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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LT87

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00216

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

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

4. TYPE OF ACTION: **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 **12/23/2014** (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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Mary Bruess, HFE NE II — 01/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 01/23/2015 (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
12/11/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5460

January 23, 2015

Mr. Lowell Berggren, Administrator
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, Minnesota 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 January 16, 2015 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. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically Delivered: January 22, 2015

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

RE: Project Number S5460025 and FMS Project F5460025

Dear Mr. Berggren:

On November 13, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 3, 2014, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance and found additional deficiencies. The most serious deficiencies at the time of FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 17, 2014, CMS forwarded the results of the LSC FMS and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective January 23, 2015 (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of December 17, 2014, in accordance with Federal law, as specified in the Act at Sections 1819 (f)(2)(B)(iii)(I)(b) and 1919 (f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2015.

On December 23, 2014, the Minnesota Department of Health and on November 25, 2014, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant

to a standard survey, completed on October 23, 2014 and the FMS Survey completed December 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 16, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on October 23, 2014 and the FMS Survey completed on December 3, 2014, effective January 16, 2015.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedy outlined in their letter of December 17, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective January 23, 2015 be rescinded. (42 CFR 488.417(b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 23, 2015 is to be rescinded. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 23, 2015 is to be rescinded.

In the CMS letter of December 17, 2014, you were advised that, in accordance with Federal law, as specified in the Act at Sections 1819 (f)(2)(B)(iii)(I)(b) and 1919 (f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the PCR Revisit forms (CMS-2567B) from the aforementioned visits. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245460	A. Building B. Wing	12/23/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **11/20/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **11/25/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/25/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/25/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/25/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **10/24/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/26/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/25/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	01/21/2015	33043	12/23/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/23/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245460	01 - MAIN BUILDING 01	11/25/2014

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0069	10/28/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 01/21/2015	Signature of Surveyor: 28120	Date: 11/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/27/2014		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245460	A. Building B. Wing **01 - MAIN BUILDING 01**	1/20/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **01/09/2015**	ID Prefix	Correction Completed **01/09/2015**	ID Prefix	Correction Completed **01/16/2015**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0051		Reg. # **NFPA 101** LSC K0056	
ID Prefix	Correction Completed **12/27/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0069		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	01/21/2015	28120	01/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/3/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: February 3, 2015

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

Re: Reinspection Results - Project Number

Dear Mr. Berggren:

On December 23, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 23, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00216	A. Building B. Wing	12/23/2014

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **11/25/2014**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **11/25/2014**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **11/25/2014**
ID Prefix **21025** Reg. # **MN Rule 4658.0615** LSC	Correction Completed **11/25/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **11/25/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Sul** LSC	Correction Completed **12/23/2014**
ID Prefix **21620** Reg. # **MN Rule 4658.1345** LSC	Correction Completed **11/26/2014**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **11/20/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/AK	01/21/2015	33043	12/23/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/23/2014

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 — ID: LT87

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/23/2014** (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:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Douglas Stevens, HFE NE II 11/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/10/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5223

November 13, 2014

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

RE: Project Number S5460025 and Complaint Number H5460047

Dear Mr. Berggren:

On October 23, 2014, 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. In addition, at the time of the October 23, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5460047.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 23, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5460047 that was found to be unsubstantiated.

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

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

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

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;
<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 December 2, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 2, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 January 23, 2015 (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 April 23, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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 _____	10/23/2014

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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form 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. A complaint investigation was completed for H5460047 at the time of the standard recertification survey and was found unsubstantiated.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt efforts were made by the facility to resolve grievances made on behalf of 2 of 2 residents (R88, R168) verbalized by two family representatives. Findings include: R88's family member (F)-A was interviewed on 10/23/14, at 2:00 p.m. and reported, "We have	F 166	POC accepted ds/tanttp 11/26/14 RECEIVED NOV 25 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/25/14

