| $\begin{array}{                                    $  | DEPARTMENT OF HEALTI           | H AND HUMA          | N SERVICES         |                   |            | <b>CENTERS FOR MED</b>            | ICARE & MEDICA                                      | AID SERVICES            |  |
|---|--------------------------------|---------------------|--------------------|-------------------|------------|-----------------------------------|---|-------------------------|--|
| 1         3.3.8.84         2.   |                                | MEDICA              | ARE/MEDICAI        | D CERTIFIC        | CATION A   |                                   |   |                         |  |
| 11.)       2,254.00       (43.) JONES HARRISON RESUBENCE       1. Intel 1         12.3       46122600       (43.) MINEAPOLIS, NN       (46.) 55416       1. Intel 1         13.       46122600       (43.) MINEAPOLIS, NN       (46.) 55416       1. Intel 1       1. Intel 1         5.       FFERCIVE DATE CHARGE OF OWNERSHIP       0. PROVIDERSHIPPI IFE CATEGORY       (20. (17.)       1. Mataina       6. Compating         6.       DALE OF SUNVEY       0.277,007.1       (14.0)       0.8 NPT       10.100       1.0.000  |                                | PART I -            | TO BE COMPI        | LETED BY T        | THE STAT   | TE SURVEY AGENCY                  | Fa  | acility ID: 00216       |  |
| 2.51XE VENDOR ON VEICHARDNO.       (L4) 3700 CEDAR LAKE AVENUE       4.0100 + 1.0000 + 1.0000 + 1.0000 + 1.0000 + 1.0000 + 1.0000 + 1.0000 + 1.0000 + 1.0000 + 1.0000 + 1.000 |                                | ER NO.              |                    |                   |            |                                   |   | <u> </u>                |  |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP       17. ROVIDES CATEGORY       0.0       (1.7)       8. Ed Servic Mail       8. E   |                                | Ю.                  | · /                |                   | NUE        | (L6) <b>55416</b>                 | <ol> <li>Termination</li> <li>Validation</li> </ol> | 4. CHOW<br>6. Complaint |  |
| 8. ACCREDITATION STATUS:  |                                | OWNERSHIP           |                    |                   |            | . ,                               |   |                         |  |
| 8. ACCERDIATION STATUS: OF SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC OP SIN WORK US ALSO IT CLUID IS ASC A School A School IT CLUID IS ASC A School A School A School IT CLUID IS ASC A School   | 6. DATE OF SURVEY <b>02/27</b> | / <b>2017</b> (L34) | -                  | 06 PRTF           | 10 NF      | 14 CORF                           |   |                         |  |
| 2.00     3.0ker     ID  | 8. ACCREDITATION STATUS:       | (L10)               | 03 SNF/NF/Distinct | 07 X-Ray          | 11 ICF/IID | 15 ASC                            |   | G DATE: (L35)           |  |
| Prom (a):       X       A       In Compliance With<br>Dragam Requirements<br>Compliance With Program Requirements<br>(a): 1 centred Market Minut Nov (a): 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0   |                                |                     | 04 SNF             | 08 OPT/SP         | 12 RHC     | 16 HOSPICE                        | 09/30   |                         |  |
| To       (h):       Program Requirements Compliance Based On:   | 11LTC PERIOD OF CERTIFICATION  | ۱                   | 10.THE FACILITY    | ' IS CERTIFIED    | AS:        |                                   |   |                         |  |
| 12 Total Facility Refs     163     (13)       12 Total Facility Refs     163     (13)       13 Iotal Certified Beds     163     (11)       13 Iotal Certified Beds     163     (11)       14 LUC CRITIFIED BED BELAKDOWN     B. Not in Compliance with Program<br>Requirements and/w Appled Waivers     5. Lifk Safety Code     9. Bedde Room       14 LUC CRITIFIED BED BELAKDOWN     B. Not in Compliance with Program<br>Requirements and/w Appled Waivers     15. FACULTY MEETS     9. Bedde Room       16 STATE SURVEY AGENCY REMARKS (F APPLICABLE SHOW LTC CANCELLATION DATE)     15. FACULTY MEETS     18. STATE SURVEY AGENCY APPROVAL     Date:       17. SURVEYOR SIGNATURE     Date:     03/30/2017     (119)     18. STATE SURVEY AGENCY APPROVAL     Date:       Carly To DBE COMPLETED BY INCEAR REGIONAL OFFICE OR SINCLE STATE ACENCY       19. DETERMINATION OF ELIGIBUITY     20. COMPLANCE WITH CIVIL       21. 1. Statement of francial Solvency (IIC7A-2572)     2. ORIGINAL DATE     23. LIC AGREEMENT       22. ORIGINAL DATE     23. LIC AGREEMENT     24. LIC AGREEMENT     26. TERMINATION ACTION:     (130)       22. ORIGINAL DATE     27. ALTERNATIVE SANCTIONS     A. Suspension of Admission:     0. Fals of Involuments Termination     0. Fals of Involuments Termination       04.01/1987     (L23)     (L41)     (L25)     0. Statis of Involuments Termination     0. Fals of Involuments Terminat   | From (a):                      |                     | x A. In Complia    | nce With          |            | And/Or Approved Waivers Of T      | The Following Requirement                           | <u>nts:</u>             |  |
| 12. Total Facility Beds       163       (1.3)         12. Total Certified Beds       163       (1.3)         13. Total Certified Beds       163       (1.3)         14. LTC CERTIFIED BED BERAKADOWN       8. Not in Compliance with Program Requirements and/or Applied Waivers:       * Code:       4       (1.2)         14. LTC CERTIFIED BED BERAKADOWN       163       (1.3)       (1.42)       (1.42)       (1.43)         16.       10.3       (1.39)       (1.42)       (1.43)       15. Staffe SURVEY AGENCY APPROVAL       Date:         17. SURVEYOR SIGNATURE       Date:       03/30/2017       (1.10)       0.50/12/017       (1.20)         PART II - TO BE COMPLETED BY HCEA REGIONAL OFFICE OR SINGLE STATE AGENCY         PART II - TO BE COMPLETED BY HCEA REGIONAL OFFICE OR SINGLE STATE AGENCY         PART II - TO BE COMPLETED BY HCEA REGIONAL OFFICE OR SINGLE STATE AGENCY         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WTH CIVIL       21. 1. State submerst Program Single Colspan="2">Notochalp Compliance Single State Agency (HCA-2572)         22. ORGINAL DATE       23. LTC ARREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       NOTOLINTAREY         Q.1. Facility is not Eligible         (124)       (121)       (125)       26. TERMINATION ACTION:       NOTOLINTAREY  | To (b) :                       |                     | Ŭ                  | *                 |            | 2. Technical Personnel            | 6. Scope of Ser                                     | vices Limit             |  |
| 12. Toda Facility Beds       163       (1.8)       B. Not in Compliance with Program Requirements and/or Applied Waivers:       -5. Lifk Safety Code       9. Bedd Room         13. Toda Certified Beds       163       (1.7)       B. Not in Compliance with Program Requirements and/or Applied Waivers:       + Code:       A. (1.2)         14. LTC CERTIFIED BED BREAKDOWN       15. IAK Safety Code       9. Bedd Room       + Code:       A. (1.2)         14. LTC CERTIFIED BED BREAKDOWN       163       (1.3)       (1.3)       (1.3)       (1.42)       (1.43)         16. STATE SURVEY AGENCY REMARKS (JF APPLICABLE SHOW LTC CANCELLATION DATE):       18. STATE SURVEY AGENCY APPROVAL       Date:         17. SURVEYOR SKINATURE       Date:       03/30/2017       (1.19)       Todat:       Tod   |                                |                     | ^                  |                   |            |                                   | _   |                         |  |
| 13. Iola Cetified Beds       163       0.17       B. Not in Compliance with Program<br>Requirements and/or Applied Waivers       • Code:       A       (1.2)         14. LTC CERTIFIED BED BREAKDOWN<br>16.3       19. SNF       19. SNF       10.5       15. FACILITY MEETS       18. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW TIC CANCELLATION DATE):         16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW TIC CANCELLATION DATE):       18. STATE SURVEY AGENCY AGENCY APPROVAL       Date:         17. SURVEYOR SIGNATURE       Date:       03/30/2017       18. STATE SURVEY AGENCY AGENCY APPROVAL       Date:         17. SURVEYOR SIGNATURE       Date:       03/30/2017       19. OPPLICABLE SHOW TIC CANCELLATION DATE:       18. STATE SURVEY AGENCY APPROVAL       Date:         17. SURVEYOR SIGNATURE       Date:       03/30/2017       19. OPPLICABLE SHOW TIC CANCELLATION DATE:       18. STATE SURVEY AGENCY APPROVAL       Date:         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL<br>RIGHTS ACT:       1. Statement of Financial Solvency (HCFA-2572)       2. Omouting Council Interest Disclosure Statu (HCFA-1513)       3. Both of the Above:         22. Tracitity is is not Eligible       (1.21)       21. I. Statement of Financial Solvency (HCFA-2572)       2. Omouting Central Interest Disclosure Statu (HCFA-1513)       3. Both of the Above:       0. Statu (HCFA-1513)       3. Both of the Above:       0. Statu (HCFA-1513)       3. Both of the Above: <td< td=""><td>12. Total Facility Beds</td><td>163 (L18)</td><td>1. A</td><td>cceptable POC</td><td></td><td></td><td></td><td>Size</td></td<>   | 12. Total Facility Beds        | 163 (L18)           | 1. A               | cceptable POC     |            |                                   |   | Size                    |  |
| 14. LTC CERTIFIED BED BREAKDOWN<br>18 SNF       19 SNF       19 SNF       10 SNF       19 SNF       10   | 13.Total Certified Beds        | 163 (L17)           | B. Not in Com      | pliance with Prog | ram        | <u>5</u> . Life Safety Code       | 9. Beds/Room  |                         |  |
| $ \begin{array}{c c c c c c c c c c c c c c c c c c c $   |                                |                     | Requirements       | and/or Applied V  | Waivers:   | * Code: A                         | (L12)   |                         |  |
| 163     10.00000000000000000000000000000000000  | 14. LTC CERTIFIED BED BREAKDO  | WN                  |                    |                   |            | 15. FACILITY MEETS                |   |                         |  |
| (137)       (1.38)       (1.49)       (1.42)       (1.43)         16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):       16. STATE SURVEY AGENCY APPROVAL       Date:         17. SURVEYOR SIGNATURE       Date :       03/30/2017       (1.19)       The start survey AGENCY APPROVAL       Date:         17. SURVEYOR SIGNATURE       Date :       03/30/2017       (1.19)       The start survey AGENCY APPROVAL       Date:         18. STATE SURVEY AGENCY APPROVAL       Date:       03/30/2017       (1.19)       The start survey AGENCY APPROVAL       Date:         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL.       RIGHTS ACT:       21. 1. Statement of Financial Solvency (HCFA-2572)       2. Omenship/Control Interest Disclosure Stimt (HCFA-1513)       3. Beth of the Above :       2. Omenship/Control Interest Disclosure Stimt (HCFA-1513)       3. Beth of the Above :       2. Omenship/Control Interest Disclosure Stimt (HCFA-1513)       3. Beth of the Above :       2. Omenship/Control Interest Disclosure Stimt (HCFA-1513)       3. Beth of the Above :       2. Omenship/Control Interest Disclosure Stimt (HCFA-1513)       3. Beth of the Above :       0.0  | 18 SNF 18/19 SNF               | 19 SNF              | ICF                | IID               |            | 1861 (e) (1) or 1861 (j) (1):     | (L15)   |                         |  |
| 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LIC CANCELLATION DATE):         17. SURVEYOR SIGNATURE       Date :         Gayle Lantto, Unit Supervisor       03/30/2017         (L20)       03/30/2017         PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY         19. DETERMINATION OF ELGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:         2.       1. Facility is Eligible to Participate         2.       2. Facility is not Eligible         (121)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:         21.       1. Statement of Financial Solvency (HCFA-2572)         2.       Participate         2.       1. Facility is not Eligible         (121)       20. COMPLIANCE WITH CIVIL RIGHTS ACT:         22. ORIGINAL DATE       23. LIC AGREEMENT         24. LIC AGREEMENT       24. LIC AGREEMENT         25. LIC EXTENSION DATE:       27. ALTERNATIVE SANCHONS         A. Suspension of Admissions:       03-Reks of Involutnary Termination         04/01/1987       04/01/1987         (L27)       B. Rescind Suspension Date:         (L28)       (L45)         28. TERMINATION DATE:       29. INTERMEDIARY/CARREE NO.         03001       01-Active         (L28)       (L31)         31. RO RECEPT OF CMS-1  | 163                            |                     |                    |                   |            |                                   |   |                         |  |
| 17. SURVEYOR SIGNATURE       Date:       18. STATE SURVEY AGENCY APPROVAL       Date:         Gayle Lantto, Unit Supervisor $0^{3/30/2017}$ $(1.19)$ $10^{3/30/2017}$ $10^{3/30/201}$ $10^{3/30/201}$ $10^{3/30/201}$ $10^{3/30/$  | (L37) (L38)                    | (L39)               | (L42)              | (L43)             |            |                                   |   |                         |  |
| Gayle Lantto, Unit Supervisor       03/30/2017       (L20)         ORIGINAL DATE       OS/01/2017       (L20)         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL<br>RIGHTS ACT:       21. 1. Statement of Financial Solverey (HCFA-2572)       2. Outcompship/Control Interest Disclosure Sunt (HCFA-1513)         2. Facility is teligible to Participate<br>  | 16. STATE SURVEY AGENCY REM    | ARKS (IF APPLICA    | BLE SHOW LTC CA    | NCELLATION        | DATE):     |                                   |   |                         |  |
| Gayle Lantto, Unit Supervisor       03/30/2017       (L20)         ORIGINAL DATE       OS/01/2017       (L20)         19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL<br>RIGHTS ACT:       21. 1. Statement of Financial Solverey (HCFA-2572)       2. Outcompship/Control Interest Disclosure Sunt (HCFA-1513)         2. Facility is teligible to Participate<br>  |                                |                     |                    |                   |            |                                   |   |                         |  |
| City E Linke, Our Operator       (1.9)       Track       Track       (1.00)       Track       (1.00)       <  | 17. SURVEYOR SIGNATURE         |                     | Date :             |                   |            | 18. STATE SURVEY AGENCY.          | APPROVAL  | Date:                   |  |
| 19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:       21. 1. Statement of Financial Solvency (HCFA-2572)         2. Facility is Eligible to Participate       (L21)       21. 1. Statement of Financial Solvency (HCFA-2572)         2. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         OF PARTICIPATION       BEGINNING DATE       ENDING DATE       ENDING DATE       26. TERMINATION ACTION:       (L30)         VOLUNTARY       00       INVOLUNTARY       00-       INVOLUNTARY         01-Merger, Closure       05-Fail to Meet Health/Safety       02-Dissatisfaction W/ Reimbursement       06-Fail to Meet Agreement         03-Risk of Involuntary Termination       OTHER       01-Merger, Closure       03-Risk of Involuntary Termination       OTHER         (L27)       B. Rescind Suspension Date:       (L44)       04-Other Reason for Withdrawal       07-Provider Status Change       00-Active         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS       30. REMARKS         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       03-01       04-Other Reason for Withdrawal       04-Other   | Gayle Lantto, Unit Supervi     | isor                | 0                  | 3/30/2017         | (L19)      | Mark Meath,                       | Enforcement Special                                 | list 05/01/2017 (L20)   |  |
| X       1. Facility is Eligible to Participate       2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)         2. Facility is not Eligible       (L21)         2. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT         0f PARTICIPATION       BEGINNING DATE       ENDING DATE         (L24)       (L41)       (L25)         25. LTC EXTENSION DATE:       27. ALTERNATIVE SANCTIONS         A. Suspension of Admissions:       (L44)         (L27)       B. Rescind Suspension Date:         (L27)       B. Rescind Suspension Date:         (L27)       B. Rescind Suspension Date:         (L28)       (L44)         1. C28       (L30)         31. RO RECEIPT OF CMS-1539       32. DETERMINITION OF APPROVAL DATE   | PAF                            | RT II - TO BE       | COMPLETED F        | BY HCFA RI        | EGIONAI    | OFFICE OR SINGLE ST               | FATE AGENCY   |                         |  |
| X       1. Facility is for Eligible to Participate       3. Both of the Above :         2. Facility is not Eligible       (L21)         22. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT         OF PARTICIPATION       BEGINNING DATE       ENDING DATE         04/01/1987       ENDING DATE       ENDING DATE         (L24)       (L41)       (L25)         25. LTC EXTENSION DATE:       27. ALTERNATIVE SANCTIONS         A. Suspension of Admissions:       (L44)         (L27)       B. Rescind Suspension Date:       (L44)         (L27)       B. Rescind Suspension Date:       (L45)         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS         03001       (L28)       (L31)         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE  | 19. DETERMINATION OF ELIGIBIL  | ITY                 | 20. COM            | IPLIANCE WITH     | H CIVIL    |                                   |   |                         |  |
|   | X 1. Facility is Eligible to P | articipate          | RIGH               | ITS ACT:          |            |                                   |   | HCFA-1513)              |  |
| 22. ORIGINAL DATE       23. LTC AGREEMENT       24. LTC AGREEMENT       26. TERMINATION ACTION:       (L30)         OF PARTICIPATION       BEGINNING DATE       ENDING DATE       OD       INVOLUNTARY       00         04/01/1987       (L11)       (L25)       01-Merger, Closure       05-Fail to Meet Health/Safety         02-Dissatisfaction W/ Reimbursement       06-Fail to Meet Agreement       03-Risk of Involuntary Termination       OTHER         02. DISTERMENTION DATE:       27. ALTERNATIVE SANCTIONS       (L44)       04-Other Reason for Withdrawal       OTHER         04-0ther Reason for Withdrawal       04-Other Reason for Withdrawal       OTHER       00-Active         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS       30. REMARKS         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE       (L31)  |                                | -                   |                    |                   |            |                                   | ·   |                         |  |
| OF PARTICIPATION     BEGINNING DATE     ENDING DATE     ENDING DATE     VOLUNTARY     OO     INVOLUNTARY       04/01/1987     (L41)     (L25)     02-Dissatisfaction W/ Reinbursement     06-Fail to Meet Health/Safety       25. LTC EXTENSION DATE:     27. ALTERNATIVE SANCTIONS<br>A. Suspension of Admissions:     (L44)     03-Risk of Involuntary Termination     OTHER<br>07-Provider Status Change<br>07-Provider Status Change<br>00-Active       28. TERMINATION DATE:     29. INTERMEDIARY/CARRIER NO.     30. REMARKS       30. REMARKS       31. RO RECEIPT OF CMS-1539     32. DETERMINATION OF APPROVAL DATE<br>02/27/2017  |                                | (L21)               |                    |                   |            |                                   |   |                         |  |
| 04/01/1987     01-Merger, Closure     05-Fail to Meet Health/Safety       (L24)     (L41)     (L25)       25. LTC EXTENSION DATE:     27. ALTERNATIVE SANCTIONS<br>A. Suspension of Admissions:     03-Risk of Involuntary Termination<br>04-Other Reason for Withdrawal     07-Provider Status Change<br>00-Active       (L27)     B. Rescind Suspension Date:     (L44)       28. TERMINATION DATE:     29. INTERMEDIARY/CARRIER NO.     30. REMARKS       31. RO RECEIPT OF CMS-1539     32. DETERMINATION OF APPROVAL DATE  | 22. ORIGINAL DATE              | 23. LTC AGREE       | MENT 24            | 4. LTC AGREEN     | MENT       | 26. TERMINATION ACTION:           | (I  | .30)                    |  |
| (L24)       (L41)       (L25)       02-Disstisfaction W/ Reimbursement       06-Fail to Meet Agreement         25. LTC EXTENSION DATE:       27. ALTERNATIVE SANCTIONS       03-Risk of Involuntary Termination       07-Provider Status Change         (L27)       B. Rescind Suspension Date:       (L44)       04-Other Reason for Withdrawal       07-Provider Status Change         (L27)       B. Rescind Suspension Date:       (L44)       04-Other Reason for Withdrawal       07-Provider Status Change         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS       30. REMARKS         03001         (L28)       (L31)         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE         02/27/2017       02/27/2017  | OF PARTICIPATION               | BEGINNINC           | 6 DATE             | ENDING DA         | TE         | VOLUNTARY 00                      | INVOLUNT  | TARY                    |  |
| (L24)       (L41)       (L25)       Other Reason for Withdrawal       OTHER<br>07-Provider Status Change<br>00-Active         25. LTC EXTENSION DATE:       27. ALTERNATIVE SANCTIONS<br>A. Suspension of Admissions:       (L44)       03-Risk of Involuntary Termination<br>04-Other Reason for Withdrawal       OTHER<br>07-Provider Status Change<br>00-Active         28. TERMINATION DATE:       29. INTERMEDIARY/CARRIER NO.       30. REMARKS         03001       (L28)       (L31)         31. RO RECEIPT OF CMS-1539       32. DETERMINATION OF APPROVAL DATE<br>02/27/2017       (L31)   | 04/01/1987                     |                     |                    |                   |            |                                   |   | -                       |  |
| 25. LIC EATENSION DATE: 27. ALLERNATIVE SANCTIONS<br>A. Suspension of Admissions:<br>(L44)<br>(L27) B. Rescind Suspension Date:<br>(L45)<br>28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.<br>(L28) (L31)<br>31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE<br>02/27/2017  | (L24)                          | (L41)               |                    | (L25)             |            |                                   |   | leet Agreement          |  |
| A. Suspension of Admissions:<br>(L44)<br>(L27) B. Rescind Suspension Date:<br>(L45)<br>28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.<br>(L28) (L31)<br>31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE<br>02/27/2017   | 25. LTC EXTENSION DATE:        |                     |                    |                   |            |                                   | OTHER   |                         |  |
| (L27) B. Rescind Suspension Date:<br>(L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.<br>03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE<br>02/27/2017 (L28) (L31)  |                                | A. Suspension       | n of Admissions:   | (1.4.4)           |            | or other recusoir for whitehowing |   | Status Change           |  |
| (L45)     30. REMARKS       28. TERMINATION DATE:     29. INTERMEDIARY/CARRIER NO.     30. REMARKS       03001       (L28)     (L31)       31. RO RECEIPT OF CMS-1539     32. DETERMINATION OF APPROVAL DATE       02/27/2017     02/27/2017  | (L27)                          | B. Rescind St       | spension Date:     | (L44)             |            |                                   | 00-Active   |                         |  |
| 03001<br>(L28) (L31)<br>31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE<br>02/27/2017   |                                |                     |                    | (L45)             |            |                                   |   |                         |  |
| (L28) (L31)<br>31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE<br>02/27/2017  | 28. TERMINATION DATE:          | 29                  | . INTERMEDIARY/    | CARRIER NO.       |            | 30. REMARKS                       |   |                         |  |
| 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE<br>02/27/2017   |                                |                     | 03001              |                   |            |                                   |   |                         |  |
| 02/27/2017  |                                | (L28)               |                    |                   | (L31)      |                                   |   |                         |  |
| 02/27/2017  |                                |                     |                    |                   |            |                                   |   |                         |  |
| (L32) 02/27/2017 (L33) DETERMINATION APPROVAL   | 31. RO RECEIPT OF CMS-1539     | 32                  |                    | OF APPROVAL       | DATE       |                                   |   |                         |  |
|   |                                | (L32)               | 02/27/2017         |                   | (L33)      | DETERMINATION APPR                | ROVAL   |                         |  |



