.

R94's electronic medical record lacked an order for code status and as a result the "banner" in the electronic medical record was blank.

R46's face sheet dated 2/26/21, indicated R46 had diagnoses of dementia and malnutrition.

R46's paper medical record lacked a POLST but did include a Code Status Form, dated 9/18/20, that indicated R46 was to be a DNR but the facility should call the son first as R46 had a healthcare directive. The Code Status form included a note that this was reviewed with a family member over the telephone, was signed by a witness, but lacked a physician signature.

R46's electronic medical record lacked an order for code status and as a result the "banner" in the electronic medical record was blank.

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During an interview on 2/23/21, at 3:54 p.m., the director of nursing (DON) stated the expectation was if staff found a resident without a pulse or not breathing, they would look at the POLST or advanced directive, call 911, and then begin CPR. The DON stated the POLST was in the paper medical record and staff should check there first. The DON stated she did not know how or when was POLST obtained and referred to the admissions coordinator.

During an interview on 2/23/21, at 4:23 p.m. admissions coordinator (AC)-A stated prior to admission when they met with the resident and/or family, any POLST or advanced directive was scanned into an electronic folder on the shared drive (computer network) to which all nurses have access. The scanned copy was also loaded into the electronic medical record. AC-A stated when meeting with the resident and/or family to go over admission paperwork, she would make copies of any advanced directives or POLST. AC-A stated if a resident did not have a POLST or an advanced directive, the facility would complete a Code Status Form indicating the resident's preference and that form would be scanned into the electronic medical record.

The facility's Advanced Care Directive policy dated August 2020, indicated advance directives were discussed on admission and appropriate paperwork obtained from the family. The policy indicated the paperwork was scanned into the electronic health record.

The facility's Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillation policy dated 12/20, indicated staff should check a resident's code status in the medical record (it did

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F 678	Continued From page 28 not designate electronic or paper and perform CPR on residents who do not have a valid DNR order or if they wish to have CPR. The IJ was removed on 2/24/21, at 3:08 p.m., but noncompliance remained at a lower scope and severity level of E which indicated no actual harm but potential for more than minimal harm that is not immediate jeopardy.	F 678		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement preventative measures and speech therapy recommendations for residents at risk for aspiration, choking and swallowing difficulties for 2 of 2 residents (R91, R103) who were reviewed for swallowing difficulties. Findings include: R103's Facesheet dated 12/18/20, indicated diagnoses of anxiety disorder, dementia, depression, and pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit. R103's quarterly Minimum Data Set (MDS) dated	F 689	1. The Director of Nursing, or designee, will review the policy Comprehensive Baseline Care Planning and update if needed. 2. The Director of Nursing, or designee, will review the therapy recommendations for R91 (R103 has passed away) and update the plan of care as needed. 3. The Director of Nursing, or designee, will review all current resident therapy information for all residents in speech therapy and update the resident□s plans of care as needed. 4. The Director of Nursing, or designee, will audit all resident charts who were discharged from ST in the last 30 days	4/10/21

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F 689	Continued From page 29 10/9/20, had no indication of cognition as unable to complete cognitive assessment. R103's quarter MDS dated 1/16/19, indicated severe cognitive impairment. The MDS indicated R103 needed supervision (oversight, encouragement or cueing) with eating. R103's care plan dated 12/17/20, indicated R103 searched out food related to frequent hunger and staff were to follow safety precautions to prevent injuries. The care plan further indicated R103 required set up assistance of one staff to eat. In addition, R103 had a choking episodes on 10/11/20, and 12/16/20, that required Heimlich maneuver performed and emergency services interventions. R103's goal was to not choke on food items. Staff were directed to monitor as needed for any signs or symptoms of dysphagia. R103 could feed himself but staff were to anticipate needs and assist. R103's emergency department nurse handoff reported dated 10/11/20, indicated R103 had dementia and was nonverbal. R103 choked on a burger that day at lunch. Staff started CPR. When paramedics arrived R103 had a pulse but was not breathing adequately. A nasal airway was inserted and R103 suctioned and started to cough on his own. R103 got some food up and started to breath on his own. R103's hospital discharge summary dated 10/13/20, indicated R103's discharge diagnoses included aspiration (when food, saliva, liquids, or vomit was breathed into the lungs or airways leading to the lungs), pneumonia (infection of lungs) versus aspiration pneumonitis (inflammation of lung), acute hypoxic respiratory failure due to aspiration, suspect chronic	F 689	and ensure the plans of care are up to date and current regarding ST recommendations. Results of the audit will be brought to the quality committee for review. 5. The Interdisciplinary Team will discuss and determine how ST recommendations are brought to the team for review including how education on recommendations will occur and how plans of care will be updated. 6. The Director of Nursing, or designee, will audit ST recommendations monthly to ensure they are added to the Interdisciplinary Team Meeting agenda and all residents on speech therapy are discussed and Care Plans updated accordingly. 7. The Director of Nursing, or designee will audit those with current ST recommendations weekly for 8 weeks to ensure that ST recommendations are implemented at meal time. 8. The Director of Nursing, or designee, will train nursing staff who are responsible for care plan updates on the process for ST recommendations and how to update plans of care. Substantial Compliance will be achieved by April 10, 2021.	

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dysphagia secondary to dementia, and frontal lobe dementia. The discharge summary indicated R103 had a witnessed aspiration event 10/11/20, at the facility, while he ate and became unresponsive when he choked. Food and oral pharynx (back of the mouth cavity down the throat to the epiglottis) was cleared at the scene and in the emergency room. R103 was discharged back to the facility on a pureed diet with thin liquids.

R103's hospital SLP evaluation on 10/12/20, R103's feeding assistance required frequent cues and help and one to one supervision as needed. Staff are to check R103's mouth frequently for oral residue or pocketing. R103 was impulsive with eating and drinking which increased his risk for aspiration. Since wife did not wish for modified diet it was recommended to provide pureed with thin for now and supervision due to impulsive eating and drinking. R103 required feeding assistance which included frequent cues and help was required. Recommended small bolus and slow rate of intake.
R103's Interdisciplinary Team Progress Note dated 10/15/20, indicated R103 had a history of putting too much food into his mouth and his wife stated he had a choking episodes a few years ago at an adult day care.

R103's Speech Therapy Treatment Note dated, 10/30/20, indicated R103 followed verbal cues to eat at a slow pace.

R103's Speech Therapy Treatment Note dated 11/4/20, indicated R103 was cued to take small bites and chew food well. R103 responded readily to the cue to chew well and needed a second cue to take smaller bites.

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R103's Speech Therapy Treatment Note dated 11/5/20, indicated R103 trialed non pureed food and required moderate to maximum cues for slow pace and maximum cues for smaller bites. R103 needed visual and physical barriers when he ate to prevent taking the next bite too fast.

R103's Speech Therapy Treatment Note dated 11/9/20, indicated the SLP-C educated R103's nurse on his habits of taking large bites which increased aspiration risk due to difficulty of masticating a bolus (prepare food to swallow) with a full oral cavity. SLP-C also educated that R103 responded better to cues for a slower rate of intake than smaller bites. R103's nurse stated understanding.