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

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F 166	Continued From page 1 been going through the entire chain of command on numerous occasions and numerous dates and times without getting satisfaction from the facility and without obtaining a resolution to the multiple concerns expressed." F-A delineated the following concerns that had been reported: 1) call lights turned off before resident needs were met (such as toileting), so allegedly the facility could report meeting the goal of answering call lights within seven minutes, 2) long call light times during staff break times, and 3) R88's arm positioning device was not used correctly in the resident's wheelchair. F-A expressed frustration related to staff turnover that resulting in the need to train new staff in proper wheel chair positioning. F-A was unaware of any facility grievance process, and said such a process had not been explained. R88's Minimum Data Set (MDS) indicated the resident had experienced a stroke, but was cognitively intact. R168's family member (F-B) reported frustration regarding unresolved concerns brought to the attention of facility staff. When interviewed on 10/21/14, at 11:30 a.m. F-A reported the following concerns had been expressed to facility staff: 1) R168's glasses had been missing for at least a month, 2) questioned whether adequate oral care was being provided, 3) whether briefs were being utilized for bowel incontinence, 4) medication was unavailable when staff were on break, 5) clothing set out for special occasion was not put on the resident without explanation, and 6) situations where staff were unavailable for up to 30 minutes to assist R168 for outings. R168's MDS dated dated 9/12/14, revealed the resident had dementia and moderate cognitive impairment. The director of nursing (DON) was interviewed on	F 166	Jones-Harrison does make prompt efforts to resolve resident grievances, whether presented verbally or in writing. R88's family verbally expressed her concerns at the resident care conference on 10/31/14, at which time she was re-educated about the Grievance Policy and provided with the Grievance Report form. The concerns and responses were recorded on a Grievance Report form by the LSW present at the conference. R168's family spoke with the Unit Nurse Manager on 11/18/14 and was given the opportunity to reiterate her concerns. She has been offered the opportunity to complete a written report, but has not done so to date. A Grievance Report form has been completed by the UNM and procedure completed. The facility's Grievance Policy was reviewed and revised on 11/4/14.	

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F 166	Continued From page 2 10/22/14, at 2:39 p.m. and verified the facility had not ensured a grievance/concern report had been utilized when residents and/or families voiced concerns. During an interview on 10/23/14, at 9:20 a.m. two social workers, (LSW)-B, LSW-C, both confirmed grievance forms had not been utilized for any concerns reported during the previous year. At 9:37 a.m. the director of social services also verified grievance forms had not been utilized in the previous year, therefore, concerns had not been logged and reviewed at the facility's quality committee meetings to improve care for residents. At 11:47 a.m. the administrator confirmed grievances were not logged or brought the the quality committee for review. A Resident Grievance Policy and Procedure dated 12/12, indicated residents and their families were provided a copy of the grievance policy and form at the time of admission. The purpose read: "To comply with the resident right to voice grievances without fear of retaliation and to provide a safe environment." A form titled Grievance Report directed the form was to be submitted to the administrator for signature and and to provide a response within 10 working days.	F 166	All staff members were trained on the revised policy on November 11, 12, and 13, 2014 by the Director of Social Services and Assistant Administrator. The Director of Social Services reviewed the policy at Resident Council on 11/4/14 and copies of the Grievance Report form were made available to residents. A copy of the facility Grievance Policy and Procedure, including the Grievance Report form, is provided upon admission with acknowledgment of receipt by the resident and/or their responsible party when the Admission Acknowledgment Form is signed. To ensure that this policy is being followed, the Assistant Administrator will retain all completed Grievance Reports and will keep a log of summarizing details. The log will	

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F 166	Continued From page 3	F 166	be reviewed with the Administrator weekly and at quarterly QA meetings to monitor trends. The Director of Social Services and the Assistant Administrator will be responsible for ensuring compliance of this regulation. The facility will be in compliance by 11/20/2014.	11/20/14
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		

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F 278	Continued From page 4 Based on interview and document review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 1 resident (R108) reviewed for pressure ulcers. Findings include: R108's Departmental Notes dated 8/6/14 revealed, "Seen on wound rounds. lt. outer malleous [left outer ankle] .7cm x 1 cm, irregular edges, pink in color. 100% slough." The resident's MDS dated 8/7/14, however, noted R108 had a stage 2 ulcer (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed without slough--yellow or white tissue that adheres to the ulcer bed in strings or thick clumps). No other pressure ulcers were identified as present. A subsequent Departmental Note dated 10/21/14, also indicated the resident had a stage 2 ulcer on the left outer malleolus measuring 0.3 x 0.5 centimeters (cm) with 100% slough. A registered nurse (RN)-C was interviewed on 10/23/14, at 11:30 a.m. She explained that if slough was present on the wound, then the wound would be considered unstageable (known, but not stageable due to coverage of wound bed by slough and/or eschar--dead tissue). She verified the presence of slough on R108's wound and that the wound should have been coded as unstagable on the MDS assessment.	F 278	Resident # 108's MDS assessment was corrected on 10/24/14 to reflect the accurate coding of the pressure ulcer. Going forward, MDS nurses will code all pressure ulcers following instructions on p. M-4 of the MDS manual. All residents with pressure ulcers will be audited to ensure their MDS assessments are accurately coded. This will be done by the MDS RN's weekly starting 10/31/14 to ensure the correction has been achieved and sustained. The facility will be in compliance by 11/25/2014.	11/25/14
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