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245460

May 1, 2017

Mr. Lowell Berggren, Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, MN 55416

Dear Mr. Berggren:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 6, 2017 the above facility is certified for:

163 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 163 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us Phone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 30, 2017

Mr. Lowell Berggren, Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, Minnesota 55416

RE: Project Number S5460027

Dear Mr. Berggren:

On January 30, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 12, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On February 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 6, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 12, 2017, effective February 6, 2017 and therefore remedies outlined in our letter to you dated January 30, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

mark meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

## **POST-CERTIFICATION REVISIT REPORT**

|                         | MULTIPLE CONSTRUCTION |                                       |   | DATE OF REVISI | T  |
|-------------------------|-----------------------|---------------------------------------|---|----------------|----|
| IDENTIFICATION NUMBER   | A. Building           |                                       |   |                |    |
| 245460 <sub>Y1</sub>    | B. Wing               | Y2                                    | 2 | 2/27/2017      | Y3 |
| NAME OF FACILITY        |                       | STREET ADDRESS, CITY, STATE, ZIP CODE |   |                |    |
| JONES HARRISON RESIDENC | CE                    | 3700 CEDAR LAKE AVENUE                |   |                |    |
|                         |                       | MINNEAPOLIS, MN 55416                 |   |                |    |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITEM   | DATE                 | ITEM   | DATE                                   | ITEM             |                                    | DATE                    |  |
|--|----------------------|--|--|------------------|------------------------------------|-------------------------|--|
| Y4   | Y5                   | Y4   | Y5                                     | Y4               |                                    | Y5                      |  |
| ID Prefix F0156<br>Reg. # 483.10(d)(3)(g)(1)(4)<br>(13)(16)-(18) | Completed            | Reg. # (3),483   | (c)(2)(i-ii,iv,v)<br>3.21(b)(2) Comple | ed Reg. #        | F0323<br>483.25(d)(1)(2)(n)(1)-(3) | Correction<br>Completed |  |
| LSC  | 02/06/2017           | LSC  | 02/06/20                               | 17 LSC           |                                    | 02/06/2017              |  |
| ID Prefix  | Correction           | ID Prefix  | Correcti                               | on ID Prefix     |                                    | Correction              |  |
| Reg. #   | Completed            | Reg. #<br>   | Comple                                 | ed Reg. #<br>LSC |                                    | Completed<br>           |  |
| ID Prefix  | Correction           | ID Prefix  | Correcti                               | on ID Prefix     |                                    | Correction              |  |
| Reg. #   | Completed            | Reg. #   | Comple                                 | ed Reg. #        |                                    | Completed               |  |
| LSC  |                      | LSC  |  | LSC              |                                    | _                       |  |
| ID Prefix  | Correction           | ID Prefix  | Correcti                               | on ID Prefix     |                                    | Correction              |  |
| Reg. #   | Completed            | Reg. #   | Comple                                 | ed Reg. #        |                                    | Completed               |  |
| LSC  |                      | LSC  |  | LSC              |                                    | _                       |  |
| ID Prefix  | Correction           | ID Prefix  | Correcti                               | on ID Prefix     |                                    | Correction              |  |
| Reg. #   | Completed            | Reg. #   | Comple                                 | ed Reg. #        |                                    | Completed               |  |
| LSC  |                      | LSC  |  | LSC              |                                    | _                       |  |
| REVIEWED BY RE<br>STATE AGENCY X (IN                             | VIEWED BY<br>ITIALS) | <b>DATE</b><br>03/30/2017  | SIGNATURE OF SURVEYO                   | PR<br>15507      | <b>DATE</b><br>02/27/              | 2017                    |  |
|  | VIEWED BY<br>ITIALS) | DATE   | TITLE                                  |                  | DATE                               |                         |  |
| FOLLOWUP TO SURVEY CO<br>1/12/2017                               | MPLETED ON           | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |  |                  |                                    |                         |  |