R103's Speech Therapy Treatment Note dated 11/11/20, indicated R103 demonstrated impulsivity with large bites and not finishing previous bolus before taking his next bite. R103 was cued to take liquids every three bites to facilitate chewing. R103 had difficulty chewing when he took too many large bites before finishing the previous bolus. R103 would need close supervision at meals due to impulsivity, large bites, inconsistent when he ate and he would benefit from cueing.

R103's physician progress note dated 11/12/20, indicated R103's diet had been upgraded to mechanical soft by speech therapy. R103 had Speech therapy (ST) continued to follow.

R103's Speech Therapy Treatment Note dated 11/18/20, indicated R103 managed mechanical soft and thin liquids but had risk factors. Risk factors included impulsivity resulting in large bites

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(not responsive to cues for smaller bites) and increased rate of intake (responsive to cues and environmental modifications such as fork use resulting in smaller bites then with spoon for finger food use.)

R103's Speech Therapy Treatment Note dated 11/20/20, indicated R103 was to continue mechanical soft with thin liquids and recommended close supervision with oral intake and cues to slow pace as needed.

R103's Speech Progress and Discharge Summery dated 11/30/20, indicated R103's goal to safely consume solids was met while R103 used a slow pace and given verbal and visual cues. R103's goal to use swallow precautions was not met due to impulsivity related to dementia. R103's goal to manage mechanical soft food and liquids was met with direct supervision in the dining room and caregiver proving visual and verbal cues to minimize risk of aspiration. R103's wife did not want R103 on pureed textures and understood the risk for aspiration/choking with mechanical soft or regular textures. Caregiver education completed regarding recommendations for diet texture and need for supervision and cueing at a slower pace which nursing stated understanding. R103 discharged on mechanical soft with thin liquids and recommendations for cueing small bites, slow pace and direct supervision at meals.

R103's Speech Therapy Plan of Care dated 12/10/20, indicated start of care 10/30/20, and ended care 11/20/20. R103's long term goal was to manage mechanical soft foods with thin liquids with direct supervision in the dining room. To safely do this care givers were to provide visual

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and verbal cues to minimize the risk of aspiration, dehydration and malnutrition. R103 was responsive to verbal cues to eat slowly.

R103's Speech Therapy Discharge Instructions dated 11/20/20, indicated caregivers were trained on R103's diet texture and recommendations to safely consume upgraded texture.

A progress note dated 12/16/20, at 6:36 p.m. indicated R103 ate supper and licensed practical nurse (LPN)-C noted R103's head was down. LPN-C approached R103 and noted he had been choking on the food he had been eating. LPN-C started the Heimlich maneuver and told an aide to call 911. Other staff members came, lowered R103 to the floor and chest compressions were started. After several attempts to clear R103's airway the paramedics arrived and took over. The paramedics were able to remove some food from his mouth. R103 noted to have breathing difficulties, oxygen was given and R103 was taken to the hospital.

Progress note dated 12/17/20, at 12:29 a.m. indicated R103 was admitted to the intensive care unit (ICU). The ICU nurse reported R103 had a piece of meat taken out of R103's left lung and R103 was placed on a ventilator.

Progress note dated 12/17/20, at 9:45 a.m. indicated on 12/16/20, R103 ate dinner in the dining room and noted to have lost consciousness due to a choking episode. R103 had a prior choking episode in 10/2020 which the Heimlich maneuver was performed and R103 was admitted to the hospital. R103 was lowered to the floor and CPR performed, 911 called and paramedics continued CPR and resident was

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transferred to the hospital and admitted into the ICU.

Progress note dated 12/18/20, at 4:53 a.m. indicated R103 expired.

During an interview on 2/23/21, at 2:08 p.m. LPN-C reported R103 was independent with his meals but LPN-C supervised all residents in the dining room. LPN-C worked the day R103 choked. At the time of the incident, LPN-C had been feeding another resident at a table about 10 feet away and looked over and saw R103's head down. LPN-C went over to ask if R103 was ok but R103 did not respond. LPN-C reported R103 had recently been hosptialized prior to the incident due to a choking incident therefore LPN-C started the Heimlich maneuver and yelled for help. Someone came to assist him and called 911. While doing the Heimlich maneuver, LPN-C was not able to get the lodged food out. When the paramedics arrived they did CPR and took R103 away on a stretcher.

During an interview on 2/23/21, at 2:27 p.m. LPN-C reported prior to the incident when R103 choked he had been on a pureed diet and did well with it. R103 did not seem to mind the pureed diet and ate well. R103's diet had been upgraded after he had been seen by SLP-C. When diets are first upgraded we would observe residents at meals. At the time of the incident when R103 chocked LPN-C only provided supervision while he feed another resident at a different table about 10 feet away. The meal was meat with bread and LPN-C had to chop up the meat before he served his meal to R103.

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R91's facesheet dated 2/25/20, indicated diagnoses that included cerebrovascular disease (stroke), dementia, severe protein-calorie malnutrition, adult failure to thrive, oropharyneal dysphagia (swallowing difficulties with mouth and pharynx), chronic obstructive pulmonary disease (COPD), pneumonitis (inflammation of the lungs) due to inhalation of food and vomit.

R91's significant change Minimum Data Set (MDS) dated 2/22/20, indicated R91 had severe cognitive impairment. R91 needed supervision (oversight, encouragement or cueing).

R91's care plan dated 2/18/21, indicated R91 required limited assistance of one staff to eat. Staff were to anticipate needs and assist. In addition, R91's care plan indicated to receive pureed textures and nectar thick liquids.

R91's hospital paperwork dated 11/10/20, indicated a care assistant reported concern with coughing with breakfast on 11/1/20. Speech language pathology (SLP) discharge summery indicated R91 had severe oropharyneal dysphagia with aspiration during swallows with all diet texture consistencies. A pureed diet with nectar thick liquids was attempted but R91 displaced signs of aspiration. R91 was placed on pureed with nectar due to comfort status with hospice and quality of life.

R91's Nutrition Assessment dated 2/8/21, indicated double portions of pureed textures and nectar thick liquids due to dysphagia (swallowing difficulties) diagnosis. R91 had chewing and swallowing difficulty. R91 required supervision and limited assist with eating. Nutritional interventions included R91 could feed himself and

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staff were to anticipate R91's needs and assist. remove green?

R91's documentation in electronic medical record dated 2/12/21, until 2/23/21, indicated R91 ate independently or had supervision. Independent was defined as no help from staff or staff oversight at anytime. Supervision defined as oversight encouragement or cueing.

R91's physician ordered dated 2/25/20, indicated R91 had been discharged from hospice on 2/8/21. After R91 had a swallowing incident in the dining room an order was made for speech therapy on 2/25/21, to evaluate and treat for swallowing difficulties.

R91's SLP Rehabilitation Screen dated 2/25/20, at 7:55 a.m. indicated a swallowing problem and change of condition. R91 noted with possible aspiration episode on pureed textures, nectar thick liquids and impulsivity with oral intake. SLP recommended swallow evaluation to determine least restrictive diet and safety strategies to train caregivers.

