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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EZ92
Facility ID: 00216

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245460**

2.STATE VENDOR OR MEDICAID NO.
(L2) **461242600**

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

4. TYPE OF ACTION: 7 (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 02/27/2017 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **163** (L18)
13.Total Certified Beds **163** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	163			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 03/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/27/2017
(L33)

DETERMINATION APPROVAL

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, 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 Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245460 Y1	A. Building B. Wing Y2	2/27/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES HARRISON RESIDENCE	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) LSC	Correction Completed 02/06/2017	ID Prefix F0280 Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) LSC	Correction Completed 02/06/2017	ID Prefix F0323 Reg. # 483.25(d)(1)(2)(n)(1)-(3) LSC	Correction Completed 02/06/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) GL/mm	DATE 03/30/2017	SIGNATURE OF SURVEYOR 15507	DATE 02/27/2017
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/12/2017	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EZ92
Facility ID: 00216

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245460**

2. STATE VENDOR OR MEDICAID NO. (L2) **461242600**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/12/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **163** (L18)

13. Total Certified Beds **163** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	163			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NEII 02/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, *Enforcement Specialist* 02/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically 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:

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		2/6/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1	F 156		

Continued From page 1

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3	F 156		

and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident’s stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 4	F 156		

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility’s per diem rate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate liability notices for 2 of 3 residents (R50, R35) who were discharged from Medicare services. Findings include:	F 156	It is the policy at Jones Harrison Residence to inform residents of changes in their services and of their liability notice when they are being discharged from Medicare. The facility policy & procedure on issuing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	**01/12/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 6 R50 was admitted to the facility on 8/11/16, and remained at the facility. R35 was admitted to the facility on 10/18/16, and discharged on 12/1/16. On 1/10/17, at approximately 9:00 a.m. liability notices were requested, including those for R50 and R35 from the director of nursing (DON). A few hours later the DON provided one of the three notices, and explained the notices for R50 and R35 would be provided shortly. The following day at approximately 10:00 a.m. the DON verified the liability notices for R50 and R35 could not be found, and the employee who was responsible for providing the notices was no employed with the facility. The DON verified she was aware it was the facility's responsibility to provide two-day notices when a resident was going to be discharged from Medicare. A policy and procedure was requested but not provided.	F 156	liability notices was reviewed and revised. The Medicare nurse will be responsible to issue liability notices when Medicare coverage is ending. The Facility will file the notice in the medical record upon completion and scan the document in the shared drive. The Medicare team will discuss potential 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 ensure compliance. Facility will be in compliance by February 6th, 2017.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type,	F 280		2/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7	F 280		

amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to review and revise the care plan following falls to minimize the risk for further falls for 1 of 4 residents (R77) reviewed for falls. Findings include: R77's care plan dated 8/5/14, revealed "FALLS/SAFETY: Potential for falls/injury related to wandering behavior, history of falls, antidepressant use, incontinence and Alzheimer's." Interventions directed staff to	F 280	It is the policy at Jones Harrison Residence that residents' comprehensive care plan will be reviewed and revised after a fall by IDT to minimize risk of further falls. R 77 care plan was reviewed by IDT and updated to ensure appropriate interventions were implemented to minimize further risk of falls. Care plans will be reviewed at IDT after each fall, and appropriate interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 monitor falls per protocol, update family and physician as indicated, observe for changes in gait, mobility, and transferring, maintain a clutter-free environment, anticipate needs for safety, monitor for wandering behavior, and guide to . Guide to specific destinations." R77's Care Area Assessment dated 7/27/16, revealed R77 was at risk for falls related to dementia and a history of falls. She had experienced one fall in her room with no injury. Staff was to assist her with mobility and transfers and the goal was to be free of falls. Resident Incident Reports revealed the following falls: 1) On 8/29/16, the resident was walking in the dining room, turned around and lost her balance and sat on the floor. No injuries were noted, and the report indicated the care plan was updated, however, the description of the initial interventions to prevent further falls was left blank. A full description of what was happening in the three hours prior to the fall was left blank. The staff's theory as to what happened to cause the fall was "poor judgement." The plan read "no change." The following day on 8/30/16, the interdisciplinary team (IDT) met and indicated the resident lost her balance and fell on the floor. She was wearing shoes and her glasses at the time of the fall, therefore, the IDT determined they would continue with the plan of care and the report did not include new interventions the team considered. 2) On 9/8/16, staff found R77 on the floor. R77 reported she "'stumbled on her feet' while walking	F 280	will be discussed and added to the plan of care. The DON will be responsible to audit and monitor this process. Facility will be in compliance by February 6th, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10	F 280		