| DEPARTMENT OF HEALT                                | H AND HUMA       | N SERVICES                       |                   |                  | <b>CENTERS FOR MED</b>   | DICARE & MEDICAID SERVICES                     |
|--|------------------|----------------------------------|-------------------|------------------|--|--|
|  |                  |                                  |                   |                  | AND TRANSMITTAL  | ID: EZ92                                       |
|  | PART I -         | TO BE COMPI                      | LETED BY 1        | THE STAT         | <b>TE SURVEY AGENCY</b>  | Facility ID: 00216                             |
| 1. MEDICARE/MEDICAID PROVID                        | ER NO.           | 3. NAME AND AL                   |                   |                  |  | 4. TYPE OF ACTION: <u>2</u> (L8)               |
| (L1) <b>245460</b><br>2.STATE VENDOR OR MEDICAID N |                  | (L3) JONES HAP<br>(L4) 3700 CEDA |                   |                  |  | 1. Initial 2. Recertification                  |
| (L2) 461242600                                     | NU.              | (L4) 5700 CEDAI                  |                   | NUL              | (L6) <b>55416</b>  | 3. Termination4. CHOW5. Validation6. Complaint |
|  | ONAIDOUND        |                                  |                   |                  |  | 7. On-Site Visit 9. Other                      |
| 5. EFFECTIVE DATE CHANGE OF (L9)                   | OWNERSHIP        | 7. PROVIDER/SU                   | 05 HHA            | JORY<br>09 ESRD  | <u>02</u> (L7)<br>13 PTIP 22 CLIA                                | 8. Full Survey After Complaint                 |
|  | 2/2017 (L34)     | 01 Hospital<br>02 SNF/NF/Dual    | 05 HHA<br>06 PRTF | 09 ESKD<br>10 NF | 14 CORF  |  |
| 8. ACCREDITATION STATUS:                           | (L10)            | 03 SNF/NF/Distinct               | 07 X-Ray          | 11 ICF/IID       |  | FISCAL YEAR ENDING DATE: (L35)                 |
| 0 Unaccredited 1 TJC<br>2 AOA 3 Other              | <u> </u>         | 04 SNF                           | 08 OPT/SP         | 12 RHC           | 16 HOSPICE   | 09/30  |
| 11LTC PERIOD OF CERTIFICATIO                       | N                | 10.THE FACILITY                  | ' IS CERTIFIED    | AS:              |  |  |
| From (a):  |                  | A. In Complia                    | nce With          |                  | And/Or Approved Waivers Of                                       | The Following Requirements:                    |
| To (b) :   |                  | Ű                                | equirements       |                  | 2. Technical Personnel   | 6. Scope of Services Limit                     |
|  |                  | Compliance                       | e Based On:       |                  | 3. 24 Hour RN  | 7. Medical Director                            |
| 12. Total Facility Beds                            | 163 (L18)        | 1. A                             | cceptable POC     |                  | 4. 7-Day RN (Rural SN  | F)8. Patient Room Size                         |
| 13.Total Certified Beds                            | 163 (L17)        | X B. Not in Con                  | poliance with Pro | gram             | 5. Life Safety Code  | 9. Beds/Room                                   |
|  |                  |                                  | and/or Applied    |                  | * Code: <b>B</b> *   | (L12)  |
| 14. LTC CERTIFIED BED BREAKDO                      | OWN              | •                                |                   |                  | 15. FACILITY MEETS   |  |
| 18 SNF 18/19 SNF                                   | 19 SNF           | ICF                              | IID               |                  | 1861 (e) (1) or 1861 (j) (1):                                    | (L15)  |
| 163  |                  |                                  |                   |                  |  |  |
| (L37) (L38)  | (L39)            | (L42)                            | (L43)             |                  |  |  |
| 16. STATE SURVEY AGENCY REM                        | ARKS (IF APPLICA | ABLE SHOW LTC CA                 | NCELLATION        | DATE):           |  |  |
|  |                  |                                  |                   |                  |  |  |
| 17. SURVEYOR SIGNATURE                             |                  | Date :                           |                   |                  | 18. STATE SURVEY AGENCY  | APPROVAL Date:                                 |
| Jane Teipel, HFE NEII                              |                  | 0                                | 2/08/2017         |                  | Mark Meath   | Enforcement Specialist 02/27/2017              |
|  |                  |                                  |                   | (L19)            |  | (L20)  |
| PA   | RT II - TO BE    | COMPLETED I                      | BY HCFA RI        | EGIONAI          | OFFICE OR SINGLE S   | TATE AGENCY                                    |
| 19. DETERMINATION OF ELIGIBII                      | LITY             |                                  | IPLIANCE WIT      | H CIVIL          |  | ncial Solvency (HCFA-2572)                     |
| X 1. Facility is Eligible to I                     | Participate      | RIGH                             | ITS ACT:          |                  | <ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol> | Interest Disclosure Stmt (HCFA-1513)           |
| 2. Facility is not Eligible                        |                  |                                  |                   |                  |  |  |
|  | (L21)            |                                  |                   |                  |  |  |
| 22. ORIGINAL DATE                                  | 23. LTC AGREE    | MENT 24                          | 4. LTC AGREEN     | MENT             | 26. TERMINATION ACTION:  | (L30)  |
| OF PARTICIPATION                                   | BEGINNINC        | G DATE                           | ENDING DA         | TE               | VOLUNTARY _00  | INVOLUNTARY                                    |
| 04/01/1987   |                  |                                  |                   |                  | 01-Merger, Closure   | 05-Fail to Meet Health/Safety                  |
| (L24)  | (L41)            |                                  | (L25)             |                  | 02-Dissatisfaction W/ Reimburse                                  | ement 06-Fail to Meet Agreement                |
| 25. LTC EXTENSION DATE:                            | 27. ALTERNATI    | VE SANCTIONS                     |                   |                  | 03-Risk of Involuntary Terminatio                                | n OTHER  |
|  | A. Suspension    | n of Admissions:                 |                   |                  | 04-Other Reason for Withdrawal                                   | 07-Provider Status Change                      |
| (L27)  |                  |                                  | (L44)             |                  |  | 00-Active                                      |
| (L27)  | B. Rescind St    | uspension Date:                  |                   |                  |  |  |
|  |                  |                                  | (L45)             |                  |  |  |
| 28. TERMINATION DATE:                              | 29               | . INTERMEDIARY/                  | CARRIER NO.       |                  | 30. REMARKS  |  |
|  |                  | 03001                            |                   |                  |  |  |
|  | (L28)            |                                  |                   | (L31)            |  |  |
| 31. RO RECEIPT OF CMS-1539                         | 32               | . DETERMINATION                  | OF APPROVAI       | LDATE            |  |  |
|  | (L32)            |                                  |                   | (L33)            | DETERMINATION APPI   | DOVAL  |
|  | (1.32)           |                                  |                   | (L33)            | DETERMINATION APPE   | NO VAL   |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 30, 2017

Mr. Lowell Berggren, Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, Minnesota 55416

RE: Project Number S5460027

Dear Mr. Berggren:

On January 12, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

## <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

### DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 21, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- 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;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions

> are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

## Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

## Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

## Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by April 12, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 July 12, 2017 (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.

## INFORMAL DISPUTE RESOLUTION

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

| DEPART                   | MENT OF HEALTH   | AND HUMAN SERVICES  |                    |     | 1   |               | APPROVED                   |
|--------------------------|--|---|--------------------|-----|---|---------------|----------------------------|
| CENTER                   | RS FOR MEDICARE  | & MEDICAID SERVICES   |                    |     | 0   | <u>MB NO.</u> | 0938-0391                  |
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |   |               | E SURVEY<br>IPLETED        |
|                          |  | 245460  | B. WING            | i   |   | 01/           | 12/2017                    |
| NAME OF I                | PROVIDER OR SUPPLIER   | •   |                    | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE   |               |                            |
|                          | ARRISON RESIDEN  | <b>~</b> E  |                    | 3   | 3700 CEDAR LAKE AVENUE  |               |                            |
| UCINEST                  | Annioon neoidein   |   |                    | N   | MINNEAPOLIS, MN 55416   |               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE          | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT  | ſS  | F                  | 000 |   |               |                            |
|                          | signature is not req<br>page of the CMS-2  | led in ePOC and therefore a<br>uired at the bottom of the first<br>567 form. Electronic<br>POC will be used as<br>bliance.  |                    |     |   |               |                            |
| F 156<br>SS=D            | revisit of your facilit<br>validate that substa<br>regulations has bee<br>your verification.<br>483.10(d)(3)(g)(1)(4 | acceptable POC an on-site<br>y may be conducted to<br>antial compliance with the<br>en attained in accordance with<br>4)(5)(13)(16)-(18) NOTICE OF<br>SERVICES, CHARGES | F                  | 156 |   |               | 2/6/17                     |
| 00-0                     | (d)(3) The facility m<br>remains informed o<br>of contacting the ph  | ust ensure that each resident<br>of the name, specialty, and way<br>hysician and other primary care<br>onsible for his or her care.                                     |                    |     |   |               |                            |
|                          | (1) The resident hat his or her rights and   | tion and Communication.<br>s the right to be informed of<br>d of all rules and regulations<br>conduct and responsibilities<br>ay in the facility.                       |                    |     |   |               |                            |
|                          | notices orally (mean   | has the right to receive<br>ning spoken) and in writing<br>a a format and a language he<br>a, including:  |                    |     |   |               |                            |
|                          | The facility must fur  | as specified in this section.<br>rnish to each resident a written<br>rights which includes -  |                    |     |   |               |                            |
|                          |  | the manner of protecting<br>der paragraph (f)(10) of this   |                    |     |   |               |                            |
| LABORATOR                | Y DIRECTOR'S OR PROVID   | DER/SUPPLIER REPRESENTATIVE'S SIGN  | NATURE             |     | TITLE   |               | (X6) DATE                  |
| Electron                 | ically Signed  |   |                    |     |   |               | 02/07/2017                 |

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.

|                          |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                     |  | FORM                     | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|--|--------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  | (X3) DATE                | E SURVEY<br>PLETED                  |
|                          |  | 245460  | B. WING             |  | <b>01</b> / <sup>.</sup> | 12/2017                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | -                        |                                     |
| JONES H                  | ARRISON RESIDEN  | CE  |                     | 3700 CEDAR LAKE AVENUE<br>MINNEAPOLIS, MN 55416  |                          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                     | (X5)<br>COMPLETION<br>DATE          |
| F 156                    | Continued From pa  | age 1   | F 156               |  |                          |                                     |
|                          | procedures for esta<br>including the right to  | i the requirements and<br>ablishing eligibility for Medicaid,<br>o request an assessment of<br>ection 1924(c) of the Social   |                     |  |                          |                                     |
|                          | email), and telepho<br>State regulatory an<br>resident advocacy of<br>Survey Agency, the<br>State Long-Term C<br>protection and advo<br>services where stat<br>in long-term care fa<br>agency for informat | addresses (mailing and<br>one numbers of all pertinent<br>d informational agencies,<br>groups such as the State<br>e State licensure office, the<br>are Ombudsman program, the<br>ocacy agency, adult protective<br>te law provides for jurisdiction<br>acilities, the local contact<br>tion about returning to the<br>Medicaid Fraud Control Unit; |                     |  |                          |                                     |
|                          | complaint with the s<br>concerning any sus<br>federal nursing faci<br>not limited to reside<br>exploitation, misapp<br>in the facility, non-c<br>directives requirem                                       | at the resident may file a<br>State Survey Agency<br>spected violation of state or<br>ility regulations, including but<br>ent abuse, neglect,<br>propriation of resident property<br>compliance with the advance<br>ents and requests for<br>ng returning to the community.   |                     |  |                          |                                     |
|                          | and local advocacy<br>not limited to the St<br>Long-Term Care Of<br>(established under<br>Americans Act of 1<br>U.S.C. 3001 et seq   | contact information for State<br>organizations including but<br>tate Survey Agency, the State<br>mbudsman program<br>section 712 of the Older<br>965, as amended 2016 (42<br>and the protection and<br>as designated by the state, and  |                     |  |                          |                                     |

