Electronically delivered
January 27, 2022

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

RE: CCN: 245460
Cycle Start Date: January 19, 2022

Dear Administrator:

On January 19, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On January 17, 2022, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

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 forimposition:

- 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.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2022

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

Re: Event ID: CKOF11

Dear Administrator:

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 01/19/2022

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/18/22 through 1/19/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Departement of Health (MDH). Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5460085C (MN80216), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5460086C (MN80135). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 3, 2022

Randy Snyder, Executive Director
Board of Nursing Home Administrators
Park Plaza Building
2829 University Avenue Southeast, Suite 440
Minneapolis, Minnesota 55414

Dear Mr. Snyder:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the Board of Nursing Home Administrators whenever we determine that substandard quality of care has been provided to residents. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life, § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection Control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Jones Harrison Residence, 3700 Cedar Lake Avenue, Minneapolis, MN, 55416, which was completed on January 19, 2022, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F678 Cardio-Pulmonary Resuscitation (cpr) S/S J

Quality of Life (§ 483.24). Regulations in this area grant residents the right to the highest practicable physical, mental, and psychosocial well-being in an environment that promotes maintenance or enhancement of each resident's quality of life.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The administrator is Annette Greely, Administrator.

If you have any questions, please feel free to contact me.

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

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 01/19/2022

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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E 000	Initial Comments On 1/18/22 through 1/19/22, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/18/22 through 1/19/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). Additionally, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not found NOT to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The following compliant H5460085C (MN80216) was SUBSTANTIATED at PAST NON-COMPLIANCE with a deficiency cited at immediate jeopardy (IJ) at F678. The IJ began on 1/17/22 when the facility failed to appropriately assess, monitor, and intervene to ensure a resident's request for life saving cardio-pulmonary resuscitation (CPR) was immediately implemented upon finding 1 of 1 resident (R7) unresponsive. The immediate jeopardy was removed on 1/17/22 when the facility had	F 000		

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

Electronically Signed | 01/27/2022

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F 000	Continued From page 1 implemented appropriate corrective action to prevent the situation from recurring. The following complaints were found to be UNSUBSTANTIATED: H5460086C (MN80135). No extended survey was required for a finding of past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. NO PLAN OF CORRECTION is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000		
F 678 SS=J	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 initiate cardiopulmonary resuscitation (CPR) in accordance with physician orders and resident wishes for 1 of 1 residents (R7) who required emergency care. This resulted in an immediate jeopardy (IJ) situation when CPR was not initiated when R7 was found without a pulse and respirations. The deficiency was identified as past noncompliance and issued at Immediate Jeopardy (IJ).	F 678	Past noncompliance: no plan of correction required.	1/27/22

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F 678	Continued From page 2	F 678		

The IJ began on 1/17/22, when the facility failed to provide CPR for R7 after R7 was found unresponsive and later died. The administrator and director of nursing (DON) were notified of the IJ at past noncompliance on 1/19/22 at 5:50 p.m.. Corrective action was taken prior to the survey. The facility corrected the deficient practice on 1/17/22.

Findings include:

R7's admission Minimum Data Set (MDS) assessment dated 1/14/22, indicated R7 had no cognitive impairment, required extensive assistance with transfers, dressing, toileting, personal hygiene, and bed mobility. R7 was diagnosed with obstructive uropathy (a condition in which the flow of urine is blocked that causes urine to back up and injure one or both of the kidneys), urinary retention, gait instability, and major depression. R7 was expected to be discharged to the community after his stay at the facility.

R7's facility admissions orders dated 12/29/21, identified R7's advance directives as "Full Resuscitative Measures".

R7's admission progress note dated 1/6/22, indicated "Advance Directives: Full Code (Full attempts at resuscitation including intubation)".