and fell down." The cause of the fall was poor judgement as well as the resident liked to walk and and "may have become tired from wandering." The conclusion was to continue the plan of care. New interventions such as ensuring the resident had rest periods were not identified on the interventions to minimize the risk for further falls.

3) On 10/18/16, R77 was picking up something from the floor, lost her balance and fell. The root cause was the resident likes to clean tables after meals and was difficult to redirect. The conclusion was to continue with the plan of care.

The following day the IDT met to discuss R77's fall in the great room. It was noted the resident was independent with ambulation and bent down to pick up an item from the floor and fell. It was also noted the resident was very anxious and active. Approaches such as ensuring the floor was clean was not identified as a consideration to minimize the risk for further falls.

R77's quarterly Minimum Data Set (MDS) dated 10/21/16, indicated the resident had severely impaired cognition, required limited assistance with mobility and supervision with transferring, and had experienced two or more falls since the prior assessment. Diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, with physician orders including the antidepressant medication Celexa, as well as pain medications Tramadol and Tylenol.

Licensed practical nurse (LPN)-B was interviewed regarding R77's falls on 1/11/17, at 7:28 a.m. LPN-B explained R77 was very independent in walking around the unit and sometimes she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11	F 280		

walked around the unit at night.

During an interview on 1/11/17, at 9:48 a.m. with registered nurse (RN)-A she stated R77 was independently ambulatory and walked a lot. RN-A verified the care plan was not updated after her falls, but did make sure she was wearing shoes and socks. When asked about interventions after the fall on 9/8/16, RN-A said it may have been fatigue from wandering, and the staff should have probably addressed that by assisting the resident to lie down.

Nursing assistant (NA)-A stated on 1/12/17 8:33 a.m. she had never seen R77 fall, but had seen her trying to pick up items from the floor. When NA-A saw this, she would tell the resident she was going to fall and help her to pick up the item.

RN-B explained on 1/12/17, at 9:51 a.m. that R77 was falling because her dementia was progressing and she wandered looking for her family. "We are just checking on her, and the staff should assist her when she tries to pick up stuff from the floor." Regarding the fall 9/8/16, RN-B stated, "The staff should have put her in bed after they noticed increased fatigue, and they should have directed the resident back to bed. That's what they should have done." As for the fall on 8/29/16, RN-B said rest periods should have been encouraged.

The facility's 7/16, Fall Risk Assessment indicated, "Each resident receives adequate supervision and assistance to prevent accidents. It is important for facility staff to understand the facilities [sic] responsibility as well as their own, to ensure the safest environment possible...The plan of care is update [sic] to reflect the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 intervention. Appropriate interventions are implemented."	F 280		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure additional measures were considered following falls to minimize the risk for further falls for 1 of 4 residents (R77) reviewed for falls.	F 323	It is the policy at Jones Harrison Residence that each resident receives adequate supervision and assistive devices to prevent accidents. R77 care plan was reviewed by IDT and	2/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 Findings include: R77 was observed in the dining room having lunch on 1/10/17, at 12:08 a.m. Following the meal at 1:31 p.m. the resident was walking in the hallway. R77 informed the surveyor she would like to go "upstairs." The therapeutic recreation coordinator redirected R77 toward the dining room and stated, "I am going to do some puzzles with her." The following morning at 7:12 a.m. R77 was in bed with her eyes closed and call light was within her reach. At 7:47 a.m. the resident was having coffee in the dining room, and then had her head down and eyes closed. Licensed practical nurse(LPN)-A explained the resident "got up before I came for my shift...she is kind of sleepy." R77's Care Area Assessment dated 7/27/16, revealed R77 was at risk for falls related to dementia and a history of falls. She had experienced one fall in her room with no injury. Staff was to assist her with mobility and transfers and the goal was to be free of falls. Resident Incident Reports revealed the following falls: 1) On 8/29/16, the resident was walking in the dining room, turned around and lost her balance and sat on the floor. No injuries were noted, and the report indicated the care plan was updated, however, the description of the initial interventions to prevent further falls was left blank. A full description of what was happening in the three hours prior to the fall was left blank. The staff's theory as to what happened to cause the fall was "poor judgement." The plan read "no change."	F 323	updated to ensure appropriate interventions were implemented to minimize further falls. Resident's care plans will be reviewed at IDT after each fall and appropriate interventions will be added to the plan of care. . The DON will be responsible to audit and monitor this process. Facility will be in compliance by February 6th, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14	F 323		