Facility ID: 00216

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|                          |   | AND HUMAN SERVICES   |                    |    |   | FORM      | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |    | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245460   | B. WING            |    |   | 01/       | 12/2017                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                    |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| JONES H                  | ARRISON RESIDENC  | CE   |                    |    | 700 CEDAR LAKE AVENUE<br>/INNEAPOLIS, MN 55416  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 156                    | as established unde<br>Disabilities Assistar<br>2000 (42 U.S.C. 15<br>[§483.10(g)(4)(ii) wi<br>November 28, 2017<br>(iii) Information rega<br>eligibility and covera<br>[§483.10(g)(4)(iii) w<br>November 28, 2017<br>(iv) Contact informa<br>Disability Resource<br>Section 202(a)(20)(<br>Act); or other No W<br>[§483.10(g)(4)(iv) w<br>November 28, 2017<br>(v) Contact informa<br>Control Unit; and<br>[§483.10(g)(4)(v) w<br>November 28, 2017<br>(vi) Information and<br>grievances or comp<br>suspected violation<br>facility regulations,<br>resident abuse, neg<br>misappropriation of<br>facility, non-complia<br>directives requirem<br>information regardin<br>(g)(5) The facility m<br>manner accessible<br>residents, resident | er the Developmental<br>nee and Bill of Rights Act of<br>001 et seq.)<br>ill be implemented beginning<br>7 (Phase 2)]<br>arding Medicare and Medicaid<br>age;<br>vill be implemented beginning<br>7 (Phase 2)]<br>ation for the Aging and<br>Center (established under<br>(B)(iii) of the Older Americans<br>rong Door Program;<br>vill be implemented beginning<br>7 (Phase 2)]<br>tion for the Medicaid Fraud<br>ill be implemented beginning<br>7 (Phase 2)]<br>tion for the Medicaid Fraud<br>ill be implemented beginning<br>7 (Phase 2)]<br>contact information for filing<br>plaints concerning any<br>of state or federal nursing<br>including but not limited to<br>glect, exploitation,<br>resident property in the<br>ance with the advance<br>ents and requests for<br>ng returning to the community.<br>uust post, in a form and<br>and understandable to | F 1                | 56 |   |           |                                     |

|                          |   | AND HUMAN SERVICES   |                    |     |  | FORM             | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|-----|--|------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION   | (X3) DATE        | E SURVEY<br>PLETED                  |
|                          |   | 245460   | B. WING            |     |  | 01/ <sup>.</sup> | 12/2017                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                    |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                  |                                     |
| JONES H                  | ARRISON RESIDENC  | Æ  |                    |     | 700 CEDAR LAKE AVENUE<br>/INNEAPOLIS, MN 55416   |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE               | (X5)<br>COMPLETION<br>DATE          |
| F 156                    | and telephone num<br>agencies and advoor<br>Survey Agency, the<br>protective services<br>jurisdiction in long-t<br>of the State Long-To<br>program, the protect<br>home and commun<br>and the Medicaid F<br>(ii) A statement that<br>complaint with the S<br>concerning any sus<br>federal nursing facil<br>limited to resident a<br>misappropriation of<br>facility, and non-cor<br>directives requirement<br>I) and requests for it<br>to the community.<br>(g)(13) The facility r<br>written information,<br>applicants for admisi<br>information about h<br>Medicare and Medi<br>receive refunds for<br>such benefits.<br>(g)(16) The facility r<br>and services to the<br>admission and durin<br>(i) The facility must<br>and in writing in a la<br>understands of his of<br>regulations governing | Ige 3<br>bers of all pertinent State<br>cacy groups, such as the State<br>State licensure office, adult<br>where state law provides for<br>term care facilities, the Office<br>ferm Care Ombudsman<br>ction and advocacy network,<br>hity based service programs,<br>raud Control Unit; and<br>the resident may file a<br>State Survey Agency<br>spected violation of state or<br>lity regulation, including but not<br>abuse, neglect, exploitation,<br>resident property in the<br>mpliance with the advanced<br>ents (42 CFR part 489 subpart<br>information regarding returning<br>must display in the facility<br>and provide to residents and<br>ssion, oral and written<br>iow to apply for and use<br>caid benefits, and how to<br>previous payments covered by<br>must provide a notice of rights<br>resident prior to or upon<br>ng the resident's stay.<br>inform the resident both orally<br>anguage that the resident<br>or her rights and all rules and<br>ng resident conduct and<br>ng the stay in the facility. |                    | 156 |  |                  |                                     |

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|                          | -  | AND HUMAN SERVICES   |                     |    |  | FORM             | APPROVED                   |
|--------------------------|--|--|---------------------|----|--|------------------|----------------------------|
|                          |  | & MEDICAID SERVICES  | <u></u>             |    |  |                  | 0938-0391                  |
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 |    |  |                  | E SURVEY<br>PLETED         |
|                          |  | 245460   | B. WING _           |    |  | 01/ <sup>.</sup> | 12/2017                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | ST | TREET ADDRESS, CITY, STATE, ZIP CODE   |                  |                            |
| JONES H                  | ARRISON RESIDENC   | )E   |                     |    | 700 CEDAR LAKE AVENUE<br>IINNEAPOLIS, MN 55416   |                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE               | (X5)<br>COMPLETION<br>DATE |
| F 156                    | Continued From pa  | ge 4   | F 15                | 56 |  | _                |                            |
|                          |  | t also provide the resident with<br>d notice of Medicaid rights and  |                     |    |  |                  |                            |
|                          |  | information, and any<br>nust be acknowledged in  |                     |    |  |                  |                            |
|                          | (g)(17) The facility r   | nust   |                     |    |  |                  |                            |
|                          | writing, at the time of  | licaid-eligible resident, in<br>of admission to the nursing<br>e resident becomes eligible for   |                     |    |  |                  |                            |
|                          | nursing facility serv  | services that are included in<br>ices under the State plan and<br>ent may not be charged;  |                     |    |  |                  |                            |
|                          | facility offers and fo   | ms and services that the<br>or which the resident may be<br>mount of charges for those   |                     |    |  |                  |                            |
|                          | changes are made   | dicaid-eligible resident when<br>to the items and services<br>aphs (g)(17)(i)(A) and (B) of  |                     |    |  |                  |                            |
|                          | before, or at the tim<br>periodically during t<br>available in the faci<br>services, including | must inform each resident<br>ne of admission, and<br>the resident's stay, of services<br>lity and of charges for those<br>any charges for services not<br>licare/ Medicaid or by the<br>ate. |                     |    |  |                  |                            |

Facility ID: 00216

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|                          |   | AND HUMAN SERVICES   |                    |    |  | FORM        | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|----|--|-------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |    | E CONSTRUCTION   | (X3) DATE   | E SURVEY<br>PLETED                  |
|                          |   | 245460   | B. WING            |    |  | 01/1        | 12/2017                             |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                    | S  | TREET ADDRESS, CITY, STATE, ZIP CODE   |             |                                     |
| JONES H                  | ARRISON RESIDENC  | CE   |                    |    | 700 CEDAR LAKE AVENUE<br>IINNEAPOLIS, MN 55416   |             |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE          | (X5)<br>COMPLETION<br>DATE          |
| F 156                    | <ul> <li>(i) Where changes<br/>and services covered<br/>Medicaid State plan<br/>notice to residents of<br/>reasonably possible</li> <li>(ii) Where changes<br/>items and services<br/>facility must inform<br/>60 days prior to imp<br/>(iii) If a resident diet<br/>transferred and doef<br/>facility must refund<br/>representative, or e<br/>deposit or charges<br/>per diem rate, for th<br/>resided or reserved<br/>facility, regardless of<br/>discharge notice refund<br/>the resident representative<br/>the resident within of<br/>date of discharge friend<br/>v) The terms of an a<br/>behalf of an individu<br/>facility must not cor<br/>these regulations.<br/>This REQUIREMEN<br/>by:<br/>Based on interview<br/>facility failed to provide<br/>the resident of provide<br/>the resident of the terms of<br/>the terms of an an<br/>an an a</li></ul> | in coverage are made to items<br>ed by Medicare and/or by the<br>n, the facility must provide<br>of the change as soon as is<br>e.<br>are made to charges for other<br>that the facility offers, the<br>the resident in writing at least<br>olementation of the change.<br>s or is hospitalized or is<br>es not return to the facility, the<br>to the resident, resident<br>estate, as applicable, any<br>already paid, less the facility's<br>ne days the resident actually<br>l or retained a bed in the<br>of any minimum stay or<br>quirements.<br>et refund to the resident or<br>tive any and all refunds due<br>30 days from the resident's<br>rom the facility.<br>admission contract by or on<br>ual seeking admission to the<br>offlict with the requirements of<br>NT is not met as evidenced<br><i>v</i> and document review, the<br><i>v</i> ide appropriate liability notices<br>(R50, R35) who were | F1                 | 56 | It is the policy at Jones Harrison<br>Residence to inform residents of ch<br>in their services and of their liability<br>when they are being discharged fro<br>Medicare. | notice<br>m |                                     |

Facility ID: 00216

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|                          | OF DEFICIENCIES  | & MEDICAID SERVICES  | (X2) MI II TI       | PLE CONSTRUCTION  |                                 | 0938-0391<br>SURVEY        |
|--------------------------|--|--|---------------------|---|---------------------------------|----------------------------|
|                          | OF CORRECTION  | IDENTIFICATION NUMBER:   |                     | 3   |                                 | PLETED                     |
|                          |  | 245460   | B. WING             |   | 01/                             | 12/2017                    |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                                 |                            |
| JONES I                  | HARRISON RESIDEN   | CE   |                     | 3700 CEDAR LAKE AVENUE<br>MINNEAPOLIS, MN 55416   |                                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | ) BE                            | (X5)<br>COMPLETION<br>DATE |
| F 156<br>F 280<br>SS=D   | R50 was admitted<br>remained at the fac<br>facility on 10/18/16<br>On 1/10/17, at app<br>notices were reque<br>and R35 from the of<br>few hours later the<br>three notices, and<br>and R35 would be<br>The following day a<br>DON verified the lia<br>could not be found<br>responsible for pro<br>employed with the<br>was aware it was th<br>provide two-day no<br>going to be dischard<br>A policy and procee<br>provided.<br>483.10(c)(2)(i-ii,iv,)<br>PARTICIPATE PLA<br>483.10<br>(c)(2) The right to part<br>including the right to<br>be included in the p<br>request meetings a | to the facility on 8/11/16, and<br>cility. R35 was admitted to the<br>, and discharged on 12/1/16.<br>roximately 9:00 a.m. liability<br>ested, including those for R50<br>director of nursing (DON). A<br>DON provided one of the<br>explained the notices for R50 | F 150               | <ul> <li>liability notices was reviewed and r</li> <li>The Medicare nurse will be responsive liability notices when Medical coverage is ending.</li> <li>The Facility will file the notice in the medical record upon completion at the document in the shared drive.</li> <li>The Medicare team will discuss per liability notices at rounds each week</li> <li>The Medicare nurse/DON will be responsible for compliance.</li> <li>The Liability notices will be reviewed quarterly at the facilities QA to ensite compliance.</li> <li>Facility will be in compliance by Fer 6th, 2017.</li> </ul> | e<br>nd scan<br>otential<br>ek. | 2/6/17                     |

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|               |                                   | AND HUMAN SERVICES  |               |     |  | FORM | APPROVED           |
|---------------|-----------------------------------|---|---------------|-----|--|------|--------------------|
|               | TOF DEFICIENCIES                  | & MEDICAID SERVICES   | (X2) MUI      | TIP |  |      | 0938-0391          |
|               | OF CORRECTION                     | IDENTIFICATION NUMBER:  |               |     |  |      | PLETED             |
|               |                                   | 245460  | B. WING       |     |  | 01/  | 10/0017            |
| NAME OF F     | PROVIDER OR SUPPLIER              | 240400  |               |     | STREET ADDRESS, CITY, STATE, ZIP CODE                            | 01/  | 12/2017            |
|               |                                   |   |               |     | 3700 CEDAR LAKE AVENUE   |      |                    |
| JONES F       | ARRISON RESIDENC                  | JE  |               | I   | MINNEAPOLIS, MN 55416  |      |                    |
| (X4) ID       |                                   |   | ID            |     | PROVIDER'S PLAN OF CORRECTIO                                     |      | (X5)               |
| PREFIX<br>TAG |                                   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)     | PREFIX<br>TAG | X   | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF |      | COMPLETION<br>DATE |
|               |                                   |   |               |     | DEFICIENCY)  |      |                    |
| F 000         |                                   | _   |               |     |  |      |                    |
| F 280         |                                   | •   | F 2           | 80  |  |      |                    |
|               |                                   | , and duration of care, and any d to the effectiveness of the |               |     |  |      |                    |
|               | plan of care.                     |   |               |     |  |      |                    |
|               | (in) The right to rea             | eive the services and/or items                                |               |     |  |      |                    |
|               | included in the plan              |   |               |     |  |      |                    |
|               |                                   |   |               |     |  |      |                    |
|               |                                   | the care plan, including the                                  |               |     |  |      |                    |
|               | right to sign after sign of care. | gnificant changes to the plan                                 |               |     |  |      |                    |
|               | or care.                          |   |               |     |  |      |                    |
|               |                                   | nall inform the resident of the                               |               |     |  |      |                    |
|               |                                   | n his or her treatment and                                    |               |     |  |      |                    |
|               | planning process m                | sident in this right. The<br>nust                             |               |     |  |      |                    |
|               |                                   |   |               |     |  |      |                    |
|               |                                   | lusion of the resident and/or                                 |               |     |  |      |                    |
|               | resident representa               | itive.  |               |     |  |      |                    |
|               | (ii) Include an asse              | ssment of the resident's                                      |               |     |  |      |                    |
|               | strengths and need                | S.  |               |     |  |      |                    |
|               | (iii) Incorporate the             | resident's personal and                                       |               |     |  |      |                    |
|               |                                   | s in developing goals of care.                                |               |     |  |      |                    |
|               |                                   |   |               |     |  |      |                    |
|               | 483.21<br>(b) Comprehensive       | Coro Plana  |               |     |  |      |                    |
|               |                                   | Cale Flaits   |               |     |  |      |                    |
|               | (2) A comprehensiv                | ve care plan must be-   |               |     |  |      |                    |
|               | (i) Developed withir              | n 7 days after completion of                                  |               |     |  |      |                    |
|               | the comprehensive                 | assessment.   |               |     |  |      |                    |
|               | (ii) Prepared by an               | interdisciplinary team, that                                  |               |     |  |      |                    |
|               | includes but is not l             |   |               |     |  |      |                    |
|               | (A) The attending p               | hypipion  |               |     |  |      |                    |
|               | (A) The altending p               | nysician.   |               |     |  |      |                    |
|               |                                   |   |               |     |  |      |                    |

