
C&T REMARKS - CMS 1539 FORM

CCN# 24-5460

At the time of the standard survey completed January 12, 2012, the facility was not in substantial compliance and the most serious deficiencies 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On March 12, 2012, the Minnesota Department of Health and, on February 21, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 12, 2012, effective February 21, 2012. Therefore, the remedies outlined in our letter dated January 30, 2012, will not be imposed. See attached CMS-2567B forms for the results of the March 12, 2012 and February 21, 2012 revisits.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5460

March 27, 2012

Ms. Jo Ann Buytendorp, Administrator
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, Minnesota 55416

Dear Ms. Buytendorp:

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

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

Effective February 21, 2012 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,

A handwritten signature in black ink that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 16, 2012

Ms. Jo Ann Buytendorp, Administrator
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, Minnesota 55416

RE: Project Number S5460022

Dear Ms. Buytendorp:

On January 30, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 12, 2012. 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 March 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 21, 2012 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 12, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 21, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 12, 2012, effective February 21, 2012 and therefore remedies outlined in our letter to you dated January 30, 2012, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Gayle Lantto".

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File

5460r112.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245460	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/12/2012
Name of Facility JONES HARRISON RESIDENCE		Street Address, City, State, Zip Code 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 <u>F0170</u> Reg. # <u>483.10(i)(1)</u> LSC _____	Correction Completed 02/13/2012	ID Prefix <u>F0274</u> Reg. # <u>483.20(b)(2)(ii)</u> LSC _____	Correction Completed 02/21/2012	ID Prefix <u>F0279</u> Reg. # <u>483.20(d), 483.20(k)(1)</u> LSC _____	Correction Completed 02/21/2012
ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 02/21/2012	ID Prefix <u>F0364</u> Reg. # <u>483.35(d)(1)-(2)</u> LSC _____	Correction Completed 02/12/2012	ID Prefix <u>F0371</u> Reg. # <u>483.35(i)</u> LSC _____	Correction Completed 02/12/2012
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By GL/sd	Date: 03/16/12	Signature of Surveyor: 15507	Date: 03/12/12		
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:		
Followup to Survey Completed on: 1/12/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245460	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 2/21/2012
Name of Facility JONES HARRISON RESIDENCE		Street Address, City, State, Zip Code 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 _____ Reg. # NFPA 101 LSC K0056	Correction Completed 01/23/2012	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By PS/sd	Date: 03/16/12	Signature of Surveyor: 28120	Date: 02/21/12
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/10/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y0DK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00216

C&T REMARKS - CMS 1539 FORM

CCN# 24-5460

At the time of the standard survey completed January 12, 2012 the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 2437

January 30, 2012

Ms. Jo Ann Buytendorp, Administrator

Jones Harrison Residence

3700 Cedar Lake Avenue

Minneapolis, Minnesota 55416

RE: Project Number S5460022

Dear Ms. Buytendorp:

On January 12, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

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

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 February 21, 2012, 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 February 21, 2012 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 April 12, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 12, 2012 (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 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Jones Harrison Residence

January 30, 2012

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Christy Johnson". The signature is written in a cursive, flowing style.

Christy Johnson, Unit Supervisor

Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File

5460S12.rtf

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

PRINTED: 01/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2012
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NAME OF PROVIDER OR SUPPLIER

JONES HARRISON RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE

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
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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.

F 170 483.10(i)(1) RIGHT TO PRIVACY -
SS=C SEND/RECEIVE UNOPENED MAIL

The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.

This REQUIREMENT is not met as evidenced by:

Based on interview and document review, the facility failed to consistently deliver resident mail on Saturdays for 2 of 2 residents (R180, R59) that reported concerns with mail delivery. This practice had the potential to affect all 152 residents residing in the facility.

Findings include:

R180, who frequently attended resident council meetings, stated during an interview starting at 9:00 a.m. on 1/12/12, mail was not being delivered on Saturdays.

F 000

F 170

RECEIVED

FEB 13 2012

COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

It is the policy of Jones-Harrison to deliver resident mail on Saturdays.

On 1/13/12 the Skilled Care Resident Mail Delivery policy was reviewed and revised by the Director of Therapeutic Recreation to ensure that resident mail is delivered on Saturday. Training for the staff of the department on the revised policy was completed on that same day.

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing 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.