Progress note dated 11/10/2020, at 1:22 p.m. indicated R91 admitted with a diet order for pureed and nectar thick liquid. R91 needed help with feeding.

Progress note dated 11/11/2020, at 4:01 p.m. indicated nursing reported R91 ate pureed textured food well, but struggled with nectar thickened liquids. R91 needed cueing at meals.

Progress note dated 2/23/21, at 6:00 a.m. indicated R91 had possible aspiration. Registered nurse (RN)-A assisted another resident with

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evening meals when a visitor came from the "promenade" saying, "someone needed to help." R91 was at his table coughing and spit out some pureed food. Nursing assistant (NA)-E gave R91 a cup to spit food into. R91 continued to cough, face slightly ruddy appearance, some tearing and clear nasal drainage. R91 was able to talk and continued with occasional cough. R91 continued to eat but RN-A encouraged R91 to wait till he was able to drink some thickened liquids without coughing. After a few sips of thickened liquids R91 started to eat again. R91 observed for eating too much, too quickly.

During an observation on 2/22/21, at 5:20 p.m. R91 sat in a room connected to the main dining room and noted to cough while he ate.

-At 5:23 p.m. R91 coughed. R91 ate alone with no staff around him. Nursing staff in the adjacent room did not respond when R91 coughed.

-At 5:26 p.m. R91 coughed again. R91's face was red, his eyes appeared wet, started to gag and could not talk. A non staff member went to get a staff person's attention to respond. (NA)-E came and brought R91 a cup. R91 spit green food that he could not swallow into the cup. R91 continued to cough and spit up food.

-At 5:30 p.m. R91 eyes watered as he continued to cough and spit up food. Registered nurse (RN)-C and RN-A spoke to R91. R91 struggled to respond but after some time they gave R91 his plate again to finish his meal. R91 took fast bites one after another.

-At 5:33 p.m. R91 sat alone while he continued to eat his meal.

During an observation at 2/22/21, at 5:46 p.m. R91 started to cough again. A staff member

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heard him, walked up and asked if he was okay. R91 continued to cough and the staff member asked R91 to take a breather and he coughed again. R91's face had been red, eyes watered while he reached for his thickened water. RN-C rubbed R91's back while she told R91 he had phlegm in his throat. R91's eye watered, nose ran and he started to gag and spit more food out. RN-C told R91 to get all the phlegm out. R91 continued to spit up green, undigested pureed food into his shirt protector.

-At 5:49 p.m. RN-C took R91's tray away. R91 continued to cough and spit up green undigested food into his shirt protector. RN-C told R91 he must have some type of an "allergic reaction" happening.

During an observation on 2/22/21, at 5:55 p.m. R91 sat alone, continued to cough and spit food into a napkin.

During an observation on 2/22/21, at 6:02 p.m. RN-C directed R91 to his room. R91 went alone to his room and laid in his bed.

During an observation on 2/22/21, at 6:28 p.m. R91 laid in his bed and continue to cough.

During an observation on 2/24/21, at 8:04 a.m. an unidentified staff member brought R91 his meal tray. The unidentified staff member put butter on R91's food and left to the main dining room. R91 started to eat his meal and was the only person in the room adjacent from the main dining room.

During an observation on 2/24/21, at 12:32 p.m. R91 sat alone at a table in the adjacent room by the main dining room. R91 coughed and took a drink of his thickened water and took a deep

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JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

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breath. All staff were in the mian dining room and did not respond.

During an observation on 2/25/21, at 11:41 a.m. R91 ate pudding and drank juice at a table by himself in the room adjacent from the main dining room. R91 coughed while he ate his pudding, took a drink of his apple juice and coughed again. NA-G had been typing on a phone in the adjacent room and did not respond.

During an interview on 2/22/21, at 6:08 p.m. NA-E reported R91 coughed often at meals. In addition, NA-E explained the incident on 2/22/21, R91 started to cough mid meal. NA-E gave R91 a cup to spit the food he tried to swallow and coughed up. R91's face had been red, hard for him to talk, his eyes and nosed started to water. R91 continued to eat and started to cough again and staff took him away.

On 2/22/21, at approximately 6:12 p.m. the director of nursing (DON) stated with COVID it was hard to separate and provide assistance with the space they had. The DON further stated they had to rotate residents from one room to another.

During an interview on 2/22/21, at 6:17 p.m. RN-A explained the incident when a visitor came to notify nursing staff something had been wrong with R91 during the dinner meal on 2/22/21. RN-A further explained, NA-E responded and gave R91 a cup to spit the uneaten food into. In addition, RN-A explained how she had watched R91 and had him stop eating until he had been able to swallow again without coughing. RN-A had R91 take a few bites and when no issues noted went back to assist another resident eat in the adjacent dining room. RN-A further explained,

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after about 15 minutes she heard R91 cough again in the other room. RN-A stated she went into respond and found R91 continued to have issues swallowing his meal. Reported his face appeared panicked, had facial discoloration, noted to be tearing up and running from the nose but did not think he had choked.

During an interview on 2/22/21, at 6:24 p.m. NA-E stated he did not respond initially to R91's incident when he heard him cough since the director of nursing (DON), RN-A, and RN-C were in the adjacent room as well. NA-E gave R91 a cup to spit the food he gagged up since there was too much backed up food in his mouth to swallow. NA-E stated, R91 couldn't swallow all the food which caused him to cough and gag.

During an interview on 2/22/21, at 6:28 p.m. R91 reported his throat still hurt from the incident. When asked, R91 reported he had been scared since he could not breath. R91 said something was stuck in his throat.

During an interview on 2/22/21, at 6:33 p.m. RN-C reported R91 ate fast at meals. The food appeared too thick for R91. RN-C further reported when R91 started to cough, staff pulled his food away to cough up the food he could not swallow. R91 was noted to spit out a lot of food and phlegm. RN-C thought it might be good to have someone in the adjacent room with R91 at meals and was glad the visitor was there and able to get help.

During an interview on 2/23/21, at 1:48 p.m. NA-F stated she did not work with R91 often. When NA-F worked with R91, she had noted R91 to cough in between bites and drinks but nothing

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that was alarming. During morning meal on 2/23/21, NA-F reported hearing R91 cough two times while he ate but had not been anything alarming. NA-F reported the pureed food occasionally appeared too thick for R91. The room where R91 ate was for residents who were more independent. Residents who need supervision and assistance ate in the main dining room.

During an interview on 2/23/21, at 1:55 p.m. RN-D stated R91 was independent with his meals and did not need assistance besides setting up and supervision. RN-D further stated, if a resident noted to cough often she would request for SLP to evaluate their food and fluid textures.

During an interview on 2/23/21, at 2:24 p.m. LPN-C reported R91 sat in room behind the main Rue De France dining room since he was independent with his meals and only needed set up.

During an interview on 2/23/21, at 4:13 p.m. the cardiopulmonary resuscitation (CPR) instructor (CPR)-B reported some signs of chocking would be hands to the throat, inability to move air, production of a productive cough, and feared look on the face.