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|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |  | FORM               | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|--|--------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  | (X3) DATE          | E SURVEY<br>PLETED                  |
|                          |  | 245460  | B. WING             | <br>   | <b>01</b> /1       | 12/2017                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     | REET ADDRESS, CITY, STATE, ZIP CODE  |                    |                                     |
| JONES H                  | ARRISON RESIDENC   | E   |                     | 00 CEDAR LAKE AVENUE<br>INNEAPOLIS, MN 55416   |                    |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE                 | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | Continued From pa<br>(B) A registered nur<br>resident.<br>(C) A nurse aide wit<br>resident.<br>(D) A member of for<br>(E) To the extent pro-<br>the resident and the<br>An explanation mus<br>medical record if the<br>and their resident re-<br>not practicable for the<br>resident's care plan<br>(F) Other appropria<br>disciplines as deternor<br>or as requested by<br>(iii) Reviewed and re-<br>team after each ass<br>comprehensive and<br>assessments.<br>This REQUIREMEN<br>by:<br>Based on observat<br>interview, the facility<br>the care plan follow | ge 8<br>se with responsibility for the<br>th responsibility for the<br>od and nutrition services staff.<br>acticable, the participation of<br>e resident's representative(s).<br>It be included in a resident's<br>e participation of the resident<br>epresentative is determined<br>he development of the<br>te staff or professionals in<br>mined by the resident's needs<br>the resident.<br>evised by the interdisciplinary<br>sessment, including both the | F 2                 | DEFICIENCY)<br>It is the policy at Jones Harrison<br>Residence that residents' comprehe<br>care plan will be reviewed and revis<br>after a fall by IDT to minimize risk o<br>further falls.<br>R 77 care plan was reviewed by ID | ensive<br>sed<br>f |                                     |
|                          | R77's care plan dat<br>"FALLS/SAFETY: F<br>to wandering behav<br>antidepressant use  | Potential for falls/injury related rior, history of falls,  |                     | updated to ensure appropriate<br>interventions were implemented to<br>minimize further risk of falls.<br>Care plans will be reviewed at IDT a<br>each fall, and appropriate interventi   | after              |                                     |

Facility ID: 00216

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|                          |  | AND HUMAN SERVICES   |                     |    | FC  | ORM A  | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|----|---|--------|-------------------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 |    |   | ) DATE | SURVEY<br>PLETED                    |
|                          |  | 245460   | B. WING             |    |   | 01/1   | 2/2017                              |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | 1                   |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |        |                                     |
| JONES I                  | HARRISON RESIDEN   | CE   |                     |    | 700 CEDAR LAKE AVENUE<br>IINNEAPOLIS, MN 55416  |        |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | x  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | E      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | monitor falls per prophysician as indicating gait, mobility, and the clutter-free environt safety, monitor for vision of the clutter falls:<br>1) On 8/29/16, the clutter of the clutter falls:<br>1) On 8/29/16, the clutter of the clutter falls:<br>1) On 8/29/16, the clutter of the clutter falls for the falls for the clutter falls for the clutter for the clutter of the clu | otocol, update family and<br>ted, observe for changes in<br>ransferring, maintain a<br>ment, anticipate needs for<br>wandering behavior, and guide<br>ic destinations."<br>ssessment dated 7/27/16,<br>at risk for falls related to<br>tory of falls. She had<br>Il in her room with no injury.<br>her with mobility and transfers | F 2                 | 80 | will be discussed and added to the plan<br>care.<br>The DON will be responsible to audit a<br>monitor this process.<br>Facility will be in compliance by Februa<br>6th, 2017. | Ind    |                                     |

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|                          |  | AND HUMAN SERVICES  |                   |     |   | FORM      | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | PLE CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245460  | B. WING           |     |   | 01/       | 12/2017                             |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| JONES I                  | ARRISON RESIDENC   | CE  |                   |     | 3700 CEDAR LAKE AVENUE<br>MINNEAPOLIS, MN 55416   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | and fell down." The<br>judgement as well a<br>and and "may have<br>wandering." The co<br>plan of care. New in<br>the resident had res<br>on the interventions<br>further falls.<br>3) On 10/18/16, R7<br>from the floor, lost h<br>cause was the resid<br>meals and was diffi<br>conclusion was to co<br>The following day th<br>fall in the great roor<br>was independent w<br>to pick up an item fi<br>also noted the resid<br>active. Approaches<br>was clean was not<br>minimize the risk fo<br>R77's quarterly Min<br>10/21/16, indicated<br>impaired cognition,<br>with mobility and su<br>and had experience<br>prior assessment. If<br>Alzheimer's disease<br>osteoporosis, with p<br>antidepressant med<br>pain medications The<br>Licensed practical r | cause of the fall was poor<br>as the resident liked to walk<br>become tired from<br>inclusion was to continue the<br>interventions such as ensuring<br>st periods were not identified<br>to minimize the risk for<br>7 was picking up something<br>her balance and fell. The root<br>dent likes to clean tables after<br>cult to redirect. The<br>continue with the plan of care.<br>The IDT met to discuss R77's<br>m. It was noted the resident<br>ith ambulation and bent down<br>rom the floor and fell. It was<br>dent was very anxious and<br>such as ensuring the floor<br>identified as a consideration to<br>or further falls.<br>imum Data Set (MDS) dated<br>the resident had severely<br>required limited assistance<br>upervision with transferring,<br>ed two or more falls since the | F2                | 280 |   |           |                                     |

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|                          |  | AND HUMAN SERVICES   |                   |     |  | FORM     | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|--|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | PLE CONSTRUCTION   | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |  | 245460   | B. WING           | i   |  | 01/      | 12/2017                             |
| NAME OF                  | PROVIDER OR SUPPLIER   | -  |                   | Ś   | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |                                     |
| JONES I                  | ARRISON RESIDENC   | CE   |                   |     | 3700 CEDAR LAKE AVENUE<br>MINNEAPOLIS, MN 55416  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | registered nurse (R<br>independently amb<br>verified the care pla<br>falls, but did make s<br>and socks. When a<br>the fall on 9/8/16, R<br>fatigue from wande<br>probably addressed<br>to lie down.<br>Nursing assistant (I<br>a.m. she had never<br>her trying to pick up<br>NA-A saw this, she<br>was going to fall an<br>RN-B explained on<br>was falling because<br>progressing and sh<br>family. "We are just<br>should assist her w<br>from the floor." Reg<br>stated, "The staff sl<br>they noticed increas<br>have directed the re<br>what they should ha<br>8/29/16, RN-B said<br>been encouraged.<br>The facility's 7/16, F<br>indicated, "Each res<br>supervision and ass<br>It is important for fa<br>facilities [sic] respo<br>ensure the safest e | unit at night.<br>T on 1/11/17, at 9:48 a.m. with<br>N)-A she stated R77 was<br>ulatory and walked a lot. RN-A<br>an was not updated after her<br>sure she was wearing shoes<br>sked about interventions after<br>RN-A said it may have been<br>ring, and the staff should have<br>d that by assisting the resident<br>NA)-A stated on 1/12/17 8:33<br>r seen R77 fall, but had seen<br>o items from the floor. When<br>would tell the resident she<br>d help her to pick up the item.<br>1/12/17, at 9:51 a.m. that R77 | F                 | 280 |  |          |                                     |

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|                          |   | AND HUMAN SERVICES   |                                       |    |  | FORM     | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---------------------------------------|----|--|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                                       |    |  | (X3) DAT | E SURVEY<br>IPLETED                 |
|                          |   | 245460   | B. WING _                             |    |  | 01/      | 12/2017                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  | · · · · · · · · · · · · · · · · · · · |    | REET ADDRESS, CITY, STATE, ZIP CODE  |          |                                     |
| JONES H                  | IARRISON RESIDEN  | CE   |                                       |    | 00 CEDAR LAKE AVENUE<br>INNEAPOLIS, MN 55416   |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                   | ĸ  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE       | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | Continued From pa   | ige 12   | F 28                                  | 80 |  |          |                                     |
|                          | intervention. Appro<br>implemented."  | priate interventions are   |                                       |    |  |          |                                     |
| F 323<br>SS=D            |   | 1)-(3) FREE OF ACCIDENT<br>VISION/DEVICES  | F 3                                   | 23 |  |          | 2/6/17                              |
|                          | (d) Accidents.<br>The facility must er  | isure that -   |                                       |    |  |          |                                     |
|                          |   | vironment remains as free<br>rds as is possible; and   |                                       |    |  |          |                                     |
|                          |   | eceives adequate supervision<br>rices to prevent accidents.  |                                       |    |  |          |                                     |
|                          | appropriate alterna<br>bed rail. If a bed of<br>must ensure correct   | e facility must attempt to use<br>tives prior to installing a side or<br>r side rail is used, the facility<br>tt installation, use, and<br>d rails, including but not limited<br>ments.  |                                       |    |  |          |                                     |
|                          |   | dent for risk of entrapment to installation.   |                                       |    |  |          |                                     |
|                          |   | s and benefits of bed rails with<br>dent representative and obtain<br>rior to installation.  |                                       |    |  |          |                                     |
|                          | appropriate for the<br>This REQUIREMEN<br>by:<br>Based on observat<br>interview, the facilit<br>measures were cor | bed's dimensions are<br>resident's size and weight.<br>NT is not met as evidenced<br>tion, document review and<br>y failed to ensure additional<br>nsidered following falls to<br>or further falls for 1 of 4<br>riewed for falls. |                                       |    | It is the policy at Jones Harrison<br>Residence that each resident receive<br>adequate supervision and assistive<br>devices to prevent accidents.<br>R77 care plan was reviewed by IDT |          |                                     |

Facility ID: 00216

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| TATEMENT                 | OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  | (X3) DAT                                   | <u>. 0938-039</u><br>E SURVEY<br>IPLETED |  |
|--------------------------|---|---|---------------------|--|--|--|--|
|                          |   | 245460  | B. WING _           |  | 01/  | 12/2017                                  |  |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |  |  |
| JONES I                  | ARRISON RESIDEN   | CE  |                     | 3700 CEDAR LAKE AVENUE<br>MINNEAPOLIS, MN 55416  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPP<br>DEFICIENCY)  | ULD BE                                     | (X5)<br>COMPLETIC<br>DATE                |  |
| F 323                    | lunch on 1/10/17, a<br>meal at 1:31 p.m. t<br>hallway. R77 inform<br>like to go "upstairs.<br>coordinator redirec<br>room and stated, "I<br>with her." The follow<br>was in bed with her<br>within her reach. A<br>having coffee in the<br>her head down and<br>practical nurse( LP<br>"got up before I can<br>sleepy."<br>R77's Care Area As<br>revealed R77 was<br>dementia and a his<br>experienced one fa<br>Staff was to assist<br>and the goal was to<br>Resident Incident F<br>falls:<br>1) On 8/29/16, the<br>dining room, turned<br>and sat on the flood<br>the report indicated<br>however, the description of what<br>hours prior to the fa<br>theory as to what h | in the dining room having<br>at 12:08 a.m. Following the<br>he resident was walking in the<br>ned the surveyor she would<br>"The therapeutic recreation<br>ted R77 toward the dining<br>I am going to do some puzzles<br>wing morning at 7:12 a.m. R77<br>r eyes closed and call light was<br>t 7:47 a.m. the resident was<br>e dining room, and then had<br>d eyes closed. Licensed<br>N)-A explained the resident<br>me for my shiftshe is kind of<br>ssessment dated 7/27/16,<br>at risk for falls related to<br>story of falls. She had<br>all in her room with no injury.<br>her with mobility and transfers | F 32                | <ul> <li>updated to ensure appropriate interventions were implemented minimize further falls.</li> <li>Resident's care plans will be replication of the propriation of the propriation of the properties of the pr</li></ul> | viewed at<br>ate<br>e plan of<br>audit and |  |  |