Review of the 1/18/22, facility investigation and interviews with staff identified:
1) Nursing assistant (NA)-A answered R7's call light between 10:15-10:30 a.m. on 1/17/22. R7 requested his cell phone be plugged into his charger. NA-A then left the room. At about 10:45 a.m., R7's roommate pressed the call light and

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F 678	Continued From page 3	F 678		

stated he pressed it for R7 who was "wrestling around". NA-A discovered R7 was not responsive and left immediately to tell the nurse licensed practical nurse (LPN-A).
2) LPN-A acknowledged she was notified R7 was unresponsive by NA-A and did not check on R7 for "about 10 minutes".
3) LPN-B stated she was approached by LPN-A at approximately 10:55 a.m. to assess R7. Both LPN-A and LPN-B entered R7 room and reported R7 had no pulse or respirations. LPN-B left room to call 911 and notify the house supervisor (HS). Neither LPN-A or LPN-B started CPR. The HS arrived to R7 room with crash cart and did not perform CPR shortly before the paramedics arrived. The paramedics did not perform CPR due to their assessment.
4) No resuscitation measures were attempted. R7 pronounced dead.
5) LPN-A stated she determined that R7 had no respirations or pulse when she first arrived to his room. When asked about her knowledge of R7 code status, LPN-A replied, "I didn't even think about that".

During interview on 1/19/22 at 2:07 p.m., the house supervisor (HS) identified she was working on 1/17/22 and was notified by the facility scheduler that R7 had died. HS arrived on the unit and asked LPN-A what R7's code status was. LPN-A informed HS that R7 died, "a long time ago" and did not know his code status. HS obtained the crash cart and ran to R7's room and determined his condition was irreversible by cold skin temperature and mottled appearance of lower extremities. R7 had also lost all bowel function (commonly occurs after death) and as a result had a bowel movement. Paramedics (EMS) arrived and did not perform CPR. HS stated EMS

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F 678	Continued From page 4	F 678		

asked LPN-A why CPR was not performed. LPN-A continued to state R7 had "died a long time ago" without elaboration. HS identified CPR was supposed to be performed per R7's code status and, "I was so emotional and sad because we did not do what we should have done." HS indicated R7's code status was present and visible in the code status banner of the electronic medical record for R7 and on his face sheet.

Interviewed on 1/19/22 at 11:21 a.m., with the administrator identified R7 code status was full code. The administrator stated CPR was not performed when R7 became unresponsive and delayed life saving treatment, resulting in R7's death.

Interview on 1/19/22 at 10:28 a.m., with the DON identified R7 was considered a full code. The DON stated LPN-A was suspended immediately after event on 1/17/22, and terminated by the facility on 1/18/22 due to her failure to immediately act when NA-A reported to LPN-A, R7 was unresponsive and failed to immediately assess and intervene and begin CPR.

Interview on 1/19/22 at 6:15 p.m., with the medical director (MD) identified a resident whose Advance Directives indicated a "full code" should receive necessary lifesaving treatment including CPR.

The February 2021, CPR and Automated External Defibrillator Policy identified when a resident is found unresponsive, yell "CODE BLUE" and the location down the hall, determine code status by looking at the code status banner in the electronic medical record, perform CPR for resident who have requested CPR, continue CPR

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F 678	Continued From page 5 until cardiac status returns or staff is relieved by another employee trained in CPR or the paramedics have arrived and asked you to stop CPR. The immediate jeopardy past non-compliance that began on 1/17/22, was verified during the 1/18/22 through 1/19/22 survey to have been corrected by 1/17/22. Corrective action was taken prior to the survey when the DON and HS immediately educated all staff currently working that same day on 1/17/22 to the CPR policy following the incident. Staff not working were emailed notification to check in with the DON or HS prior to work and a notice was placed in the time clock computer that flashed a message notifying staff to see the DON and HS to re-educate them to CPR policies and procedures. Verification of corrective action was confirmed by the interviews with a variety of nursing staff, management, the medical director, and review of documentation of staff training. In addition, facility polices were reviewed and audits had been scheduled.	F 678		