The following day on 8/30/16, the interdisciplinary team (IDT) met and indicated the resident lost her balance and fell on the floor. She was wearing shoes and her glasses at the time of the fall, therefore, the IDT determined they would continue with the plan of care and the report did not include new interventions the team considered.

2) On 9/8/16, staff found R77 on the floor. R77 reported she "'stumbled on her feet' while walking and fell down." The cause of the fall was poor judgement as well as the resident liked to walk and and "may have become tired from wandering." The conclusion was to continue the plan of care. New interventions such as ensuring the resident had rest periods were not identified on the interventions to minimize the risk for further falls.

3) On 10/18/16, R77 was picking up something from the floor, lost her balance and fell. The root cause was the resident likes to clean tables after meals and was difficult to redirect. The conclusion was to continue with the plan of care.

The following day the IDT met to discuss R77's fall in the great room. It was noted the resident was independent with ambulation and bent down to pick up an item from the floor and fell. It was also noted the resident was very anxious and active. Approaches such as ensuring the floor was clean was not identified as a consideration to minimize the risk for further falls.

R77's quarterly Minimum Data Set (MDS) dated 10/21/16, indicated the resident had severely impaired cognition, required limited assistance with mobility and supervision with transferring,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15	F 323		

and had experienced two or more falls since the prior assessment. Diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, with physician orders including the antidepressant medication Celexa, as well as pain medications Tramadol and Tylenol.

The care plan for R77 dated 8/5/14, revealed "FALLS/SAFETY: Potential for falls/injury related to wandering behavior, history of falls, antidepressant use, incontinence and Alzheimer's." Interventions directed staff to monitor falls per protocol, update family and physician as indicated, observe for changes in gait, mobility, and transferring, maintain a clutter-free environment, anticipate needs for safety, monitor for wandering behavior, and guide to . Guide to specific destinations."

Licensed practical nurse (LPN)-B was interviewed regarding R77's falls on 1/11/17, at 7:28 a.m. LPN-B explained R77 was very independent in walking around the unit and sometimes she walked around the unit at night.

During an interview on 1/11/17, at 9:48 a.m. with registered nurse (RN)-A she stated R77 was independently ambulatory and walked a lot. RN-A verified the care plan was not updated after her falls, but did make sure she was wearing shoes and socks. When asked about interventions after the fall on 9/8/16, RN-A said it may have been fatigue from wandering, and the staff should have probably addressed that by assisting the resident to lie down.

Nursing assistant (NA)-A stated on 1/12/17 8:33 a.m. she had never seen R77 fall, but had seen her trying to pick up items from the floor. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16	F 323		

NA-A saw this, she would tell the resident she was going to fall and help her to pick up the item.

The director of rehabilitation on 1/12/17, at approximately 9:30 a.m. and stated she did regular screening of residents as well as when a significant change triggered by the MDS, and there had been no significant change assessments, recommendations or physician orders received for R77.

RN-B explained on 1/12/17, at 9:51 a.m. that R77 was falling because her dementia was progressing and she wandered looking for her family. "We are just checking on her, and the staff should assist her when she tries to pick up stuff from the floor." Regarding the fall 9/8/16, RN-B stated, "The staff should have put her in bed after they noticed increased fatigue, and they should have directed the resident back to bed. That's what they should have done." As for the fall on 8/29/16, RN-B said rest periods should have been encouraged.