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|                          |   | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                    |    |   | FORM                     | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|----|---|--------------------------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |    | E CONSTRUCTION  | (X3) DATE                | E SURVEY<br>PLETED                  |
|                          |   | 245460  | B. WING            |    |   | <b>01</b> / <sup>.</sup> | 12/2017                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                    |    | TREET ADDRESS, CITY, STATE, ZIP CODE  |                          |                                     |
| JONES H                  | HARRISON RESIDEN  | CE  |                    | -  | 700 CEDAR LAKE AVENUE<br>/IINNEAPOLIS, MN 55416   |                          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                     | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | The following day of<br>team (IDT) met and<br>balance and fell on<br>shoes and her glas<br>therefore, the IDT of<br>continue with the pl<br>not include new inte<br>considered.<br>2) On 9/8/16, staff f<br>reported she "sturn<br>and fell down." The<br>judgement as well a<br>and and "may have<br>wandering." The co<br>plan of care. New in<br>the resident had reso<br>on the interventions<br>further falls.<br>3) On 10/18/16, R7<br>from the floor, lost f<br>cause was the reside<br>meals and was diffi<br>conclusion was to co<br>The following day th<br>fall in the great roor<br>was independent w<br>to pick up an item f<br>also noted the reside<br>active. Approaches<br>was clean was not<br>minimize the risk for<br>R77's quarterly Min<br>10/21/16, indicated<br>impaired cognition, | <ul> <li>an 8/30/16, the interdisciplinary d indicated the resident lost her the floor. She was wearing uses at the time of the fall, determined they would lan of care and the report did erventions the team</li> <li>found R77 on the floor. R77 abled on her feet' while walking e cause of the fall was poor as the resident liked to walk become tired from onclusion was to continue the anterventions such as ensuring st periods were not identified s to minimize the risk for</li> <li>77 was picking up something her balance and fell. The root dent likes to clean tables after icult to redirect. The continue with the plan of care.</li> <li>he IDT met to discuss R77's m. It was noted the resident <i>vi</i>th ambulation and bent down from the floor and fell. It was dent was very anxious and as such as ensuring the floor identified as a consideration to</li> </ul> | F 3                | 23 |   |                          |                                     |

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|                          |   | AND HUMAN SERVICES   |                    |     |  | FORM                     | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|-----|--|--------------------------|-------------------------------------|
| STATEMEN                 | OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION   | (X3) DATE                | E SURVEY<br>PLETED                  |
|                          |   | 245460   | B. WING            |     |  | <b>01</b> / <sup>.</sup> | 12/2017                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                    |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                          |                                     |
| JONES I                  | ARRISON RESIDENC  | CE   |                    |     | 700 CEDAR LAKE AVENUE<br>IINNEAPOLIS, MN 55416   |                          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                       | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | and had experience<br>prior assessment. I<br>Alzheimer's disease<br>osteoporosis, with p<br>antidepressant med<br>pain medications Th<br>The care plan for R<br>"FALLS/SAFETY: I<br>to wandering behav<br>antidepressant use<br>Alzheimer's." Interv<br>monitor falls per pro<br>physician as indicat<br>gait, mobility, and tr<br>clutter-free environs<br>safety, monitor for v<br>to . Guide to specifi<br>Licensed practical r<br>regarding R77's fall<br>LPN-B explained R<br>walking around the<br>walked around the<br>During an interview<br>registered nurse (R<br>independently amb<br>verified the care pla<br>falls, but did make s<br>and socks. When a<br>the fall on 9/8/16, R<br>fatigue from wande<br>probably addressed<br>to lie down.<br>Nursing assistant (f<br>a.m. she had never | ed two or more falls since the<br>Diagnoses included<br>e, major depressive disorder,<br>ohysician orders including the<br>dication Celexa, as well as<br>ramadol and Tylenol.<br>177 dated 8/5/14, revealed<br>Potential for falls/injury related<br>vior, history of falls,<br>, incontinence and<br>rentions directed staff to<br>otocol, update family and<br>ted, observe for changes in<br>ransferring, maintain a<br>ment, anticipate needs for<br>wandering behavior, and guide<br>ic destinations."<br>hurse (LPN)-B was interviewed<br>ls on 1/11/17, at 7:28 a.m.<br>77 was very independent in<br>unit and sometimes she | F 3                | 223 |  |                          |                                     |

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|                          |   | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES   |                   |     |   | FORM      | 02/08/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     |   | (X3) DATE | E SURVEY<br>IPLETED                 |
|                          |   | 245460  | B. WING           | ì   |   | 01/       | 12/2017                             |
| NAME OF                  | PROVIDER OR SUPPLIER  | •   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -         |                                     |
| JONES H                  | HARRISON RESIDEN  | CE  |                   | -   | 3700 CEDAR LAKE AVENUE<br>MINNEAPOLIS, MN 55416   |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE      | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | NA-A saw this, she<br>was going to fall an<br>The director of reha<br>approximately 9:30<br>regular screening of<br>significant change to<br>there had been no<br>assessments, reco<br>orders received for<br>RN-B explained on<br>was falling because<br>progressing and sh<br>family. "We are just<br>should assist her w<br>from the floor." Reg<br>stated, "The staff sl<br>they noticed increat<br>have directed the re<br>what they should ha<br>8/29/16, RN-B said<br>been encouraged.<br>The facility's 7/16, F<br>indicated, "Each res<br>supervision and ass<br>It is important for fa<br>facilities [sic] respo<br>ensure the safest e<br>plan of care is upda | would tell the resident she<br>ad help her to pick up the item.<br>abilitation on 1/12/17, at<br>a.m. and stated she did<br>of residents as well as when a<br>triggered by the MDS, and<br>significant change<br>mmendations or physician<br>R77.<br>1/12/17, at 9:51 a.m. that R77<br>e her dementia was<br>he wandered looking for her<br>t checking on her, and the staff<br>when she tries to pick up stuff<br>garding the fall 9/8/16, RN-B<br>hould have put her in bed after<br>sed fatigue, and they should<br>esident back to bed. That's<br>ave done." As for the fall on<br>I rest periods should have |                   | 323 |   |           |                                     |

Facility ID: 00216

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|                          |   |  |   | Ŧ5                  | 1460027   | FORM                   | 01/19/2017<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---|---------------------|---|------------------------|-------------------------------------|
| STATEMEN                 | S FOR MEDICARE  | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NUM  | R/CLIA  | (X2) MULTIP         | LE CONSTRUCTION   | (X3) DATE SI<br>COMPLE | URVEY                               |
|                          |   | 245460   |   | B. WING             |   | 01/1                   | 1/2017                              |
|                          | ROVIDER OR SUPPLIER   | NCE  | 3700 CE   |                     | TATE, ZIP CODE<br>E AVENUE<br>N 55416   |                        |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY MUST   | ATEMENT OF DEFICIENCI<br>T BE PRECEDED BY FULL<br>INTIFYING INFORMATION)   | REGULATORY  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE               | (X5)<br>COMPLETION<br>DATE          |
| K 000                    | INITIAL COMMEN  | ſS   |   | K 000               |   |                        |                                     |
|                          | FIRE SAFETY   |  |   |                     |   |                        |                                     |
|                          | Minnesota Departn<br>Marshal Division or<br>of this survey, Jone<br>found in complianc<br>participation in Mec<br>Subpart 483.70(a),<br>2012 edition of Nat<br>Association (NFPA      | Survey was conduct<br>nent of Public Safety<br>n January 11, 2017. A<br>s Harrison Residence<br>with the requirement<br>dicare/Medicaid at 42<br>Life Safety from Fire<br>ional Fire Protection<br>) Standard 101, Life<br>ter 19 Existing Healt     | , Fire<br>At the time<br>ce was<br>onts for<br>2 CFR,<br>e, and the<br>Safety         |                     | Ť   |                        |                                     |
|                          | with a full basemer<br>constructed in 1992<br>Type II(222) constr<br>sprinkler protected<br>fire alarm system v<br>corridors and spac<br>monitored for autor<br>notification. The fai | sidence is a 3-story<br>nt. The building was<br>2 and was determine<br>uction. The building<br>. The facility has a co<br>vith smoke detection<br>es open to the corric<br>matic fire departmen<br>cility has a licensed of<br>a census of 153 at th | ed to be of<br>is fully fire<br>omplete<br>in the<br>lor, that is<br>t<br>capacity of |                     |   |                        |                                     |
|                          | The requirement a MET.  | t 42 CFR Subpart 48  | 3.70(a) is  |                     |   |                        |                                     |
|                          | ^   |  |   |                     |   |                        |                                     |
|                          |   |  |   |                     |   |                        | 14.5<br>10                          |
| LABORATO                 | DRY DIRECTOR'S OR PRO   | VIDER/SUPPLIER REPRES  | ENTATIVE'S SIG  | GNATURE             | TITLE   |                        | (X6) DATE                           |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 30, 2017

Mr. Lowell Berggren, Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, Minnesota 55416

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5460027

Dear Mr. Berggren:

The above facility was surveyed on January 9, 2017 through January 12, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at (651) 201-3794 or email: gayl.lantto@state.mn.us.

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

## Mark meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

| Minnesc  | ta Department of He   | alth  |                     |                               | -    | -                        |
|--|---|---|---------------------|-------------------------------|------|--------------------------|
| -  |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |                               |      |                          |
|  |   | 00216   | B. WING             |                               | 01/1 | 2/2017                   |
| NAME OF I  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE               |      |                          |
| JONES H  | HARRISON RESIDEN  | ?F  |                     | -                             |      |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL | D BE | (X5)<br>COMPLETE<br>DATE |
| 2 000  | Initial Comments  |   | 2 000               |                               |      |                          |
|  | *****ATTE   | NTION*****  |                     |                               |      |                          |
|  | NH LICENSING  | CORRECTION ORDER  |                     |                               |      |                          |
|  | 144A.10, this correpursuant to a surver<br>found that the defice<br>herein are not corrected shall<br>with a schedule of f<br>the Minnesota Depu-<br>Determination of wit<br>corrected requires<br>requirements of the<br>number and MN Ru<br>When a rule contai<br>comply with any of<br>lack of compliance.<br>re-inspection with a<br>result in the assess | ction order has been issued<br>y. If, upon reinspection, it is<br>iency or deficiencies cited<br>ected, a fine for each violation<br>be assessed in accordance<br>ines promulgated by rule of<br>artment of Health.<br>hether a violation has been<br>compliance with all<br>e rule provided at the tag<br>ule number indicated below.<br>Ins several items, failure to<br>the items will be considered<br>Lack of compliance upon<br>iny item of multi-part rule will<br>ment of a fine even if the item |                     |                               |      |                          |
|  | that may result from<br>orders provided that<br>the Department wit  | n non-compliance with these<br>tt a written request is made to<br>hin 15 days of receipt of a   |                     |                               |      |                          |
|  | You have agreed to<br>receipt of State lice<br>the Minnesota Dep<br>Informational Bullet<br>http://www.health.s<br>obul.htm The State<br>delineated on the a  | participate in the electronic<br>nsure orders consistent with<br>artment of Health<br>in 14-01, available at<br>tate.mn.us/divs/fpc/profinfo/inf<br>blicensing orders are   |                     |                               |      |                          |
| MATE NUMP CORPECTION OF CONVERSION PLANEADINA         (P21 MULTIPLE CONSTRUCTION A BUILDING: |   | (X6) DATE<br>02/07/17   |                     |                               |      |                          |

If continuation sheet 1 of 14

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             |  |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|---|---|-----------------------------|--|---------------------------------|-------------------------|--|
|                          |   | 00216   | B. WING                     |  | 01/12/2017                      |                         |  |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY, S             | TATE, ZIP CODE   | • • •                           |                         |  |
| IONES F                  | ARRISON RESIDEN   | CE  | DAR LAKE AV<br>POLIS, MN 55 |  |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 000                    | you electronically.<br>is necessary for Sta<br>enter the word "cor<br>text. You must then<br>State licensure pro-<br>completion date, th<br>corrected prior to e<br>Minnesota Departm<br>On 1/9/17 through<br>Department's staff,<br>the following correct<br>Please indicate in y<br>correction that you<br>and identify the dat<br>Minnesota Departm<br>the State Licensing<br>federal software. Ta<br>assigned to Minnes<br>Nursing Homes. | Ith orders being submitted to<br>Although no plan of correction<br>ate Statutes/Rules, please<br>rected" in the box available for<br>indicate in the electronic<br>cess, under the heading<br>e date your orders will be<br>lectronically submitting to the   |                             |  |                                 |                         |  |
|                          | column entitled "ID<br>statute/rule out of o<br>"Summary Stateme<br>and replaces the "T<br>correction order. Th<br>findings which are i<br>after the statement<br>evidence by." Follo   | <ul> <li>Prefix Tag." The state</li> <li>compliance is listed in the</li> <li>ent of Deficiencies" column</li> <li>To Comply" portion of the</li> <li>nis column also includes the</li> <li>in violation of the state statute</li> <li>, "This Rule is not met as</li> <li>wing the surveyors findings</li> <li>Method of Correction and</li> </ul> |                             |  |                                 |                         |  |
|                          | FOURTH COLUMN<br>"PROVIDER'S PLA<br>APPLIES TO FEDE   | ARD THE HEADING OF THE<br>N WHICH STATES,<br>N OF CORRECTION." THIS<br>ERAL DEFICIENCIES ONLY.<br>R ON EACH PAGE.   |                             |  |                                 |                         |  |