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F 282	Continued From page 5 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance for repositioning to minimize the risk for pressure ulcer development for 4 of 4 residents (R66, R158, R3, R108) who were observed for repositioning, and to provide care for incontinence for 2 of 2 residents (R66, R158, R3) in the sample who were observed for incontinence care and were incontinent. Findings include: R66's care plan onset date of 3/14/06, noted the resident was at risk for pressure ulcers due to decreased mobility. Staff were directed to turn and reposition or off load (relieve pressure) every two hours. R66 was also incontinent of bowel and bladder and required an every two hour check and change and to provide perineal cleansing after each incontinence episode. A nursing assistant assignment sheet also directed staff to reposition and provide incontinence care for the resident every two hours R66 was continuously observed on 10/20/14, from 4:30 p.m. until 7:15 p.m. R66 was seated for 2 hours and forty-five minutes in a specialty wheel chair at a dining room table. There was no offer or attempt at a position change or provide incontinence care during this time. At 7:15 p.m. NA-A and NA-B used the mechanical lift to transfer R66 to bed and perform bedtime cares. R66 was incontinent a large amount of urine in the incontinence brief.. R66 had deep red	F 282	Resident #s 3, 66, 108, and 158 had their tissue tolerances, Braden scales and Bowel & Bladder assessments re-done by the licensed staff and their plan of care revised. The following facility policies were reviewed to ensure accuracy; Tissue Tolerance, Pressure Ulcer Risk Assessment, Repositioning, Pressure Ulcer Prevention, and Bowel and Bladder Evaluation. Facility nursing staff was re-educated on these policies and procedures on November 11th, 12th and 13th 2014. The charge nurses will ensure that repositioning, incontinence care and prevention of pressure ulcers is being done per the plan of care for the residents on their unit each shift. Nursing management will	

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F 282	Continued From page 6 crevices and wrinkling of buttocks and posterior thighs and this observation was validated by NA-A and NA-B. During continuous observation on 10/22/14, from 7:55 a.m. until 10:25 a.m. two hours and thirty minutes, R66 was sitting up in the dining room. At 10:25 a.m. NA-C and NA-D used the mechanical lift to transfer R66 to bed and perform incontinence care. R66 was incontinent of urine a small amount in the incontinence brief. R66 had deep red crevices and wrinkling of buttocks and posterior thighs and this observation was validated by NA-C and NA-D. During an interview with NA-C and NA-D, on 10/22/14, at 10:30 a.m. verified R66 should have had a position change and incontinence care every two hours, but they had been unable to get to the resident until the observation. R158's care plan dated 11/7/14, noted a risk pressure ulcers development due to impaired mobility, and was incontinent. Staff were directed to turn and reposition or off load the resident every two hours whenever necessary. The NA assignment sheet was consistent with the care plan direction. R158 was continuously observed seated at a dining room table on 10/20/14, from 4:30 p.m. until 7:30 p.m. During the three hour observation, no offers or attempts were made by staff to change R158's position or provide incontinence care. During continuous observation on 10/22/14, from 8:00 a.m. until 10:56 a.m. (two hours, 56 minutes) staff again did not offer or attempt to change the resident's position or check and change the resident. NA-C and NA-D explained in an interview on	F 282	audit repositioning weekly beginning 11/20/14 on each unit to ensure the repositioning, incontinent care and prevention of pressure ulcer is being monitored and the Director of Nursing will be responsible for the oversight of this plan. The facility will be in compliance by 11/25/2014.	11/25/14

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F 282	Continued From page 7 10/22/14, at 10:20 a.m. that they usually waited until after lunch to assist R3 and R66 to bed because there were six residents on the unit who required the use of a mechanical lift and the presence of two staff. However, the NAs reported that "today" RN-B told them to "lay the residents down before lunch." The following day RN-A stated at 9:00 a.m. that R3, R66, and R158 should have had their positions changed and care for incontinence provided every two hours according to their care plans. RN-A validated six residents required the assistance of a mechanical lift and the presence of two staff. R3's care plan dated 11/22/14, noted a risk for pressure ulcers due to decreased mobility. Staff were to turn and reposition every two hours and to offload position from sitting every two hours and whenever necessary. R3's nursing assistant assignment sheet directed staff to turn and reposition/offload R3 every two hours. R3 was continuously observed on 10/20/14, from 4:45 p.m. until 7:30 p.m. (2 hours, 45 minutes) the resident was seated in a specialty wheelchair at a dining room table. R3 was totally assisted to eat and was in the dining room at 7:30 p.m. when the surveyor concluded the observation. R3 was again continuously observed on 10/22/14, from 7:50 a.m. until 10:56 a.m. (three hours, six minutes). R3 was up in the dining room from 7:50 a.m. being fed breakfast by NA-D until 8:45 a.m. At 10:00 a.m. R3 attended exercise sessions but did not have a position change or offloading from a sitting position to relieve pressure to buttocks, nor incontinence care. At 10:56 a.m. RN-C assisted NA-C in using the mechanical lift to	F 282		