During an interview on 2/25/21, at 9:02 a.m. SLP-C stated her expectation would be for staff to sit next to a resident who was impulsive, had a history of swallowing difficulties and had an upgraded diet for quality of life.

During a phone interview on 2/25/21, at 9:28 a.m. SLP-C reported she should have gotten orders for an evaluation as soon as R91 got off hospice.

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In the hospital R91 had orders to be NPO (nothing by mouth) as it was not safe for him to swallow but since R91 went on hospice the goal was to provide pureed foods with nectar thick liquids for comfort. SLP-C would have wanted to evaluate R91 to see what interventions could help make eating an upgraded diet safer and reduce the risk for aspiration. SLP-C stated she got orders that day, 2/25/20. R91 should have had staff sit next to him to monitor, supervise and cue since he had memory impairment and admitted as not safe to eat food orally.

During an interview on 2/25/21, at 11:22 a.m. the registered dietitian (RD) stated she removed the intervention to cue and encourage R91 from the care plan as she was not sure why it had been in there. RD further stated, she took it out as when she observed R91 eating at meals he was alone and no one assisted him. RD stated she had changed the care plan to reflect what was actually happening during meals.

During an interview on 2/25/21, at 11:36 a.m. NA-G reported R91 does not need assistance or anything with his meals. NA-G further stated, staff set him up and he was "good to go." R91 did not need cueing or assistance as he was able to feed himself and he was not sleepy at meals.

During an interview on 2/25/21, at approximately 3:45 p.m. the director of nursing (DON) stated staff would have noticed and responded to R91's incident on 2/22/21, "it is just you noticed first." The DON stated R91 did not need staff to sit with him as could eat independently. The DON further stated, the staff they have need to sit with residents who need physical help and R91 could physically feed himself. In addition, the DON

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stated there were nursing staff who assisted other residents in the room adjacent to the room were R91 ate alone who could supervise R91 and would be able hear if there was a problem.

During an interview on 2/23/21, at 4:13 p.m. the cardiopulmonary resuscitation (CPR) instructor reported some signs of choking would be hands to the throat, inability to move air, production of a productive cough, and feared look on the face.

During an interview on 2/25/21, at 8:36 a.m. NA-C stated she would sit close to a resident if she was told to cue or supervise them. NA-C would want to be close to remind them, intervene and help if a resident needed it.

During an interview on 2/25/21, at 8:44 a.m. LPN-B reported he would keep very close eye on someone if they recently choked and their diet was upgraded. LPN-B would follow recommendations given for the resident.

During an interview on 2/25/21, at 9:02 a.m. SLP-C stated she evaluated R103 after he returned from the hospital from a chocking incident in October 2020. SLP-C stated R103's wife wanted R103 to upgrade to a diet that SLP-C did not recommend as being safe. Since SLP-C did not feel the upgraded diet was safe for R103. SLP-C recommended and educated staff to directly supervise, sit next to R103 and cue him as he was impulsive and ate fast. SLP-C stated her expectation would be for staff to sit next to any resident who was impulsive, had a history of swallowing difficulties and an upgraded diet for quality of life.

During an interview on 2/25/21, at 10:30 a.m. the

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F 689	Continued From page 44 director of rehab stated therapists educated whoever they can and report to that department. It is the responsibility of that department to pass information on to others. When SLP-C told the nursing staff her recommendations she educated those she could. It was the responsibility of the nursing department to inform their staff. During an interview on 2/25/21, at approximately 3:45 p.m. the DON stated SLP-C could write recommendations but it was not an order. SLP-C recommendations to cue, supervise and provide direct supervision but it was just a recommendation. Therapy wrote many recommendations which are not possible and hard to follow. At the time of the incident LPN-C supervised R103 at a different table and responded as soon as he noted an issue. The DON stated direct supervision was to have a nursing in the dining area and expected her staff to only sit with residents who need physical help. The Facility Mealtimes & Assisting Residents Policy dated February 2021, indicated nursing staff will determine at the mealtime if a resident needs more assistance, i.e., assisting with feeding the meal, cueing to take bites of food.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		4/10/21

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F 692	Continued From page 45 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and assess the hydration status 2 out of 5 residents (R48, R17) who were reviewed for hydration. Findings include: R48's face sheet dated 2/25/21, indicated diagnoses of Alzheimer's disease, dementia, hypertension (HTN), gastro-esophageal reflux disease (GERD), polyneuropathy, and constipation. R48's annual Minimum Data Set (MDS) dated 1/1/21, indicated severe cognitive impairment, no swallowing difficulties, and no impairment of R48's upper or lower extremities. R48 required extensive assistance of staff for locomotion on the unit and off the unit. R48's care plan dated 10/28/20, indicated R48 required set up assistance by one staff to eat. R48 feed herself with supervision and cueing as needed. Staff were directed to monitor for signs	F 692	1. The Director of Nursing and Dietician will review the process for documenting hydration / fluid intake for residents who require monitoring for hydration. 2. The Director of Nursing, or designee, will ensure the process for documenting hydration / fluid intake for R48 and R17 is in place. 3. The Director of Nursing, or designee, and dietician will review the policy Hydration Management Program and revise if needed. 4. The dietician will calculate fluid requirements for R48 and R17 to determine fluid needs. The dietician will communicate this information to the Director of Nursing, or designee, and nursing will ensure a plan for meeting hydration needs and update the resident's plan of care as needed. 5. The dietician will calculate fluid requirements for all residents who require monitoring for fluids / dehydration. The dietician will communicate this information	

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F 692	Continued From page 46 or symptoms of dehydration and offer and encourage fluids at and between meals. R48 could usually make her needs known. R48's physician order report dated 2/25/21, indicated R48 had an order for thin liquids (no alteration needed in liquid consistency). R48's Nutrition Assessment dated 12/30/20, indicated to monitor for signs and symptoms of dehydration. There was no indication of R48's hydration status or of her fluid intake at or between meals. During an observation and interview on 2/22/21, at 2:13 p.m. in R48's room there had been no water or fluids in sight. R48 kept licking her lips and moving her tongue around in her mouth. R48 stated her teeth felt rough and dry because she had been thirsty. During an observation and interview on 2/24/21, at 7:15 a.m. in R48's room she had smacked her lips and stated "I would take anything to swallow right now. My mouth is so dry and sticky." During an observation and interview on 2/24/21, at 7:57 a.m. in the dining room R48 had been tapping the table. While R48 tapped the table, she stated "I need a swallow, my mouth is so dry." R17's face sheet dated 2/25/21, indicated diagnoses of dementia, atrial fibrillation (AF), protein calorie malnutrition, anorexia nervosa, life management difficulty, constipation, abnormal weight loss, and vascular disease.	F 692	to the Director of Nursing, or designee, and nursing will ensure a plan for meeting hydration needs and update the resident's plan of care as needed. 6. The dietician will review fluid documentation during dietician assessment to ensure documentation is appropriate and fluid needs are being met. 7. The Director of Nursing, or designee, will audit fluid documentation daily x 1 week, then 3x/week for 8 weeks, to ensure fluid documentation is completed. The audits will be brought to the interdisciplinary team meetings for review. 8. The Director of Nursing, or designee, will training nursing staff on how to document fluids in the electronic medical record. Substantial Compliance will be achieved by April 10, 2021.	

