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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 _{Y1}	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 Reg. # 483.10(d)(3)(g)(1)(4) (13)(16)-(18)	Completed	Reg. # (3),483	(c)(2)(i-ii,iv,v) 3.21(b)(2) Comple	ed Reg. #	F0323 483.25(d)(1)(2)(n)(1)-(3)	Correction 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. # 	Comple	ed Reg. # LSC		Completed 	
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Reg. #	Completed	Reg. #	Comple	ed Reg. #		Completed	
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Reg. #	Completed	Reg. #	Comple	ed Reg. #		Completed	
LSC		LSC		LSC		_	
REVIEWED BY RE STATE AGENCY X (IN	VIEWED BY ITIALS)	DATE 03/30/2017	SIGNATURE OF SURVEYO	PR 15507	DATE 02/27/	2017	
	VIEWED BY ITIALS)	DATE	TITLE		DATE		
FOLLOWUP TO SURVEY CO 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			CENTERS FOR MED	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: EZ92
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00216
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(L2) 461242600	NU.	(L4) 5700 CEDAI		NUL	(L6) 55416	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 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
	2/2017 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESKD 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 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 *	(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:		 Ownership/Control Both of the Above 	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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245460	B. WING	i		01/	12/2017
NAME OF I	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ARRISON RESIDEN	~ E		3	3700 CEDAR LAKE AVENUE		
UCINEST	Annioon neoidein			N	MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F	000			
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.					
F 156 SS=D	revisit of your facilit validate that substa regulations has bee your verification. 483.10(d)(3)(g)(1)(4	acceptable POC an on-site y may be conducted to antial compliance with the en attained in accordance with 4)(5)(13)(16)-(18) NOTICE OF SERVICES, CHARGES	F	156			2/6/17
00-0	(d)(3) The facility m remains informed o of contacting the ph	ust ensure that each resident of the name, specialty, and way hysician and other primary care onsible for his or her care.					
	(1) The resident hat his or her rights and	tion and Communication. s the right to be informed of d of all rules and regulations conduct and responsibilities ay in the facility.					
	notices orally (mean	has the right to receive ning spoken) and in writing a a format and a language he a, including:					
	The facility must fur	as specified in this section. rnish to each resident a written rights which includes -					
		the manner of protecting 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 E & MEDICAID SERVICES			FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245460	B. WING		01 / [.]	12/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JONES H	ARRISON RESIDEN	CE		3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	Continued From pa	age 1	F 156			
	procedures for esta including the right to	i the requirements and ablishing eligibility for Medicaid, o request an assessment of ection 1924(c) of the Social				
	email), and telepho State regulatory an resident advocacy of Survey Agency, the State Long-Term C protection and advo services where stat in long-term care fa agency for informat	addresses (mailing and one numbers of all pertinent d informational agencies, groups such as the State e State licensure office, the are Ombudsman program, the ocacy agency, adult protective te law provides for jurisdiction acilities, the local contact tion about returning to the Medicaid Fraud Control Unit;				
	complaint with the s concerning any sus federal nursing faci not limited to reside exploitation, misapp in the facility, non-c directives requirem	at the resident may file a State Survey Agency spected violation of state or ility regulations, including but ent abuse, neglect, propriation of resident property compliance with the advance ents and requests for ng returning to the community.				
	and local advocacy not limited to the St Long-Term Care Of (established under Americans Act of 1 U.S.C. 3001 et seq	contact information for State organizations including but tate Survey Agency, the State mbudsman program section 712 of the Older 965, as amended 2016 (42 and the protection and as designated by the state, and				

Facility ID: 00216

If continuation sheet Page 2 of 17

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

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

Facility ID: 00216

If continuation sheet Page 4 of 17

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

Facility ID: 00216

If continuation sheet Page 5 of 17

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

Facility ID: 00216

If continuation sheet Page 6 of 17

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

If continuation sheet Page 7 of 17

		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 TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		COMPLETION 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 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 (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.					