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F 282	Continued From page 8 transfer R3 to bed. NA-C said R3 only needed to lie in bed for a minute to be considered offloading from sitting. A request was made to visualize R3's buttocks due to the lack of repositioning. R3's buttocks and posterior thighs had deep red crevices and wrinkling of the skin. NA-C verified observation of condition of R3's skin. R3 was incontinent a small amount of green brown soft bowel movement. Upon cleaning the anal area, a two inch ring of redness was noted around the resident's anus. NA-C verified on 10/22/14, at 11:10 a.m. R3 should have had his position changed and incontinence care provided, but the NA did not have time until that point to provide the care for the resident. R108's care plan identified a potential for impaired skin integrity related to factors such as dementia, medication use, decreased mobility, and incontinence. Staff were directed to offload every two hours and as needed, use a pressure redistribution mattress on the bed and to observe skin daily. The NA assignment sheet also directed staff to offload the resident every two hours when in the wheelchair. R108's skin assessment dated 5/8/14, indicated the resident had the potential for alteration in skin integrity and required every two hours turning and repositioning. R108 was observed on 10/20/14, at 4:30 p.m. when the resident was seated in a wheelchair in the dining room. At 5:15 the resident was served supper. After supper, from 6:15 until 7:08 p.m. R108 remained in her wheelchair in the dining area. Throughout the observations, the resident made no attempts to move herself in the	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

(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 282	Continued From page 9 wheelchair. A nursing assistant (NA)-E assisted R108 back to her room at 7:08 p.m. Five minutes later, NA-E informed R108 that she was going to assist her to stand for two minutes, however, the resident instead stood for 15 seconds. After the observation the NA was interviewed and explained that R108 was supposed to stand for two minutes. When informed the resident had only stood for 15 seconds, NA-E replied, "Oh, was that all?" and then the NA assisted R108 back to the dining room. NA-E explained that any resident who ate an evening snack did not get assistance with evening cares until after their snack was given. NA-E reported the last time R108 had been repositioned was at 4:00 p.m. (3 hours, 13 minutes prior). A licensed practical nurse (LPN)-A was interviewed on 10/20/14, at 7:15 p.m. and stated residents who were unable to offload independently should have received assistance to do this every two hours for two minutes.	F 282		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		11/25/14

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F 314	Continued From page 10 by: Based on observation, interview and document review, the facility failed to provide timely assistance for repositioning to minimize the risk for pressure ulcer development for 4 of 4 residents (R108, R3, R66, R158) who were observed for repositioning. Findings include: R108 was observed on 10/20/14, at 4:30 p.m. when the resident was seated in a wheelchair in the dining room. At 5:15 the resident was served supper. After supper, from 6:15 until 7:08 p.m. R108 remained in her wheelchair in the dining area. Throughout the observations, the resident made no attempts to move herself in the wheelchair. A nursing assistant (NA)-E assisted R108 back to her room at 7:08 p.m. Five minutes later, NA-E informed R108 that she was going to assist her to stand for two minutes, however, the resident instead stood for 15 seconds. After the observation the NA was interviewed and explained that R108 was supposed to stand for two minutes. When informed the resident had only stood for 15 seconds, NA-E replied, "Oh, was that all?" and then the NA assisted R108 back to the dining room. NA-E explained that any resident who ate an evening snack did not get assistance with evening cares until after their snack was given. NA-E reported the last time R108 had been repositioned was at 4:00 p.m. (3 hours, 13 minutes prior). A licensed practical nurse (LPN)-A was interviewed on 10/20/14, at 7:15 p.m. and stated residents who were unable to offload independently should have received assistance to	F 314	Resident #s 3, 66, 108, and 158 had their tissue tolerances, Braden scales and Bowel & Bladder assessments re-done by the licensed staff and their plan of care revised. The following facility policies were reviewed to ensure accuracy; Tissue Tolerance, Pressure Ulcer Risk Assessment, Repositioning, Pressure Ulcer Prevention, and Bowel and Bladder Evaluation. Facility nursing staff was re-educated on these policies and procedures on November 11th, 12th and 13th 2014. Education on the importance of re-positioning and how off-loading is accomplished as it relates to prevention of pressure ulcers and incontinent care was also provided. The charge nurses will ensure that repositioning, incontinence care and prevention of pressure ulcers is being done per the plan of care for the residents on their unit each shift.	