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R17's quarterly MDS dated 12/11/20, indicated moderate impairment of cognition. R17 required limited assist of one with eating and had no swallowing difficulties. R17 had no impairment of her upper extremity but was impaired on both sides of her lower extremity. R17 had been total dependent of staff for locomotion on the unit.

R17 physician ordered dated 2/25/21, indicated R17 had no fluid restrictions as her diet ordered for thin liquids.

R17's care plan dated 12/1/20, indicated staff were to monitor for signs or symptoms of dehydration, offer and encourage fluids at and between meals.

R17's nutritional assessment dated 12/10/20, indicated R17 had an intervention to monitor for signs and symptoms of dehydration but there was no indication of fluid intake at or between meals and of R48's hydration status.

During an observation and interview on 2/22/21, at 3:30 p.m. R17's lips appeared cracked, and dry with indents. When R17 spoke, her mouth had a string of saliva sticking from the top of one lip to another. R17 said she felt like she had been thirsty and got water between meals only if she asked for it.

During an observation and interview on 2/24/21, at 7:07 a.m. in R17's room R17 said had been thirsty and when asked, she said she would like some water.

During an observation on 2/24/21, at 8:45 a.m. in the dining room NA-C and NA-D wrote down the intake of food and fluids for residents after they

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finished eating their morning meal.

During an observation and interview on 2/24/21, at 9:00 a.m. NA-C and NA-D showed how they put the percentage of a resident's food intake into Point of Care (NA documentation system). When asked where they document fluids, they reported there was no place to put a resident's fluid intake. NA-C stated she put the percentage of both food and fluids together when she cannot find a place to document fluid intake. NA-C stated she would ask registered nurse (RN)-A where she should document fluid intake.

During an observation and interview on 2/24/21, at 9:07 a.m. RN-A tried to help NA-C find a way to document fluids into Point of Care. RN-A said she could not find a place to document fluid intake and was not sure if they even documented a residents' fluid intake at meals.

During an interview on 2/24/21, at 9:09 a.m. NA-C stated the system had no place to document fluid intake but would continue to document fluid as part of the percentage of food.

During an interview on 2/24/21, at 10:15 a.m. the registered dietitian (RD) verified there had been minimal or no documentation of fluid intake at meals or between meals. She had to rely "heavily" on nursing to tell her if there was a problem. The RD reported it would be better practice to have actual documentation of fluid intake. Documentation could help her get a better understanding and assess a residents' hydration status. The RD stated it was too hard to rely heavily on word of mouth or progress notes. RD reported the facility had been working on a system to document fluid intake as it would be

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more beneficial to assess a residents hydration status.

During an interview on 2/24/21 at 10:33 a.m. NA-C reported she did not document or monitor fluids or hydration status.

During an interview on 2/25/21, at 8:49 a.m. RN-B stated that the RD monitored fluid intake through the documentation in the system, so he did not regular update her on hydration status unless the RD asked.

During an interview on 2/24/21, at 11:07 a.m. the RD reported the facility planned to implement a system to document fluid intake. The RD felt documentation of fluid intake would be best practice to help her accurately assess each resident's hydration status and risk for dehydration.

During an interview on 2/25/21, at approximately 3:45 p.m. the director of nursing (DON) stated the RD was the one who assessed each resident's hydration status. The facility did not document fluid intake as the previous RD's who worked at the facility did not want or felt it was needed. The DON reported that she deferred a resident's hydration status to the RD and her assessment.

The facility Nutrition Care Process Standards Policy #4 dated 1/1/21, indicated nutrition monitoring and evaluation was used to determine if the client had achieved or made progress toward a plan goal.

The facility "Hydration Management Program" Policy dated 2/2021, indicated fluid intake will be observed, intake and output records will be

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F 692	Continued From page 50 maintained and documented in Point Click Care. Each resident is to be provided with sufficient fluids to maintain hydration. The RD will calculate fluid requirements for all residents and calculate their needs.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		4/10/21

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 02/25/2021

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
F 755	Continued From page 51 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure timely disposal of medications in two medication rooms reviewed for medication storage, this had the potential to affect three of five residents (R77, R1001, and R1002) reviewed. In addition, the facility failed to dispose of a controlled substance in a safe manner for one of five (R33) residents reviewed for medication administration. Findings include: R77's, quarterly MDS, dated 2/1/21, indicated she was admitted to the facility on 8/13/20, and was still residing in the facility. R1001's death in facility minimum data set MDS, dated 9/18/20, indicated he was admitted to the facility 4/24/19, and was discharged on 9/18/20. R1002's death in facility minimum data set MDS, dated 8/18/20, indicated she was admitted to the facility 7/11/20, and was discharged on 8/18/20. During observation 2/22/21 at 6:46 p.m. in an unlocked and unattended nursing office near the transitional care unit on the counter to the left of the medication refrigerator was a washbasin full of pills bottles, packages of pills, various cremes, various eye drops, and various suppositories. In addition to numerous other medications in the washbasin for numerous other residents, following was an example of medications found: 1) for R77, two full bottles of Gabapentin 400 milligrams (mg) with an expiration date of	F 755	1. The Director of Nursing, or designee, will review the Medication Disposal policy and revise as needed. 2. The Director of Nursing, or designee, will train nursing staff on the medication destruction process. 3. The Director of Nursing, or designee, will audit medication destruction areas and medication storage areas daily x 2 weeks and 2x/week x 8 weeks, to ensure all medications are securely stored per regulation and all medications that require destruction have been properly destroyed. 4. Medication storage audits will be brought to the quality committee for review. 5. The Director of Nursing, or designee, will ensure all currently stockpiled medications that require disposal will be properly disposed of according to the facility policy and federal regulations. Substantial Compliance will be achieved by April 10, 2021.	

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

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F 755	Continued From page 52	F 755		

10/21/20, a full bottle of diclofenac, a half-full bottle of prednisone 5 mg; 2) for R1001, a package of acetaminophen suppositories 650 mg; and for R1002 a package for acetaminophen. When registered nurse (RN)-F opened a cupboard, which was supposed to be locked but was not, another washbasin overflowing with medication bottles.

During interview on 2/22/21, at 6:53 p.m., RN-F stated the process for destruction of meds was when a resident was discharged, the unused meds were placed in a bin and the bin placed in a locked cabinet in the office. RN-F verified the cabinet door should be locked and when the cabinet was full, the medications should be taken to the medication destruction box for disposal by the pharmacy. RN-F stated the night shift goes through the unused meds and tallies the medication name, strength, and amount on a form before taking to the Med Safe. The pharmacist and director of nursing (DON) have keys to the box and when it is full, the medications were removed from the destruction box by the pharmacist and DON, sealed in a box, and then mailed to the pharmacy for further handling. RN-F stated

During observation on 2/25/21, at 9:58 a.m. the "Passport" room contained a Med Safe where medications were to be disposed, where medications were to be wasted. Next to the Med Safe were five large, clear trash bags full of medication bottles (full and partially), ointments, suppositories, and drops. Some of the bags had "Merwin" written on them in black marker.