The facility's 7/16, Fall Risk Assessment indicated, "Each resident receives adequate supervision and assistance to prevent accidents. It is important for facility staff to understand the facilities [sic] responsibility as well as their own, to ensure the safest environment possible...The plan of care is update [sic] to reflect the intervention. Appropriate interventions are implemented."

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

F5460027

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**01/11/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on January 11, 2017. At the time of this survey, Jones Harrison Residence was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Jones Harrison Residence is a 3-story building with a full basement. The building was constructed in 1992 and was determined to be of Type II(222) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 163 beds and had a census of 153 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/9/17 through 1/12/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to review and revise the care plan following falls to minimize the risk for further falls for 1 of 4 residents (R77) reviewed for falls. Findings include: R77's care plan dated 8/5/14, revealed "FALLS/SAFETY: Potential for falls/injury related to wandering behavior, history of falls, antidepressant use, incontinence and Alzheimer's." Interventions directed staff to monitor falls per protocol, update family and physician as indicated, observe for changes in	2 570	Corrected	2/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 3	2 570		

gait, mobility, and transferring, maintain a clutter-free environment, anticipate needs for safety, monitor for wandering behavior, and guide to . Guide to specific destinations."

R77's Care Area Assessment dated 7/27/16, revealed R77 was at risk for falls related to dementia and a history of falls. She had experienced one fall in her room with no injury. Staff was to assist her with mobility and transfers and the goal was to be free of falls.

Resident Incident Reports revealed the following falls:

1) On 8/29/16, the resident was walking in the dining room, turned around and lost her balance and sat on the floor. No injuries were noted, and the report indicated the care plan was updated, however, the description of the initial interventions to prevent further falls was left blank. A full description of what was happening in the three hours prior to the fall was left blank. The staff's theory as to what happened to cause the fall was "poor judgement." The plan read "no change."

The following day on 8/30/16, the interdisciplinary team (IDT) met and indicated the resident lost her balance and fell on the floor. She was wearing shoes and her glasses at the time of the fall, therefore, the IDT determined they would continue with the plan of care and the report did not include new interventions the team considered.

2) On 9/8/16, staff found R77 on the floor. R77 reported she "'stumbled on her feet' while walking and fell down." The cause of the fall was poor judgement as well as the resident liked to walk and and "may have become tired from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 4	2 570		

wandering." The conclusion was to continue the plan of care. New interventions such as ensuring the resident had rest periods were not identified on the interventions to minimize the risk for further falls.

3) On 10/18/16, R77 was picking up something from the floor, lost her balance and fell. The root cause was the resident likes to clean tables after meals and was difficult to redirect. The conclusion was to continue with the plan of care.

The following day the IDT met to discuss R77's fall in the great room. It was noted the resident was independent with ambulation and bent down to pick up an item from the floor and fell. It was also noted the resident was very anxious and active. Approaches such as ensuring the floor was clean was not identified as a consideration to minimize the risk for further falls.

R77's quarterly Minimum Data Set (MDS) dated 10/21/16, indicated the resident had severely impaired cognition, required limited assistance with mobility and supervision with transferring, and had experienced two or more falls since the prior assessment. Diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, with physician orders including the antidepressant medication Celexa, as well as pain medications Tramadol and Tylenol.

Licensed practical nurse (LPN)-B was interviewed regarding R77's falls on 1/11/17, at 7:28 a.m. LPN-B explained R77 was very independent in walking around the unit and sometimes she walked around the unit at night.

During an interview on 1/11/17, at 9:48 a.m. with registered nurse (RN)-A she stated R77 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ___ B. WING ___	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 5	2 570		

Continued From page 5

independently ambulatory and walked a lot. RN-A verified the care plan was not updated after her falls, but did make sure she was wearing shoes and socks. When asked about interventions after the fall on 9/8/16, RN-A said it may have been fatigue from wandering, and the staff should have probably addressed that by assisting the resident to lie down.

Nursing assistant (NA)-A stated on 1/12/17 8:33 a.m. she had never seen R77 fall, but had seen her trying to pick up items from the floor. When NA-A saw this, she would tell the resident she was going to fall and help her to pick up the item.