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F 314	Continued From page 11 do this every two hours for two minutes. R108's care plan identified a potential for impaired skin integrity related to factors such as dementia, medication use, decreased mobility, and incontinence. Staff were directed to offload (relieve pressure) every two hours and as needed, use a pressure redistribution mattress on the bed and to observe skin daily. The NA assignment sheet also directed staff to offload the resident every two hours when in the wheelchair. R108's skin assessment dated 5/8/14, indicated the resident had the potential for alteration in skin integrity and required every two hours turning and repositioning. R3 was continuously observed on 10/20/14, from 4:45 p.m. until 7:30 p.m. (2 hours, 45 minutes) the resident was seated in a specialty wheelchair at a dining room table. R3 was totally assisted to eat and was in the dining room at 7:30 p.m. when the surveyor concluded the observation. R3 was again continuously observed on 10/22/14, from 7:50 a.m. until 10:56 a.m. (three hours, six minutes). R3 was up in the dining room from 7:50 a.m. being fed breakfast by NA-D until 8:45 a.m. At 10:00 a.m. R3 attended exercise sessions but did not have a position change or offloading from a sitting position to relieve pressure to buttocks. At 10:56 a.m. RN-C assisted NA-C in using the mechanical lift to transfer R3 to bed. NA-C said R3 only needed to lie in bed for a minute to be considered offloading from sitting. A request was made to visualize R3's buttocks due to the lack of repositioning. R3's buttocks and posterior thighs had deep red crevices and wrinkling of the skin. NA-C verified observation of condition of R3's skin. R3 was incontinent a small amount of green brown soft bowel movement. Upon cleaning the	F 314	Nursing management will audit repositioning weekly beginning 11/20/14 on each unit to ensure the repositioning, incontinent care and prevention of pressure ulcer is being monitored and the Director of Nursing will be responsible for the oversight of this plan. The facility will be in compliance by 11/25/2014.	

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F 314	Continued From page 12 anal area, a two inch ring of redness was noted around the resident's anus. NA-C verified on 10/22/14, at 11:10 a.m. R3 should have had his position changed every two hours, but the NA did not have time until that point to provide the care for the resident. R3's care plan dated 11/22/14, noted a risk for pressure ulcers due to decreased mobility. Staff were to turn and reposition every two hours and to offload position from sitting every two hours and whenever necessary. R3's nursing assistant assignment sheet directed staff to turn and reposition/offload R3 every two hours. R3's Minimum Data Set (MDS) assessment dated 2/20/14, noted the resident had Alzheimer's disease with severe cognitive impairment. A Braden Scale for Predicting Pressure Sore Risk dated 8/11/14, revealed R3 was at moderate risk for pressure ulcer development. R66 was continuously observed on 10/20/14, from 4:30 p.m. until 7:15 p.m. R66 was seated for two hours and 45 minutes in a specialty wheel chair at a dining room table. There was no offer or attempt at a position change during this time. At 7:15 p.m. NA-A and NA-B used the mechanical lift to transfer R66 to bed and perform bedtime cares. R66 was incontinent a large amount of urine in the incontinence brief.. R66 had deep red crevices and wrinkling of buttocks and posterior thighs and this observation was validated by NA-A and NA-B. During continuous observation on 10/22/14, from 7:55 a.m. until 10:25 a.m. two hours and thirty minutes, R66 was sitting up in the dining room. At 10:25 a.m. NA-C and NA-D used the mechanical lift to transfer R66 to bed and	F 314		

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F 314	Continued From page 13 perform incontinence care. R66 was incontinent of urine a small amount in the incontinence brief. R66 had deep red crevices and wrinkling of buttocks and posterior thighs and this observation was validated by NA-C and NA-D. During an interview with NA-C and NA-D, on 10/22/14, at 10:30 a.m. verified R66 should have had position changed/offloaded every two hours but they were unable to get to her for position change/offloading and for cares until the observation. R66's care plan with an onset date of 3/14/06, noted a risk for pressure ulcers due to decreased mobility. Staff were directed to turn and reposition or offload every two hours and whenever necessary. R66 was incontinent of bowel and bladder and required an every two hour check and change and to provide perineal cleansing after each incontinence episode. A NA assignment sheet directed staff to turn and reposition offloading every two hours. R66's MDS dated 9/19/14, noted diagnoses including Alzheimer's disease and severe cognitive impairment. A Braden skin assessment dated 9/14/14, revealed the resident was at high risk for pressure ulcer development. R158 was continuously observed seated at a dining room table on 10/20/14, from 4:30 p.m. until 7:30 p.m. During the three hour observation, no offers or attempts were made by staff to change R158's position. During continuous observation on 10/22/14, from 8:00 a.m. until 10:56 a.m. (two hours, 56 minutes) staff again did not offer or attempt to change the resident's position.	F 314		

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F 314	Continued From page 14 R158's care plan dated 11/7/14, noted a risk pressure ulcers development due to impaired mobility. Staff were directed to turn and reposition or off load the resident every two hours whenever necessary. The NA assignment sheet was consistent with the care plan direction. The Minimum Data Set (MDS) dated 7/31/14, indicated R158 had dementia and severe cognitive impairment. A Braden skin assessment dated 10/20/14, indicated the resident was at mild risk for pressure ulcer development. NA-C and NA-D explained in an interview on 10/22/14, at 10:20 a.m. that they usually waited until after lunch to assist R3 and R66 to bed because there were six residents on the unit who required the use of a mechanical lift and the presence of two staff. However, the NAs reported that "today" RN-B told them to "lay the residents down before lunch." The following day RN-A stated at 9:00 a.m. that R3, R66, and R158 should have had their positions changed every two hours according to their care plans. RN-A validated six residents required the assistance of a mechanical lift and the presence of two staff.	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		11/25/14