During interview on 2/25/21, at 9:58 a.m. RN-F stated he wasn't sure when the medications were

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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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F 755	Continued From page 53	F 755		

picked up. RN-F stated Merwin used to be their old pharmacy and he thought the new pharmacy, Thrifty White, would not pick-up medications from the old pharmacy. RN-F stated all RNs, licensed practical nurses (LPN), and trained medication aides (TMA) had keys to the "Passport" room. RN-K verified there were no forms related to disposition of the medications in the Passport Room and was not sure where they were stored.

R33's orders included orders for: 1) Vimpat (antiseizure and controlled substance) 100 milligrams (mg) twice a day; 2) aspirin 81 mg once a day; 3) citalopram hydrocholoride (anti-depressant) 10 mg each day; 3) gabapentin (antiseizure) 300 mg three times a day; 4) hydroxychloroquine (treat arthritis) 200 mg once a day; 5) Keppra (anti-seizure) 1000 mg; 6) magnesium oxide (mineral to treat osteoporosis) 400 mg once a day; 7) multivitamin once a day; 8) Senna (treat constipation) tablet 8.6 mg 2 tablets once a day; 9) Zonisamide (anti-seizure) 100 mg once a day; 10) oyster shell calcium (mineral to treat osteoporosis) 500 mg/20 mg one tablet once a day.

During observation on 2/25/21, at 8:40 a.m. during medication administration RN-G dropped R33's Vimpat (federally controlled substance) 100 mg tablet on the floor. RN-G had RN-D observe RN-G waste the Vimpat by placing it in the "hopper" (large toilet) and flush. RN-G obtained a new Vimpat 100 mg tablet and added to the other medications to be given to R33: aspirin 81 mg - 1 tablet, citalopram hydrocholoride 10 mg - 1 tab, gabapentin 300 mg - 1 capsule, hydroxychloroquine 200 mg - 1 tablet, Keppra 1000 mg - 1 tablet, magnesium oxide 400 mg - 1 tablet, a multivitamin - 1 tablet, Senna tablet 8.6

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JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

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F 755	Continued From page 54	F 755		

mg - 2 tablets, Zonisamide 100 mg - 1 tablet, and oyster shell calcium with vitamin D 500 mg/20 mg - 1 tablet. When offered the medications, R33 refused them and RN-G stated she needed to waste the medications. RN-G verified with RN-H the medications should be wasted and RN-G placed the medications in the "hopper" and flushed. The medications initially went down but then floated back up. After several attempts at flushing, RN-G contacted maintenance to assist with the "hopper" and getting the medications to flush. No destruction of medication form was completed for the resident chart. During interview, RN-G stated she only need to record the wasting of the narcotic on the narcotic sheet.

During a phone interview on 2/24/21 at 9:18 a.m., Pharmacist (Pharm)-A, stated his community pharmacy began working with the facility in March of 2020, provided a "Med Safe" (locked heavy metal safe with two keys where medications can be disposed) sometime around July of 2020. Pharm-A stated for disposal of all medications - those being returned for credit, those needing disposal, those that are wasted/destroyed, and for both controlled and non-controlled substances. Pharm-A stated the facility was to fill out form for each medication disposed of and to complete Medication disposition form. The medications are then placed in the Med Safe. The facility needs to call and let the pharmacy know when the Med Safe was full and to pick up the medications. Pharm-A stated the pharmacy brings a key and the DON has a key and both keys were need were used to unlock the Med Safe. Pharm-A stated disposition was per the facility policy and each facility should have their own policy. Pharm-A stated he was not sure if it was okay to place any medications in the sewer

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

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F 755	Continued From page 55	F 755		

system. Pharm-A stated the facility policy should direct disposition if not in the Med Safe.

During an interview on 2/25/21, at 2:02 p.m., the DON verified the facility used Merwin Pharmacy until March of 2020, when they contracted with Thrifty White Pharmacy for pharmacy services. The DON verified the Med Safe was delivered in July of 2020 and stated the floor nurses "don ' t touch the Med Safe." The DON stated nurse managers and her were the only ones who used the Med Safe. The DON stated the process for removing mediations from the Med Safe was for pharmacy to come to the facility, the DON takes the pharmacy key and unlocks the Med Safe using her key and the pharmacist's key. The DON stated the pharmacist was not allowed in the building because of COVID-19. The DON placed medications from the Med Safe into a box and then a delivery package agency picks up the package to be sent to the pharmacy. The DON was aware of the five bags of medications in the Passport Room and stated in late March, the pharmacy stated they would not come and get them and Thrifty White Pharmacy would not take them. The DON stated, "it's on my to-do-list, to get the medications removed" from the Passport room. The DON also stated it was on her list to train all RN, LPN, and TMA to use the Med Safe. The DON stated the facility followed the pharmacy's policy on the wasting of medications; she was not sure what that was now. The DON stated the only medication wasting policies were the policies from Thrifty White Pharmacy and there was no other facility policy on wasting medications.

The Controlled Medication Disposal policy from Thrifty White Pharmacy revised January 2020,

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F 755	Continued From page 56 indicated controlled substances are disposed of following state rules, which included entering the following information on the individual patient's disposition form and the state board of pharmacy's controlled medication disposition form: date medication was discontinued (or destroyed), date of destruction, resident's name, name and strength of medication, prescription number, amount of medication destroyed or to be destroyed, and signature of witnesses. The Non-Controlled Medication Disposal policy from Thrifty White Pharmacy revised January 2020, indicated at discharge, any pharmaceutical products not returned to the pharmacy for credit or sent home with the resident, should be disposed of per "state and federal regulations and facility policy." The facility policy for disposition of medications was requested and none was produced. According to the Minnesota Pollution Control Agency (MPCA), June 2019, medications cannot be disposed of in the sewer waste system. The U.S. Drug Enforcement Administration regulations, dated 9/9/14, banned controlled substance disposal in the sewer system.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		4/10/21

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F 761	Continued From page 57 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure secured storage for 2 of 4 medication rooms observed with the potential to affect 3 of 3 (R77, R1001, and R1002) residents observed for medication storage. Findings include: R77's, quarterly MDS, dated 2/1/21, indicated she was admitted to the facility on 8/13/20, and was still residing in the facility. R1001's death in facility minimum data set MDS, dated 9/18/20, indicated he was admitted to the facility 4/24/19, and was discharged on 9/18/20. R1002's death in facility minimum data set MDS, dated 8/18/20, indicated she was admitted to the	F 761	1. The Director of Nursing, or designee, will review the Medication Disposal policy and revise as needed. 2. The Director of Nursing, or designee, will train nursing staff on the medication storage process. 3. The Director of Nursing, or designee, will audit medication destruction areas and medication storage areas daily x 2 weeks and 2x/week x 8 weeks, to ensure all medications are securely stored per regulation and all medications that require destruction have been properly destroyed. 4. Contracted pharmacy will also conduct quarterly audits for compliance. 5. Medication storage audits will be brought to the quality committee for review. 6. The Director of Nursing, or designee,	