Facility ID: 00216

If continuation sheet Page 8 of 17

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

Facility ID: 00216

If continuation sheet Page 9 of 17

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

If continuation sheet Page 10 of 17

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

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

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

Facility ID: 00216

If continuation sheet Page 13 of 17

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

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/08/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245460	B. WING			01 / [.]	12/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JONES H	HARRISON RESIDEN	CE		-	700 CEDAR LAKE AVENUE /IINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	The following day of team (IDT) met and balance and fell on shoes and her glas therefore, the IDT of continue with the pl not include new inte considered. 2) On 9/8/16, staff f reported she "sturn and fell down." The judgement as well a and and "may have wandering." The co plan of care. New in the resident had reso on the interventions further falls. 3) On 10/18/16, R7 from the floor, lost f cause was the reside meals and was diffi conclusion was to co The following day th fall in the great roor was independent w to pick up an item f also noted the reside active. Approaches was clean was not minimize the risk for R77's quarterly Min 10/21/16, indicated impaired cognition,	 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 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 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. 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 	F 3	23			

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

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

Facility ID: 00216

If continuation sheet Page 17 of 17

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

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

If continuation sheet 1 of 14

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

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

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

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

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

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

STATE FORM

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

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

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
JONES H	HARRISON RESIDEN	CE	DAR LAKE AV POLIS, MN 55			
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2 830	Continued From pa	age 9	2 830			
	"FALLS/SAFETY: to wandering beha antidepressant use Alzheimer's." Interv monitor falls per pr physician as indica gait, mobility, and t clutter-free environ safety, monitor for to . Guide to specif Licensed practical regarding R77's fa LPN-B explained F walking around the walked around the	nurse (LPN)-B was interviewed Ils on 1/11/17, at 7:28 a.m. 777 was very independent in a unit and sometimes she unit at night.	•			
	registered nurse (F independently amb verified the care pl falls, but did make and socks. When a the fall on 9/8/16, F fatigue from wande	v on 1/11/17, at 9:48 a.m. with RN)-A she stated R77 was bulatory and walked a lot. RN-A an was not updated after her sure she was wearing shoes asked about interventions after RN-A said it may have been ering, and the staff should have d that by assisting the resident				
	a.m. she had neve her trying to pick u NA-A saw this, she	NA)-A stated on 1/12/17 8:33 r seen R77 fall, but had seen p items from the floor. When would tell the resident she nd help her to pick up the item.				
	approximately 9:30 regular screening of	abilitation on 1/12/17, at a.m. and stated she did of residents as well as when a triggered by the MDS, and significant change				

STATE FORM

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

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

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21426	Continued From pa	age 12	21426			
	a baseline tubercul hours of admission admission. The scr assessment of the and any current TB the directive reads, perform the second R195 was admitted	ected all residents must receive osis (TB) screening within 72 or within three months prior to reening must include an resident's risk factors for TB, symptoms. For employees "If results are negative, d step in one to three weeks." If to the facility on 11/21/16. had a TB screening				
	assessment tool co record lacked evide TST (intradermal tu completed.	ompleted on 11/21/16, the ence a first and second step uberculin skin test) was				
		at the two step TST should ed for R195 within 72 hours of guidelines.				
	screening tool was the first step TST. millimeters on 7/8/1 then administered t read as zero millim step, however, did for providing the se	as hired on 7/6/16. A TB completed that day, as well as The TST was read as zero 16. A second step TST was three days later and was again eters on 7/13/16. The second not reflect the CDC guidelines cond step one to three weeks indings of the first step TST.				
	received the secon step TST was giver first step TST was was a student and	b p.m. the IC nurse stated E-A d TST one week after the first n and not one week after the read, because the employee needed to have it completed.				
	(DON) explained th	a.m. the director of nursing nat the facility should have C testing guidelines.				

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