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F 315	Continued From page 15 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care for incontinence for 2 of 2 residents (R66, R158) in the sample who were observed for incontinence care and were incontinent of bladder. Findings include: R66 was continuously observed while seated in a wheelchair in the dining room on 10/20/14, from 4:30 p.m. until 7:15 p.m. (two hours, 45 minutes). There was no offer or attempt at assisting the resident with incontinence care during this time. At 7:15 p.m. NA-A and NA-B used the mechanical lift to transfer R66 to bed and perform bedtime cares. R66 was incontinent a large amount of urine in the incontinence brief, which was validated by NA-A and NA-B. During continuous observation again on 10/22/14, from 7:55 a.m. until 10:25 a.m. (two hours, 30 minutes) R66 was sitting in a wheelchair in the dining room. At 10:25 a.m. NA-C and NA-D used the mechanical lift to transfer R66 to bed and perform incontinence care. R66 was incontinent of urine a small amount in the incontinence brief, which was validated by NA-C and NA-D. R66's care plan onset date 3/14/06, noted the resident was incontinent of bladder and required assistance every two hours to change incontinent brief and cleanse after each incontinence	F 315	Resident #s 3, 66, 108, and 158 had their tissue tolerances, Braden scales and Bowel & Bladder assessments re-done by the licensed staff and their plan of care revised. The following facility policies were reviewed to ensure accuracy; Tissue Tolerance, Pressure Ulcer Risk Assessment, Repositioning, Pressure Ulcer Prevention, and Bowel and Bladder Evaluation. Facility nursing staff was re-educated on these policies and procedures on November 11th, 12th and 13th 2014. Education on the importance of re-positioning and how off-loading is accomplished as it relates to prevention of pressure ulcers and incontinent care was also provided. The charge nurses will ensure that repositioning, incontinence care and prevention of pressure ulcers is being done per the plan of care for the residents on their unit each shift.	

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F 315	Continued From page 16 episode. A NA sheet directed staff to check and change every two hours. An MDS dated 9/19/14, noted diagnoses including Alzheimer's disease and severe cognitive impairment, as well as incontinence. During an interview with NA-C and NA-D, on 10/22/14, at 10:30 a.m. verified R66 should have provided are for incontinence sooner, but they had been unable to get to it until the time of the observation. R158 was continuously observed seated at a dining room table on 10/20/14, from 4:30 p.m. until 7:30 p.m. During the three hour observation, no offers or attempts were made by staff to check R158 for incontinence. During continuous observation on 10/22/14, from 8:00 a.m. until 10:56 a.m. (two hours, 56 minutes) staff again did not offer or attempt to provide incontinence assistance. R158's care plan dated 11/7/14, noted the resident was incontinent of bladder and required assistance of staff to check and change the resident and provide perineal cleansing after each incontinent episode. The Minimum Data Set (MDS) dated 7/31/14, indicated R158 had dementia and severe cognitive impairment, as well as incontinence. NA-C and NA-D explained in an interview on 10/22/14, at 10:20 a.m. that they usually waited until after lunch to assist R3 and R66 with incontinence care because there were six residents on the unit who required the use of a mechanical lift and the presence of two staff. However, the NAs reported that "today" RN-B told them to "lay the residents down before lunch."	F 315	Nursing management will audit repositioning weekly beginning 11/20/14 on each unit to ensure the repositioning, incontinent care and prevention of pressure ulcer is being monitored and the Director of Nursing will be responsible for the oversight of this plan. The facility will be in compliance by 11/25/2014.	

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F 315	Continued From page 17 The following day RN-A stated at 9:00 a.m. that R66, and R158 should have been checked for incontinence every two hours according to their care plans. RN-A validated six residents required the assistance of a mechanical lift and the presence of two staff.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hot foods were properly chilled to minimize the risk of foodborne illness, having the potential to affect 150 residents in the facility. Findings include: A kitchen tour was conducted on 10/20/14, at 12:10 p.m. with the food service manager (FSM) and the day supervisor (DS). A two gallon container of chicken wild rice soup was stored in the cooler and was hot to the touch. The FSM and DS were both unsure when the soup had been placed in the cooler, nor the temperature of	F 371		10/23/14