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F 761	Continued From page 58 facility 7/11/20, and was discharged on 8/18/20. During observation 2/22/21, at 6:46 p.m. in an unlocked and unattended nursing office near the transitional care unit on the counter to the left of the medication refrigerator was a washbasin full of pills bottles, packages of pills, various cremes, various eye drops, and various suppositories. In addition to numerous other medications in the washbasin for numerous other residents, following was an example of medications found: 1) for R77, two full bottles of Gabapentin 400 milligrams (mg) with an expiration date of 10/21/20, a full bottle of diclofenac, a half-full bottle of prednisone 5 mg; 2) for R1001, a package of acetaminophen suppositories 650 mg; and 3) for R1002 a package for acetaminophen. Later, when registered nurse RN-F opened a cupboard, which was supposed to be locked but was not, another washbasin overflowing with medication bottles was observed. During observation on 2/25/21, at 9:58 a.m. the "Passport" room contained five large, clear trash bags full of medication bottles (full and partially), ointments, suppositories, drops. Some of the bags had "Merwin" written on them in black marker. The room also contained personal protective equipment (PPE) and isolation carts. During interview on 2/22/21, at 6:53 p.m., RN-F verified the medication refrigerator should be kept locked when not in use and that non-refrigerated medications should not be on the counter or in an unlocked cabinet. RN-F also verified the unsecured medications in the Passport room should be secured. RN-F stated only registered nurses, licensed practical nurses, trained	F 761	will ensure all currently stockpiled medications that require disposal will be properly disposed of according to the facility policy and federal regulations. Substantial Compliance will be achieved by April 10, 2021.	

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F 761	Continued From page 59 medication aides, and the director of nursing had keys to the room. RN-F verified in addition to storing the discarded medications, the room was used for storage of isolation carts and PPE. The Non-Controlled Medication Disposal policy from Thrifty White Pharmacy, revised January 2020, indicated at discharge, any pharmaceutical products not returned to the pharmacy for credit or sent home with the resident, should be disposed of per "state and federal regulations and facility policy." The facility policy for disposition of medications was requested and none was produced.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		4/10/21

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F 880	Continued From page 60 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 61 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to wear appropriate personal protective equitment (PPE) and perform hand hygiene for 9 of 9 residents (R81, R299, R10, R18, R57, R85, R67, R95, and R97) who were reviewed for infection control and failed to properly perform pericare to decrease risk of infection for 1 of 1 (R299) who was reviewed for pericare. In addition, the facility failed to wear appropriate personal protective equipment for 3 of 4 residents (R1, R2, R3) who were reviewed for infection control. Findings include: R81's quarterly minimum data set (MDS) dated 2/4/21, indicated R81 was over 75 years old and had diagnoses of diabetes, cancer, and dementia. R299's admission MDS dated 2/16/21, indicated R299 was over 75 years old and had a diagnosis of heart arrythmia (abnormal beat). R10's quarterly MDS dated 11/26/20, indicated R10 was over 75 years old and had diagnoses of dementia and malnutrition. R18's quarterly MDS dated 12/17/20, indicated R18 was over 75 years old and had diagnoses of dementia and malnutrition.	F 880	1. The facility□s Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, with Governing Body oversight will conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. 2. The Infection Preventionist and Director of Nursing, shall complete the following: a) Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.. b) Develop and implement a policy and procedure for source control masks. c) Develop and implement a policy and procedure for proper use of gowns. d) Review policies regarding standard and transmission-based precautions and revise as needed. 3. The facility will provide training for all staff providing direct care to residents, and all staff entering resident□s rooms, whether it be for residents□ dietary needs or cleaning and maintenance services. The training will cover standard infection control practices, including but not limited	

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JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

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F 880	Continued From page 62 R57's annual MDS dated 1/21/21, indicated R57 was over 75 years old and had diagnoses of high blood pressure, heart arrythmia (abnormal beat), and dementia. R85's annual MDS dated 2/6/21, indicated R85 was over 75 years old and had diagnoses of heart disease, anemia, high cholesterol, and diabetes. R67's quarterly MDS dated 2/16/21, indicated R67 was over 75 years old and had diagnoses of diabetes, high blood pressure, and dementia. R95's quarterly MDS dated 2/11/21, indicated R95 was over 75 years old and had diagnoses of high blood pressure and a stroke which left him with hemiplegia (one [left] sided paralysis). R97's quarterly MDS dated 2/11/21, indicated R97 was over 75 years old and had diagnoses of anemia, high blood pressure, and dementia. PPE USE AND HAND HYGIENE During an observation on 2/22/21, from 2:23 p.m. through 2:30 p.m., license practical nurse (LPN)-D wore a mask and glasses but face shield was on top of his head when he gave medications to R81 and R299. During an observation on 2/22/21, from 5:03 p.m. through 5:06 p.m., LPN-D wore a mask and glasses but face shield was on top of his head when he prepared R299's medications and then delivered to R299, who was not wearing a mask. LPN-D leaned into R299, within a foot, to talked into her ear as he explained he was giving her medications.	F 880	to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. a) The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion. b) The training will include competency testing of staff and will be documented. c) Residents and their representatives will receive education on the facility□s Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident□s capacity. 4. The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions. 5. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors, and residents. 6. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us. 7. The Director of Nursing, Infection Preventionist, and other facility leadership	

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 02/25/2021

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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F 880	Continued From page 63 During an interview on 2/22/21, at 5:06 p.m. LPN-D verified he should be wearing his face shield down over his face when interacting with the residents and in resident care areas: room, hallway, and dining rooms. LPN-D stated he sometimes forgets. During an observation on 2/22/21, at 5:07 p.m. an unidentified dietary assistant (DA)-U brought meal trays to the unit's dining room and was wearing a mask but no eye protection. DA-U walked within three feet of R10, who was sitting in the hallway and within 3 feet of several residents in the dining room: R18, R81, R57, R97, and one other unidentified resident. During an observation on 2/23/21, at 1:59 p.m., nursing assistant (NA)-I came out of the resident dining room, removed her face shield, wiped down the face shield, and hung it on wall art (metal trees) next to the entrance of the dining room. NA-I went back into dining room without eye protection and talked to R85, standing within two feet and leaning in to talk into his ear. NA-I then talked to R67, also leaning in to within two feet to talk in his ear. During an interview on 2/23/21, at 2:01 p.m. NA-I stated eye protection should be worn when interacting with residents. NA-I stated she talked to R85 and R67 because they had questions and she did not wear her eye protection because her shift was over. During an observation on 2/24/2021, from 7:30 a.m. through 7:33 a.m., physical therapy assistant (PTA)-A was wearing a mask with goggles on top of his head while talking to R95 in her room. PTA-A leaned over R95 to placed a sling under	F 880	will conduct real time audits on proper use of gowns to ensure PPE is in use. 8. The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program. Substantial Compliance will be achieved by April 10, 2021.	

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

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F 880	Continued From page 64	F 880		

her and used the lift to move R95 from the bed to the wheelchair with the assistance of RN-G, removed his gloves, and performed hand hygiene. PTA-A never placed his goggles over his eyes during the transfer or his time in the room.