| Minnesc                  | ta Department of He   | alth   |                         |   | FORM              | APPROVED                 |
|--------------------------|---|--|-------------------------|---|-------------------|--------------------------|
| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                          |   | 00216  | B. WING                 |   | 01/1              | 2/2017                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S          | STATE, ZIP CODE   |                   |                          |
| JONES H                  | ARRISON RESIDENC  | 1E   | AR LAKE A<br>OLIS, MN 5 |   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Continued From pa   | ge 2   | 2 000                   |   |                   |                          |
|                          | PLAN OF CORREC  | QUIREMENT TO SUBMIT A<br>CTION FOR VIOLATIONS OF<br>E STATUTES/RULES.  |                         |   |                   |                          |
| 2 570                    | MN Rule 4658.0405<br>Plan of Care; Revis  | 5 Subp. 4 Comprehensive ion  | 2 570                   |   |                   | 2/6/17                   |
|                          | care must be review<br>interdisciplinary teal<br>physician, a register<br>for the resident, and<br>disciplines as detern<br>and, to the extent p<br>participation of the re<br>guardian or chosen<br>quarterly and within | resident, the resident's legal<br>representative at least<br>seven days of the revision of<br>resident assessment required                                 |                         |   |                   |                          |
|                          | by:<br>Based on observati<br>interview, the facility<br>the care plan follow  | ent is not met as evidenced<br>on, document review and<br>y failed to review and revise<br>ing falls to minimize the risk<br>of 4 residents (R77) reviewed |                         | Corrected   |                   |                          |
|                          | Findings include:   |  |                         |   |                   |                          |
| Minnesota D              | to wandering behave<br>antidepressant use<br>Alzheimer's." Interve<br>monitor falls per pro-  | Potential for falls/injury related vior, history of falls,   |                         |   |                   |                          |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             | E CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|-----------------------------|--|-----------------------------------|-------------------------|
|                          |   | 00216  | B. WING                     |  | 01/                               | 12/2017                 |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S             | TATE, ZIP CODE   |                                   |                         |
| JONES H                  | ARRISON RESIDEN   | CE   | DAR LAKE AV<br>POLIS, MN 55 |  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570                    |   | -  | 2 570                       |  |                                   |                         |
|                          | clutter-free environ  | ransferring, maintain a<br>ment, anticipate needs for<br>wandering behavior, and guide<br>ic destinations."  | )                           |  |                                   |                         |
|                          | revealed R77 was<br>dementia and a his<br>experienced one fa  | ssessment dated 7/27/16,<br>at risk for falls related to<br>story of falls. She had<br>all in her room with no injury.<br>her with mobility and transfers<br>o be free of falls.   |                             |  |                                   |                         |
|                          | Resident Incident F falls:  | Reports revealed the following   |                             |  |                                   |                         |
|                          | dining room, turned<br>and sat on the floo<br>the report indicated<br>however, the descri<br>to prevent further fa<br>description of what<br>hours prior to the fa<br>theory as to what h | resident was walking in the<br>d around and lost her balance<br>r. No injuries were noted, and<br>d the care plan was updated,<br>ription of the initial interventions<br>alls was left blank. A full<br>was happening in the three<br>all was left blank. The staff's<br>happened to cause the fall was<br>The plan read "no change." |                             |  |                                   |                         |
|                          | team (IDT) met and<br>balance and fell on<br>shoes and her glas<br>therefore, the IDT of<br>continue with the p   | on 8/30/16, the interdisciplinary<br>d indicated the resident lost he<br>the floor. She was wearing<br>sees at the time of the fall,<br>determined they would<br>lan of care and the report did<br>erventions the team   |                             |  |                                   |                         |
|                          | reported she "stum<br>and fell down." The<br>judgement as well  | found R77 on the floor. R77<br>hbled on her feet' while walking<br>cause of the fall was poor<br>as the resident liked to walk<br>become tired from  | ,                           |  |                                   |                         |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------|--|-----------------------------------|-------------------------|
|                          |   | 00216  | B. WING             |  | 01/                               | 12/2017                 |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AL  | DRESS, CITY, ST     | ATE, ZIP CODE  |                                   |                         |
| JONES F                  | IARRISON RESIDEN  | CE   | OAR LAKE AV         |  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570                    | Continued From pa   | age 4  | 2 570               |  |                                   |                         |
|                          | plan of care. New i<br>the resident had re  | onclusion was to continue the<br>nterventions such as ensuring<br>st periods were not identified<br>s to minimize the risk for   |                     |  |                                   |                         |
|                          | from the floor, lost<br>cause was the resi<br>meals and was diff  | 77 was picking up something<br>her balance and fell. The root<br>dent likes to clean tables after<br>icult to redirect. The<br>continue with the plan of care.   |                     |  |                                   |                         |
|                          | fall in the great roo<br>was independent w<br>to pick up an item f<br>also noted the resid<br>active. Approaches  | he IDT met to discuss R77's<br>m. It was noted the resident<br>vith ambulation and bent down<br>from the floor and fell. It was<br>dent was very anxious and<br>s such as ensuring the floor<br>identified as a consideration to<br>or further falls.  |                     |  |                                   |                         |
|                          | 10/21/16, indicated<br>impaired cognition,<br>with mobility and su<br>and had experienc<br>prior assessment.<br>Alzheimer's diseas<br>osteoporosis, with<br>antidepressant me | himum Data Set (MDS) dated<br>I the resident had severely<br>required limited assistance<br>upervision with transferring,<br>ed two or more falls since the<br>Diagnoses included<br>e, major depressive disorder,<br>physician orders including the<br>dication Celexa, as well as<br>framadol and Tylenol. |                     |  |                                   |                         |
|                          | regarding R77's fal<br>LPN-B explained F  | nurse (LPN)-B was interviewed<br>Ils on 1/11/17, at 7:28 a.m.<br>177 was very independent in<br>19 unit and sometimes she<br>10 unit at night.   |                     |  |                                   |                         |
|                          |   | v on 1/11/17, at 9:48 a.m. with<br>RN)-A she stated R77 was  |                     |  |                                   |                         |

| TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|--|--|---------------------|--|-----------------------------------|-------------------------|
|  | 00216  | <br>B. WING         |  | 01/12/2017                        |                         |
| AME OF PROVIDER OR SUPPLIEF  |  | DDRESS, CITY, ST    |  | 12/2017                           |                         |
| ONES HARRISON RESIDEN  | 3700 CE  | DAR LAKE AVI        |  |                                   |                         |
|  | MINNEA   | POLIS, MN 55        | 416  |                                   | 1                       |
| PREFIX (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570 Continued From p   | age 5  | 2 570               |  |                                   |                         |
| verified the care p<br>falls, but did make<br>and socks. When<br>the fall on 9/8/16,<br>fatigue from wand  | bulatory and walked a lot. RN-A<br>lan was not updated after her<br>sure she was wearing shoes<br>asked about interventions after<br>RN-A said it may have been<br>ering, and the staff should have<br>ed that by assisting the resident   |                     |  |                                   |                         |
| a.m. she had neve<br>her trying to pick u<br>NA-A saw this, she  | (NA)-A stated on 1/12/17 8:33<br>er seen R77 fall, but had seen<br>up items from the floor. When<br>e would tell the resident she<br>nd help her to pick up the item.  |                     |  |                                   |                         |
| was falling becaus<br>progressing and s<br>family. "We are jus<br>should assist her<br>from the floor." Re<br>stated, "The staff s<br>they noticed increa<br>have directed the<br>what they should h | n 1/12/17, at 9:51 a.m. that R77<br>se her dementia was<br>he wandered looking for her<br>st checking on her, and the staf<br>when she tries to pick up stuff<br>egarding the fall 9/8/16, RN-B<br>should have put her in bed after<br>ased fatigue, and they should<br>resident back to bed. That's<br>have done." As for the fall on<br>d rest periods should have | f                   |  |                                   |                         |
| indicated, "Each re<br>supervision and as<br>It is important for f<br>facilities [sic] response<br>ensure the safest<br>plan of care is upon   | Fall Risk Assessment<br>esident receives adequate<br>ssistance to prevent accidents.<br>facility staff to understand the<br>onsibility as well as their own, to<br>environment possibleThe<br>date [sic] to reflect the<br>opriate interventions are   |                     |  |                                   |                         |
|  | THOD OF CORRECTION: The could review policies and  | )                   |  |                                   |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | Alth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|---------------------------|--|-------------------------------|
|                          |  | 00216   | B. WING                   |  | 01/12/2017                    |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY,              | STATE, ZIP CODE  |                               |
| JONES H                  | ARRISON RESIDEN  |   | DAR LAKE A<br>POLIS, MN 5 |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLET                    |
| 2 570                    | Continued From pa  | ige 6   | 2 570                     |  |                               |
|                          | plan revisions. Auc  | appropriate regarding care<br>lits could be conducted and<br>to the quality committee for   |                           |  |                               |
|                          | TIME PERIOD FOR<br>(21) days.  | R CORRECTION: Twenty-one  |                           |  |                               |
| 2 830                    | MN Rule 4658.0520<br>Proper Nursing Car  | 0 Subp. 1 Adequate and re; General  | 2 830                     |  | 2/6/17                        |
|                          | receive nursing car<br>custodial care, and<br>individual needs an<br>the comprehensive<br>plan of care as des<br>4658.0405. A nursi<br>of bed as much as<br>written order from t | general. A resident must<br>e and treatment, personal and<br>supervision based on<br>d preferences as identified in<br>resident assessment and<br>scribed in parts 4658.0400 and<br>ing home resident must be out<br>possible unless there is a<br>he attending physician that the<br>in in bed or the resident<br>bed. |                           |  |                               |
|                          | by:<br>Based on observati<br>interview, the facilit<br>measures were cor   | ent is not met as evidenced<br>ion, document review and<br>y failed to ensure additional<br>nsidered following falls to<br>or further falls for 1 of 4<br>iewed for falls.  |                           | Corrected  |                               |
|                          | Findings include:  |   |                           |  |                               |
|                          | lunch on 1/10/17, a  | in the dining room having<br>t 12:08 a.m. Following the<br>ne resident was walking in the   |                           |  |                               |

STATE FORM

| STATEMEN                 | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   |                | E SURVEY<br>PLETED      |
|--------------------------|--|---|-----------------------------|--|----------------|-------------------------|
|                          |  | 00216   | B. WING                     |  | 01/            | 12/2017                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S             | TATE, ZIP CODE   |                |                         |
| JONES H                  | HARRISON RESIDEN   | CE  | DAR LAKE AV<br>POLIS, MN 55 |  |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | hallway. R77 inform<br>like to go "upstairs.<br>coordinator redirect<br>room and stated, "I<br>with her." The follor<br>was in bed with her<br>within her reach. A<br>having coffee in the<br>her head down and<br>practical nurse( LP<br>"got up before I can<br>sleepy."<br>R77's Care Area Area | ned the surveyor she would<br>"The therapeutic recreation<br>ted R77 toward the dining<br>am going to do some puzzles<br>wing morning at 7:12 a.m. R77<br>r eyes closed and call light was<br>t 7:47 a.m. the resident was<br>e dining room, and then had<br>d eyes closed. Licensed<br>"N)-A explained the resident<br>me for my shiftshe is kind of<br>ssessment dated 7/27/16, | ,                           |  |                |                         |
|                          | dementia and a his<br>experienced one fa<br>Staff was to assist<br>and the goal was to   | at risk for falls related to<br>story of falls. She had<br>all in her room with no injury.<br>her with mobility and transfers<br>b be free of falls.<br>Reports revealed the following  |                             |  |                |                         |
|                          | dining room, turned<br>and sat on the floo<br>the report indicated<br>however, the descri<br>to prevent further fa<br>description of what<br>hours prior to the fa<br>theory as to what h  | resident was walking in the<br>d around and lost her balance<br>r. No injuries were noted, and<br>d the care plan was updated,<br>ription of the initial interventions<br>alls was left blank. A full<br>was happening in the three<br>all was left blank. The staff's<br>happened to cause the fall was<br>The plan read "no change."  |                             |  |                |                         |
|                          | team (IDT) met and<br>balance and fell on<br>shoes and her glas<br>therefore, the IDT of   | on 8/30/16, the interdisciplinary<br>d indicated the resident lost he<br>the floor. She was wearing<br>ses at the time of the fall,<br>determined they would<br>lan of care and the report did  |                             |  |                |                         |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             |  |                                   | E SURVEY<br>PLETED      |
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|                          |  | 00216   | B. WING                     |  | 01/                               | 12/2017                 |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, S             | TATE, ZIP CODE   |                                   |                         |
| JONES H                  | ARRISON RESIDENC   |   | DAR LAKE AV<br>POLIS, MN 55 |  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    |  | ige 8<br>erventions the team  | 2 830                       |  |                                   |                         |
|                          | reported she "'stum<br>and fell down." The<br>judgement as well a<br>and and "may have<br>wandering." The co<br>plan of care. New in<br>the resident had res<br>on the interventions<br>further falls.<br>3) On 10/18/16, R7 | found R77 on the floor. R77<br>abled on her feet' while walking<br>a cause of the fall was poor<br>as the resident liked to walk<br>become tired from<br>onclusion was to continue the<br>nterventions such as ensuring<br>st periods were not identified<br>to minimize the risk for<br>7 was picking up something<br>her balance and fell. The root |                             |  |                                   |                         |
|                          | cause was the resid<br>meals and was diffi<br>conclusion was to o<br>The following day th<br>fall in the great roor<br>was independent w<br>to pick up an item f   | dent likes to clean tables after<br>icult to redirect. The<br>continue with the plan of care.<br>he IDT met to discuss R77's<br>m. It was noted the resident<br>rith ambulation and bent down<br>rom the floor and fell. It was<br>dent was very anxious and  |                             |  |                                   |                         |
|                          | active. Approaches<br>was clean was not<br>minimize the risk fo  | such as ensuring the floor<br>identified as a consideration to<br>or further falls.   |                             |  |                                   |                         |
|                          | 10/21/16, indicated<br>impaired cognition,<br>with mobility and su<br>and had experience<br>prior assessment. I<br>Alzheimer's disease   | e, major depressive disorder,   |                             |  |                                   |                         |
|                          | antidepressant med   | ohysician orders including the dication Celexa, as well as ramadol and Tylenol.   |                             |  |                                   |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             |  |               | E SURVEY<br>PLETED      |
|--------------------------|--|---|-----------------------------|--|---------------|-------------------------|
|                          |  | 00216   | B. WING                     |  | 01/12/2017    |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S             | TATE, ZIP CODE   |               |                         |
| JONES H                  | HARRISON RESIDEN   | CE  | DAR LAKE AV<br>POLIS, MN 55 |  |               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | age 9   | 2 830                       |  |               |                         |
|                          | "FALLS/SAFETY:<br>to wandering beha<br>antidepressant use<br>Alzheimer's." Interv<br>monitor falls per pr<br>physician as indica<br>gait, mobility, and t<br>clutter-free environ<br>safety, monitor for<br>to . Guide to specif<br>Licensed practical<br>regarding R77's fa<br>LPN-B explained F<br>walking around the<br>walked around the | nurse (LPN)-B was interviewed<br>Ils on 1/11/17, at 7:28 a.m.<br>777 was very independent in<br>a unit and sometimes she<br>unit at night.  | •                           |  |               |                         |
|                          | registered nurse (F<br>independently amb<br>verified the care pl<br>falls, but did make<br>and socks. When a<br>the fall on 9/8/16, F<br>fatigue from wande  | v on 1/11/17, at 9:48 a.m. with<br>RN)-A she stated R77 was<br>bulatory and walked a lot. RN-A<br>an was not updated after her<br>sure she was wearing shoes<br>asked about interventions after<br>RN-A said it may have been<br>ering, and the staff should have<br>d that by assisting the resident |                             |  |               |                         |
|                          | a.m. she had neve<br>her trying to pick u<br>NA-A saw this, she  | NA)-A stated on 1/12/17 8:33<br>r seen R77 fall, but had seen<br>p items from the floor. When<br>would tell the resident she<br>nd help her to pick up the item.  |                             |  |               |                         |
|                          | approximately 9:30 regular screening of  | abilitation on 1/12/17, at<br>a.m. and stated she did<br>of residents as well as when a<br>triggered by the MDS, and<br>significant change  |                             |  |               |                         |