RN-B explained on 1/12/17, at 9:51 a.m. that R77 was falling because her dementia was progressing and she wandered looking for her family. "We are just checking on her, and the staff should assist her when she tries to pick up stuff from the floor." Regarding the fall 9/8/16, RN-B stated, "The staff should have put her in bed after they noticed increased fatigue, and they should have directed the resident back to bed. That's what they should have done." As for the fall on 8/29/16, RN-B said rest periods should have been encouraged.

The facility's 7/16, Fall Risk Assessment indicated, "Each resident receives adequate supervision and assistance to prevent accidents. It is important for facility staff to understand the facilities [sic] responsibility as well as their own, to ensure the safest environment possible...The plan of care is update [sic] to reflect the intervention. Appropriate interventions are implemented."

SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ____ B. WING ____	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 re-educate staff as appropriate regarding care plan revisions. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure additional measures were considered following falls to minimize the risk for further falls for 1 of 4 residents (R77) reviewed for falls. Findings include: R77 was observed in the dining room having lunch on 1/10/17, at 12:08 a.m. Following the meal at 1:31 p.m. the resident was walking in the	2 830	Corrected	2/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7	2 830		

hallway. R77 informed the surveyor she would like to go "upstairs." The therapeutic recreation coordinator redirected R77 toward the dining room and stated, "I am going to do some puzzles with her." The following morning at 7:12 a.m. R77 was in bed with her eyes closed and call light was within her reach. At 7:47 a.m. the resident was having coffee in the dining room, and then had her head down and eyes closed. Licensed practical nurse(LPN)-A explained the resident "got up before I came for my shift...she is kind of sleepy."

R77's Care Area Assessment dated 7/27/16, revealed R77 was at risk for falls related to dementia and a history of falls. She had experienced one fall in her room with no injury. Staff was to assist her with mobility and transfers and the goal was to be free of falls.

Resident Incident Reports revealed the following falls:

1) On 8/29/16, the resident was walking in the dining room, turned around and lost her balance and sat on the floor. No injuries were noted, and the report indicated the care plan was updated, however, the description of the initial interventions to prevent further falls was left blank. A full description of what was happening in the three hours prior to the fall was left blank. The staff's theory as to what happened to cause the fall was "poor judgement." The plan read "no change."

The following day on 8/30/16, the interdisciplinary team (IDT) met and indicated the resident lost her balance and fell on the floor. She was wearing shoes and her glasses at the time of the fall, therefore, the IDT determined they would continue with the plan of care and the report did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 not include new interventions the team considered. 2) On 9/8/16, staff found R77 on the floor. R77 reported she "'stumbled on her feet' while walking and fell down." The cause of the fall was poor judgement as well as the resident liked to walk and and "may have become tired from wandering." The conclusion was to continue the plan of care. New interventions such as ensuring the resident had rest periods were not identified on the interventions to minimize the risk for further falls. 3) On 10/18/16, R77 was picking up something from the floor, lost her balance and fell. The root cause was the resident likes to clean tables after meals and was difficult to redirect. The conclusion was to continue with the plan of care. The following day the IDT met to discuss R77's fall in the great room. It was noted the resident was independent with ambulation and bent down to pick up an item from the floor and fell. It was also noted the resident was very anxious and active. Approaches such as ensuring the floor was clean was not identified as a consideration to minimize the risk for further falls. R77's quarterly Minimum Data Set (MDS) dated 10/21/16, indicated the resident had severely impaired cognition, required limited assistance with mobility and supervision with transferring, and had experienced two or more falls since the prior assessment. Diagnoses included Alzheimer's disease, major depressive disorder, osteoporosis, with physician orders including the antidepressant medication Celexa, as well as pain medications Tramadol and Tylenol.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ____ B. WING ____	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9	2 830		

The care plan for R77 dated 8/5/14, revealed "FALLS/SAFETY: Potential for falls/injury related to wandering behavior, history of falls, antidepressant use, incontinence and Alzheimer's." Interventions directed staff to monitor falls per protocol, update family and physician as indicated, observe for changes in gait, mobility, and transferring, maintain a clutter-free environment, anticipate needs for safety, monitor for wandering behavior, and guide to . Guide to specific destinations."

Licensed practical nurse (LPN)-B was interviewed regarding R77's falls on 1/11/17, at 7:28 a.m. LPN-B explained R77 was very independent in walking around the unit and sometimes she walked around the unit at night.