During an observation on 2/24/2021, at 8:02 a.m. PTA-A was wearing a mask but his goggles were sitting on top of his head while he was in R299's bathroom with her, assisting her to the wheelchair. PTA-A moved positioned R299's wheelchair into the middle of the room. PTA-A then crawled on the floor to under her bed to retrieve R299's eye glasses from the floor, then placed them on her face, and left the room. PTA-A did not perform hand hygiene or clean the eye glasses prior to placing them on R299's face.

During an observation on 2/24/21 at 8:07 a.m. DA-C delivered dietary trays to the resident dining room, walking within three feet of R18, R81, and R57.

During an interview on 2/24/21, at 8:08 a.m. DA-C stated the expectation was dietary staff wore eye protection in the kitchen and in patient care areas: hallways, dining room, and resident rooms. DA-A stated he forgot his goggles that day but usually wore them.

During continuous observation on 2/24/2021, from 8:08 a.m. through 8:20 a.m., PTA-A with mask on but goggles on top of his head, walked around the dining room placing protective towels on R299, R81, R95, and R97, touching each resident on the back and shoulders when placing the towels. PTA-A did not perform hand hygiene between touching residents. After residents had protective towels, PTA-A delivered food trays to

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F 880	Continued From page 65	F 880		

R57, R95, R299, and R97 PTA-A did not wear goggles over his eyes at any time during this observation.

During an interview on 2/24/21, at 8:24 a.m., PTA-A stated he tried to wear his goggles but he would sometimes forget. PTA-A stated he usually put them on top of his head because they fogged when he wore them and he had not tried a face shield. PTA-A said the expectation was to wear goggles only when giving direct resident care. PTA-A stated he received training on personal protective equipment (PPE) during orientation. PTA-A stated he had not done perineal care prior to coming to the facility but they told them how to do it during orientation. PTA-A stated no one ever observed him do it or demonstrated it to him during orientation.

During an observation on 2/25/21, at 10:24 a.m. NA-H was observed with her face shield on top of her head and the plastic piece on both sides of the face shield was peeling off the foam rubber support so only the middle third of the plastic was attached to the foam rubber support. When NA-H placed the face shield down over her face, the sides of the face shield butterflied out so the sides of her face and eyes were not protected. During an interview at this time NA-H stated she knew where to get PPE and she was always able to get PPE.

RESIDENT HYGIENE

During continuous observation on 2/24/2021, from 8:08 a.m. through 8:20 a.m., residents (R81, R57, R95, and R299) were wheeled into the dining room and not offered hand hygiene before receiving their meal trays.

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F 880	Continued From page 66	F 880		

During an observation on 2/24/2021, at 8:24 a.m. PTA-A was in R18's room with mask and no eye protection. R18 was on her left side, legs drawn up to her chest, an incontinent product was underneath R18's left side, and PTA-A was cleaning bowel movement from R18's peri-area. PTA-A sometimes wiped from front to back, sometimes wiped from back to front, and sometimes wiped around in a circular motion. PTA-A sometimes used a dirty wipe to rewipe in R18's perineal area. PTA-A acknowledged he should be wiping from front to back with clean wipes each time.

The Minnesota Department of Health, PPE Grid, dated 9/25/20, indicated all staff should wear surgical masks while in the building. The Grid also indicated all staff in care areas should wear a mask and eye protection.

The facility's Nursing Care Expectations document (found in the NAR Agency Orientation booklet), dated 7/15/20, stated nursing assistants were to wash residents' hands prior to all meals.

Surveyor: Hovila, Amanda

During an interview on 2/24/21, at 1:33 p.m. the infection preventionist (IP) stated her expectation would be for staff to wear eye protection when they were on the unit and within 6 feet of resident or going into resident rooms. Since there was no COVID in building the facility relaxed their eye protection policy and would consider a low risk exposure based of the six feet rule if not wearing outside of resident rooms.

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F 880	Continued From page 67 During an interview on 2/24/21, at 2:24 p.m. the IP stated based on her decision she decided that staff do not need to wear eyewear unless within 6 feet of a resident due to low exposure. During an interview on 2/25/21, at approximately 3:35 p.m. the director of nursing (DON) stated eyewear should be apart of staff uniforms and verified staff needed to wear appropriate personal protective equipment (PPE) like eye protection. The facility For Respiratory Secretion Protection Policy undated, indicated all staff wil wear full face PPE when in the presence of other staff and residents when a 6 foot distance is unable to be maintained at all times.	F 880		

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	245460	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2021**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

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

Electronically Signed | 03/26/2021

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 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Jones Harrison Residence is located in a 4-story building with a full basement that was built 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 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. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms, and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 130 beds and had a census of 97 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 351	Continued From page 2	K 351		
K 351 SS=D	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, 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 the fire sprinkler system per the 2012 NFPA 101, Life Safety Code, sections 9.7.1.1, 19.3.5.1. This deficient practice could affect all residents within these rooms. Findings include: On a facility tour between the hours of 12:30 p.m. and 3:30 p.m. on 2-25-21, it was revealed that: 1. There was no fire sprinkler protection found in the small janitor ' s closet in the 1st-floor café. 2. The fire sprinklers behind the dryers in the women ' s restroom of the lower level.	K 351	Sprinkler has been installed in small janitor's closet in 1st floor cafe to satisfaction of Fire Marshall. Fire sprinklers behind dryers have been dusted. These sprinklers will be checked on a monthly basis by the Director of Housekeeping or designee to ensure they stay clean and dust free.	3/26/21

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K 351	Continued From page 3 This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 351		

Minnesota State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55003

Phone (651) 201-7200
Website: dps/mn.gov/divisions/sfm

SFM Fire Inspection Report

Inspection Information

Inspection Date: 2/25/2021
Inspection No: 002821

Inspection Type: HealthCare - Scheduled

Facility Information

Jones Harrison Residence
3700 Cedar Lake Avenue Minneapolis, MN 55416
Email:

***Property Use:** HC - Nursing Home - 24-hour care
Nursing homes, 4 or more persons

Occupant Loads

Description / Loads
: 97

Primary Contact

, ( ) Work Phone: | Email:

Kingsley, Roy (State Inspector) Email/Cell: roy.kingsley@state.mn.us (651) 769-7772

Violations

On the above date, an inspection was conducted for the purposes of fire and life safety. The following conditions were observed that do not meet the minimum requirements of the Minnesota State Fire Code. Failure to correct identified fire and life safety deficiencies in a timely manner is a criminal violation pursuant to Minn. Stat. § 299F.011, subd. 6. There is a variance procedure available. Please contact the inspector named for further assistance.

Code - Description	Days to Correct	Violation Status
** Hospital/Nursing Home - K351 : Sprinkler System-Installation - Violation Location: - Comments: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with (NFPA 101 2012 & NFPA 99 2012): 1. Install a fire sprinkler head in small janitor closet in the 1st floor café 2. Clean lint off sprinkler heads behind dryers, woman's rest room on the lower level. ---	59	Violation Noted - Schedule Recheck

End of Report

Printed: 02/26/2021 12:44