STATE FORM

| STREET ADD<br>3700 CEDA  | B. WING<br>PRESS, CITY, ST/<br>AR LAKE AVE<br>DLIS, MN 554<br>ID<br>PREFIX<br>TAG<br>2 830   | NUE  | RECTION<br>SHOULD BE  | (X5)<br>COMPLETI<br>DATE  |
|--|--|--|---|---|
| 3700 CEDA<br>MINNEAPC<br>OF DEFICIENCIES<br>E PRECEDED BY FULL<br>FIFYING INFORMATION)   | AR LAKE AVE<br>DLIS, MN 554<br>ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COP<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE   | RECTION<br>SHOULD BE  | (X5)<br>COMPLETI  |
| MINNEAPC<br>OF DEFICIENCIES<br>E PRECEDED BY FULL<br>FIFYING INFORMATION)  | DLIS, MN 554   | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE   | SHOULD BE   | COMPLET   |
| OF DEFICIENCIES<br>IE PRECEDED BY FULL<br>FIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE   | SHOULD BE   | COMPLET   |
|  | 2 830  |  |   |   |
| ementia was<br>lered looking for her<br>ing on her, and the staff<br>e tries to pick up stuff<br>the fall 9/8/16, RN-B<br>ave put her in bed after<br>gue, and they should<br>back to bed. That's<br>ne." As for the fall on<br>eriods should have<br>k Assessment<br>receives adequate<br>e to prevent accidents.<br>aff to understand the<br>ras well as their own, to<br>nent possibleThe<br>to reflect the<br>nterventions are<br>DF CORRECTION: The<br>rovide education to<br>portance of looking at<br>evising an appropriate<br>blan to ensure residents<br>on in a safe manner.<br>uld randomly audit to be<br>are is provided the |  |  |   |   |
|  | e tries to pick up stuff<br>the fall 9/8/16, RN-B<br>ave put her in bed after<br>gue, and they should<br>back to bed. That's<br>he." As for the fall on<br>priods should have<br>k Assessment<br>eceives adequate<br>to prevent accidents.<br>aff to understand the<br>as well as their own, to<br>nent possibleThe<br>to reflect the<br>nterventions are<br>DF CORRECTION: The<br>povide education to<br>portance of looking at<br>evising an appropriate<br>blan to ensure residents<br>on in a safe manner.<br>uld randomly audit to be | e tries to pick up stuff<br>the fall 9/8/16, RN-B<br>ave put her in bed after<br>gue, and they should<br>back to bed. That's<br>ne." As for the fall on<br>priods should have<br>k Assessment<br>eceives adequate<br>to prevent accidents.<br>aff to understand the<br>as well as their own, to<br>nent possibleThe<br>to reflect the<br>netroventions are<br>DF CORRECTION: The<br>rovide education to<br>portance of looking at<br>evising an appropriate<br>alan to ensure residents<br>on in a safe manner.<br>uld randomly audit to be<br>re is provided the<br>rought to the quality | e tries to pick up stuff<br>the fall 9/8/16, RN-B<br>ave put her in bed after<br>gue, and they should<br>back to bed. That's<br>he." As for the fall on<br>wriods should have<br>k Assessment<br>eceives adequate<br>e to prevent accidents.<br>aff to understand the<br>as well as their own, to<br>nent possibleThe<br>to reflect the<br>hterventions are<br>DF CORRECTION: The<br>rovide education to<br>bortance of looking at<br>evising an appropriate<br>blan to ensure residents<br>on in a safe manner.<br>ald randomly audit to be<br>re is provided the<br>rought to the quality | e tries to pick up stuff<br>the fall 9/8/16, RN-B<br>ave put her in bed after<br>gue, and they should<br>back to bed. That's<br>i.e." As for the fall on<br>rriods should have<br>k Assessment<br>eceives adequate<br>e to prevent accidents.<br>aff to understand the<br>as well as their own, to<br>nent possibleThe<br>to reflect the<br>therventions are<br>DF CORRECTION: The<br>rovide education to<br>portance of looking at<br>evising an appropriate<br>lan to ensure residents<br>on in a safe manner.<br>uld randomly audit to be<br>re is provided the<br>rought to the quality |

| STATEMEN                 | ta Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                           | E CONSTRUCTION   | (X3) DATE S<br>COMPL |                         |
|--------------------------|--|---|---------------------------|--|----------------------|-------------------------|
|                          |  | 00216   | B. WING                   |  | 01/12/2017           |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY,              | STATE, ZIP CODE  |                      |                         |
| JONES H                  | ARRISON RESIDEN  |   | OAR LAKE A<br>POLIS, MN 5 |  |                      |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                 | (X5)<br>COMPLET<br>DATE |
| 21426                    | Continued From pa  | ige 11  | 21426                     |  |                      |                         |
| 21426                    | MN St. Statute 144<br>Prevention And Co  | A.04 Subd. 3 Tuberculosis<br>ntrol  | 21426                     |  |                      | 2/6/17                  |
|                          | maintain a compreh<br>infection control pro-<br>current tuberculosis<br>issued by the Unite<br>Control and Prever<br>Tuberculosis Elimin<br>Morbidity and Morta<br>This program must<br>infection control pla<br>unpaid employees,<br>residents, and volu<br>Health shall provide<br>regarding implement | e provider must establish and<br>hensive tuberculosis<br>ogram according to the most<br>is infection control guidelines<br>d States Centers for Disease<br>tion (CDC), Division of<br>hation, as published in CDC's<br>ality Weekly Report (MMWR).<br>include a tuberculosis<br>an that covers all paid and<br>contractors, students,<br>inteers. The Department of<br>te technical assistance<br>intation of the guidelines. |                           |  |                      |                         |
|                          | by:<br>Based on interview<br>facility failed to ens<br>(TST) was adminis   | ent is not met as evidenced<br>and document review, the<br>ure tuberculin skin testing<br>tered as required for one of six<br>nd one of six employees (E1)<br>sulosis prevention.   |                           | Corrected  |                      |                         |
|                          | The CDC [Centers<br>Guidelines for Prev  | for Disease Control]<br>renting the Transmission of<br>perculosis in Health Care  |                           |  |                      |                         |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                             | CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|-----------------------------|---|--------------------------------|-------------------------|
|                          |   |   | A. BUILDING: _              |   |                                |                         |
|                          |   | 00216   | B. WING                     |   | 01/12/2017                     |                         |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S              | TATE, ZIP CODE  |                                |                         |
| IONES F                  | ARRISON RESIDEN   | CE  | OAR LAKE AV<br>POLIS, MN 55 |   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21426                    | Continued From pa   | age 12  | 21426                       |   |                                |                         |
|                          | a baseline tubercul<br>hours of admission<br>admission. The scr<br>assessment of the<br>and any current TB<br>the directive reads,<br>perform the second<br>R195 was admitted | ected all residents must receive<br>osis (TB) screening within 72<br>or within three months prior to<br>reening must include an<br>resident's risk factors for TB,<br>symptoms. For employees<br>"If results are negative,<br>d step in one to three weeks."<br>If to the facility on 11/21/16.<br>had a TB screening |                             |   |                                |                         |
|                          | assessment tool co<br>record lacked evide<br>TST (intradermal tu<br>completed.  | ompleted on 11/21/16, the<br>ence a first and second step<br>uberculin skin test) was   |                             |   |                                |                         |
|                          |   | at the two step TST should<br>ed for R195 within 72 hours of<br>guidelines.   |                             |   |                                |                         |
|                          | screening tool was<br>the first step TST.<br>millimeters on 7/8/1<br>then administered t<br>read as zero millim<br>step, however, did<br>for providing the se                 | as hired on 7/6/16. A TB<br>completed that day, as well as<br>The TST was read as zero<br>16. A second step TST was<br>three days later and was again<br>eters on 7/13/16. The second<br>not reflect the CDC guidelines<br>cond step one to three weeks<br>indings of the first step TST.                             |                             |   |                                |                         |
|                          | received the secon<br>step TST was giver<br>first step TST was<br>was a student and   | b p.m. the IC nurse stated E-A<br>d TST one week after the first<br>n and not one week after the<br>read, because the employee<br>needed to have it completed.  |                             |   |                                |                         |
|                          | (DON) explained th  | a.m. the director of nursing<br>nat the facility should have<br>C testing guidelines.   |                             |   |                                |                         |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                             |  |                                  | E SURVEY<br>PLETED      |
|--------------------------|--|--|-----------------------------|--|----------------------------------|-------------------------|
|                          |  | 00216  | B. WING                     |  | 01/12/2017                       |                         |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | DDRESS, CITY, S             | TATE, ZIP CODE   |                                  | 12/2011                 |
| IONES I                  | ARRISON RESIDEN  | CE   | DAR LAKE AV<br>POLIS, MN 55 |  |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21426                    | Continued From pa  | age 13   | 21426                       |  |                                  |                         |
|                          | Plan directed "Resi<br>tuberculosis sympt<br>was defined as, "Pi<br>skin testing of pers<br>TSTsto reduce the<br>boosted reaction for<br>TST result is classi<br>step of a two-step<br>1-3 weeks after the<br>The CDC guideline<br>being admitted to a<br>receive a baseline<br>assessment of the<br>and any current TE<br>intradermal tubercu<br>administered to all<br>72 hours of admiss<br>documentation of a<br>three months or if of<br>physician/nurse pra<br>procedure will be for<br>SUGGESTED MET<br>director of nursing<br>nurse could review<br>related to the comp<br>and TB monitoring<br>educated as to the<br>testing process. An<br>developed to ensur<br>results brought to t<br>review. | Tuberculosis Infection Control<br>idents are screened for<br>oms on admission." Two-step<br>rocedure used for the baseline<br>ons who will receive serial<br>the likelihood of mistaking a<br>or a new infection. If an initial<br>ified as negative, a second<br>TST should be administered<br>a first TST result was read."<br>as also directed each resident<br>a skilled nursing facility was to<br>screening including an<br>resident risk factors for TB<br>a symptoms. "A standard<br>ulin skin test (TST) will be<br>skilled facility residents within<br>sion, unless there is a written<br>a negative TST within the last<br>contraindicated in writing by a<br>followed."<br>THOD OF CORRECTION: The<br>(DON) and infection control<br>policies and procedures<br>connents of the infection control<br>program. Facility staff could be<br>TB requirements and two step<br>monitoring system could be<br>re ongoing compliance and the<br>he quality committee for<br>R CORRECTION: Twenty one- |                             |  |                                  |                         |