During an interview on 1/11/17, at 9:48 a.m. with registered nurse (RN)-A she stated R77 was independently ambulatory and walked a lot. RN-A verified the care plan was not updated after her falls, but did make sure she was wearing shoes and socks. When asked about interventions after the fall on 9/8/16, RN-A said it may have been fatigue from wandering, and the staff should have probably addressed that by assisting the resident to lie down.

Nursing assistant (NA)-A stated on 1/12/17 8:33 a.m. she had never seen R77 fall, but had seen her trying to pick up items from the floor. When NA-A saw this, she would tell the resident she was going to fall and help her to pick up the item.

The director of rehabilitation on 1/12/17, at approximately 9:30 a.m. and stated she did regular screening of residents as well as when a significant change triggered by the MDS, and there had been no significant change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10	2 830		

assessments, recommendations or physician orders received for R77.

RN-B explained on 1/12/17, at 9:51 a.m. that R77 was falling because her dementia was progressing and she wandered looking for her family. "We are just checking on her, and the staff should assist her when she tries to pick up stuff from the floor." Regarding the fall 9/8/16, RN-B stated, "The staff should have put her in bed after they noticed increased fatigue, and they should have directed the resident back to bed. That's what they should have done." As for the fall on 8/29/16, RN-B said rest periods should have been encouraged.

The facility's 7/16, Fall Risk Assessment indicated, "Each resident receives adequate supervision and assistance to prevent accidents. It is important for facility staff to understand the facilities [sic] responsibility as well as their own, to ensure the safest environment possible...The plan of care is update [sic] to reflect the intervention. Appropriate interventions are implemented."

SUGGESTED METHOD OF CORRECTION: The DON or designee, could provide education to nursing staff about the importance of looking at root cause analysis and devising an appropriate plan and/or revising care plan to ensure residents receive care and supervision in a safe manner. The DON or designee, could randomly audit to be sure the proper nursing care is provided the residents and the results brought to the quality committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 11	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculin skin testing (TST) was administered as required for one of six residents (R195) and one of six employees (E1) reviewed for tuberculosis prevention. Findings include: The CDC [Centers for Disease Control] Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care	21426	Corrected	2/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 12	21426		

Settings, 2005, directed all residents must receive a baseline tuberculosis (TB) screening within 72 hours of admission or within three months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. For employees the directive reads, "If results are negative, perform the second step in one to three weeks."

R195 was admitted to the facility on 11/21/16. While the resident had a TB screening assessment tool completed on 11/21/16, the record lacked evidence a first and second step TST (intradermal tuberculin skin test) was completed.

On 1/10/17, at 3:35 p.m. the infection control (IC) nurse explained that the two step TST should have been completed for R195 within 72 hours of admission per CDC guidelines.

Employee (E)-A was hired on 7/6/16. A TB screening tool was completed that day, as well as the first step TST. The TST was read as zero millimeters on 7/8/16. A second step TST was then administered three days later and was again read as zero millimeters on 7/13/16. The second step, however, did not reflect the CDC guidelines for providing the second step one to three weeks after the negative findings of the first step TST.

On 1/10/17, at 3:35 p.m. the IC nurse stated E-A received the second TST one week after the first step TST was given and not one week after the first step TST was read, because the employee was a student and needed to have it completed.

On 1/12/17, at 7:52 a.m. the director of nursing (DON) explained that the facility should have been following CDC testing guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: ______ B. WING ______	01/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 13 The facility's 9/13, Tuberculosis Infection Control Plan directed "Residents are screened for tuberculosis symptoms on admission." Two-step was defined as, "Procedure used for the baseline skin testing of persons who will receive serial TSTs...to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read." The CDC guidelines also directed each resident being admitted to a skilled nursing facility was to receive a baseline screening including an assessment of the resident risk factors for TB and any current TB symptoms. "A standard intradermal tuberculin skin test (TST) will be administered to all skilled facility residents within 72 hours of admission, unless there is a written documentation of a negative TST within the last three months or if contraindicated in writing by a physician/nurse practitioner. A two step TST procedure will be followed." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and infection control nurse could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated as to the TB requirements and two step testing process. A monitoring system could be developed to ensure ongoing compliance and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		