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F 371	Continued From page 18 the soup. The cook who prepared the soup had left for the day, however, had not documented the temperature and time on the facility's log. The dietary director then measured the temperature of the soup at 105 degrees Fahrenheit. Since it was unknown when the soup was placed in the cooler, the director stated, "This has to be thrown out." A half gallon container of beef broth was stored in another cooler which was cool to the touch. The temperature log also lacked a recording of the cool down period for this meat product. The FSM was interviewed on 10/20/14, at 12:30 p.m. and explained that the cooks were to cool potentially hazardous foods properly according to the facility's procedure, recording the time and temperature to ensure food was cooled at safe temperatures. A Cooling Potentially Hazardous Foods policy directed staff to place food in shallow containers, no more than four inches to chill food rapidly. "Chill cooked, hot food from 140 degrees Fahrenheit to 70 degrees within 2 hours."	F 371	On 10/20/14 the container of soup was immediately thrown away. On the same date the policy and procedure titled, "Cooling Potentially Hazardous Foods", was reviewed and staff members were provided re-education on the importance of cooling foods to prevent food borne illness on October 20th, 21st, and 22nd. A log will be maintained starting 10/20/14 to ensure foods are cooled properly and the Dietary Services Manager will be responsible for daily audits and compliance.	10/23/14
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		11/26/14

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F 431	Continued From page 19 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were removed from the medication carts for 3 of 3 residents (R75, R93, R32) whose medications had expired. Findings include: R75's Novolog insulin with an expiration date of 10/14/14, was stored for use on the Devon Court medication cart on 10/22/14, at 9:23 a.m. The resident's Medication Administration Record (MAR) included a current physician's order for the medication per sliding scale, and the record	F 431		

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F 431	Continued From page 20 showed the medication had been administered to R75 four times after the medication expiration date. A licensed practical nurse (LPN)-C was present at the time of the observation, and verified the insulin was expired and should not have been used. R93's Novolog insulin was stored for use on the D3 west medication cart on 10/22/14, at 10:16 a.m., however, the bottle did not contain an expiration date. The bottle did have an open date recorded as 9/22/14. LPN-E stated the facility's policy was to discard the medication after 28 days of being opened, which would have been 10/19/14. The MAR for R93 revealed a twice daily order for a daily injection of Novolog. R32's loratadine medication for allergies was found without an expiration date on the Liberty Way unit on 10/22/14 at 9:45 a.m. LPN-D verified the bottle did not contain an expiration date, and said the bottle would be removed from the cart and a request the pharmacy would ensure an expiration date on the bottle. R32's MAR included a physician order for loratadine 10 milligrams daily as needed. The facility's 2014 Labeling and Storage of Medication & Expiration Guidelines policy directed staff as follows: "All prescription medication containers will be labeled with an expiration or beyond-use date...Medications that exceed the labeled expiration or beyond-use date will be removed from storage and disposed of according to procedure...Labeling of multi-dose vials to assure product integrity is done per the chart of Medication and expiration guidelines (see chart).	F 431	Resident #s 75, 93, and 32's expired medications were removed from the medication carts while surveyors were here and re-ordered. The re-ordered insulin was labeled when opened. All units have the current medication storage and expiration guidelines from Merwin Pharmacy available for reference to ensure the facility is following the policy of labeling, storage of medication and expiration guidelines. The facility policy "Labeling and Storage of Medication and Expiration Guidelines" was reviewed for accuracy. Licensed staff education on the importance of labeling medications and removing expired medications from the medication carts and med rooms was completed from November 20-26, 2014. Nursing staff will audit the medication carts weekly to ensure the expired medications are being removed, in addition to quarterly checks by Merwin Pharmacy. Facility will be in compliance by 11/26/2014.	

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	245460	A. BUILDING _____ B. WING _____	10/23/2014

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 431	Continued From page 21 The facility's 4/14 Medication Storage and Expiration Guidelines indicated Novalin insulin was considered expired 28 days after the first use.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		11/25/14

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F 441	Continued From page 22 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement proper handwashing and glove during resident cares for 3 of 3 residents (R66, R158, R3) whose cares were observed. Findings include: R66 was continuously observed during evening cares on 10/20/14, at 7:03 p.m. Two nursing assistants (NA)-A and NA-B entered R66's room and without washing or sanitizing their hands, they donned gloves and proceeded with cares. NA-A used swabs to wipe out R66's mouth, and then washed the resident's face, removed her blouse, performed underarm washing, and assisted the resident to change into a night gown. Both NAs assisted in removing R66's pants, socks and heavily urine saturated incontinence brief. While wearing the same contaminated gloves, NA-A reached over to the bedside stand, picked up a tube of washing cream and squirted it onto the washcloth. Perineal cleansing was performed, and NA-A removed the soiled gloves and without hand washing, left the room to obtain a clean incontinence brief. Although NA-A donned new gloves, hand washing was not performed. NA-A and NA-B assisted the resident with positioning, covering with blankets, placing the call light, and moving the mechanical lift before removing their gloves. Hand washing or	F 441	Resident #s 66, 158, and 3's charts were reviewed by the infection control nurse to ensure no adverse acute condition changes were noted during the time frame of 8/1/2014-11/5/2014. It was determined after review that resident #s 66, 158 and 3 are stable with no acute infection. The hand washing policy was reviewed for accuracy. All staff at Jones Harrison were re-educated on the importance of hand washing and glove use and when to wash their hands throughout their shift, in accordance with the hand washing policy and procedure, and demonstrated the technique of	

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F 441	Continued From page 23 sanitizing was also not performed by either NA at the conclusion of cares. R158 was continuously observed during cares on 10/22/14, at 6:53 a.m. NA-C entered R158's room to assist the resident with morning cares. NA-C entered R158's room and donned gloves without washing or sanitizing hands. NA-C transferred the resident to a wheelchair and then onto the toilet. The resident's incontinence brief was heavily saturated with urine and she voided on the toilet. NA-C removed the urine saturated incontinence brief, but failed to change gloves and wash hands. NA-C assisted R158 to put on socks, shoes, and pants, and then handed the resident a wet wash cloth to wash her face. NA-C proceed to assist R158 with her blouse, which she had difficulty buttoning due to the gloves. R158 then stood while NA-C completed pericare, applied a clean brief, and was assisted to sit in the wheelchair. While still wearing the same contaminated gloves, NA-C handed R158 a hairbrush, applied a transfer belt, and touched the wheelchair handles. NA-C made the bed, placed the call light, and handed R158 her glasses. At the conclusion of cares, NA-C removed her gloves and washed her hands. R158's care was observed following a bowel movement on 10/22/14, at 7:45 a.m. NA-D assisted R158 to the bathroom, and then donned gloves without hand washing. NA-D removed a moistened towelette and handed it to R158 for wiping the front perineal area. NA-D then assisted R158 to stand and completed perineal cleansing on the resident's back side. The resident's clothing was then adjusted and she was positioned in her wheelchair. NA-D then removed the gloves and without hand washing or	F 441	washing their hands at the skills fair on November 11th, 12th and 13th 2014. Audits are being done daily to ensure the nursing staff is following correct hand washing technique and hand sanitizer dispensers have been ordered for all 2nd floor rooms. The infection control RN will be responsible for the fulfillment of this plan. The facility will be in compliance by 11/25/2014.	

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F 441	Continued From page 24 sanitizing, assisted R158 back to the dining room for breakfast. R3 was assisted back to bed on 10/22/14, at 10:56 a.m. NA-C donned gloves without hand washing or sanitizing, and pulled down R3's pants to check her incontinence brief. The resident had been incontinent of bowel, and perineal cleansing was performed with moistened towelettes. While wearing the same contaminated gloves, NA-C put a clean brief on R3 and adjusted the resident's clothing. NA-C then moved the mechanical lift into place, adjusted the straps to the mechanical lift and called for assistance. The DON assisted with the transfer, having performed appropriate hand washing before and after the transfer. NA-C, however, removed the gloves and without hand washing, assisted R3 to the dining room. A registered nurse (RN)-B was interviewed on 10/23/14, at 8:30 a.m. RN-B verified hand washing should have been performed after staff entered a resident's room and and donned gloves, as well as after contaminated gloves had been removed. The facility's 3/10 policy titled Hand washing, directed staff to wash hands thoroughly before and after direct resident contact, after direct or indirect contact with resident secretions or blood to prevent the spread of infection. Furthermore, the policy directed staff to wash hands before donning gloves and after the removal of gloves.	F 441		

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	245460	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/27/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Jones Harrison Residence was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok FB 11-21-14 RECEIVED NOV 20 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC; 12-2-14

EMT; 10-23-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administration — (X6) DATE: 11/18/14

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Jones Harrison Residence is 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 147 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's kitchen cooking equipment has not been	K 069		

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

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K 069	Continued From page 2 maintained in accordance with Sec. 9.2.3 and NFPA 10. This deficient practice could affect some residents if near the kitchen. Findings include: On facility tour between 9:30 AM and 11:30 AM on 10/27/2014, record review revealed that the semi-annual kitchen hood suppression system inspection occurred at the 8-month mark and not at the required 6-month mark. This deficient practice was verified by the Facilities Director at the time of the inspection.	K 069	In addition to being scheduled in the maintenance computerized software system, kitchen hood suppression system inspections have been added to Microsoft Outlook Calendar. It will recur semi-annually in January and July. This will appear as an "event" in the maintenance chief engineer's calendar as well and the Director of Facilities' calendar. These checks will be monitored by both the Director of facilities and the Chief Engineer. This action occurred on October ~~27~~ 28, 2014.	

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5223

November 13, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5460025 and Complaint Number H5460047

Dear Mr. Berggren:

The above facility was surveyed on October 20, 2014 through October 23, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5460047 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 me.

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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosures

cc: Original - Facility
Licensing and Certification File