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

PRINTED: 01/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 170	Continued From page 1 At 9:15 a.m. on 1/12/12, resident services staff (RS)-A was interviewed regarding the delivery of resident mail on Saturdays. The RS stated they didn't work weekends, but knew all mail went through the receptionist area for the entire campus. That mail was delivered to each unit and then therapeutic recreational (TR) staff were responsible for delivering resident mail. R59 stated at 10:55 a.m. on 1/12/12, that mail was not delivered on the weekends until Sunday and residents "didn't like it." Family member (FM) -1 visiting R59 at this time, stated they visited R59 every day, but didn't know for sure if mail was delivered on Saturdays. Licensed practical nurse-C was interviewed at 9:05 a.m. on 1/12/12, and stated mail was delivered to the receptionist and was then delivered to the unit where activity staff then delivered the mail. Registered nurse (RN)-A stated at 9:07 a.m. on 1/12/11, that mail went through the receptionist on Saturdays and was then delivered to the units. The TR director stated at 9:55 a.m. on 1/12/12, TR staff wasn't involved in delivering mail to residents on Saturdays. TR Assistant-A stated at 10:00 a.m. on 1/12/12, that mail was delivered to the facility late on Saturday afternoons and TR staff did not deliver resident mail until Sunday morning. The director of social services stated at 10:05 a.m. on 1/12/12, there was no mail laying around on Monday mornings when they arrived at work	F 170	On 1/14/12 R180, R59 and all of the skilled residents did receive their mail on Saturday. Per the policy a TR staff person delivered the mail. The Director of TR will complete weekly audits with the residents for the next 60 days to ensure they are receiving their mail on Saturday. This will be effective 2/13/12. ~~William Starnitz~~, DLF Director of TR is responsible for compliance.		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 170	Continued From page 2 and mail delivery had not come up in resident council meetings. Nursing assistant (NA)-B stated at 10:10 a.m. on 1/12/12, they worked the day shift every other weekend and deliver mail to residents on Saturdays. NA-A stated at 10:25 a.m. on 1/12/12, they worked the day shift every other weekend, but the mail was not delivered to the facility until after their shift ended at 2:30 p.m. The facility's policy on Skilled Care Resident Mail Delivery, revised 8/03, revealed that "Saturday mail is delivered no later than Sunday afternoon by the therapeutic recreational (TR) staff person on duty." The policy also indicated that if the TR staff was unable to deliver the mail, then the house supervisor was to be notified so the task could be delegated to another staff person.	F 170			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	It is the policy and procedure of Jones Harrison Residence that a comprehensive assessment of a resident within 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition.		

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

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NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 274	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were assessed for ongoing skin bruising to ensure adequate interventions were in place to minimize further bruising for 1 of 4 residents (R184) reviewed for non-pressure related skin conditions. Findings include: R184 was observed at 4:15 p.m. on 1/09/12, with a purple discoloration covering the top of the left hand. R184 stated that the area was the result of a blood thinning medication. The resident indicated that there had been no incident that caused the discoloration, but that due to the medication a discoloration could develop just from mild straining, such as pulling on a pair of pants. R18's significant change Minimum Data Set assessment (MDS) dated 12/9/11, indicated R184 had no cognition issues and had pressure related skin breakdown. However, an assessment of ongoing bruising and related medications was lacking. R184's current physician orders dated 12/12/11, indicated the R184 had received 325 milligrams (mg) of aspirin (a platelet aggregation inhibitor/blood thinner) daily since 11/1/11.	F 274	Resident #184 has had a new Skin Evaluation/Comprehensive Skin Risk Data Collection assessment and a review and revision of the comprehensive care plan for skin integrity. Resident #18 has had a new Skin Evaluation/Comprehensive Skin Risk Data Collection assessment and a review and revision of the comprehensive care plan for skin integrity. The Skin Evaluation/Comprehensive Skin Risk Data Collection and the policy and procedure has been reviewed and		

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F 274	Continued From page 4 The care plan at the time of the MDS, dated 10/19/11, indicated R184 was at risk for bruising. The care plan goals were to observe R184's skin daily during cares and to have a nurse complete a body audit assessment weekly. An incident report dated 10/28/11, related to a fall indicated R184 had fragile skin and bruised easily. Weekly body audit forms for R184 were reviewed. The assessment on 12/5/11, indicated R184 had old bruises present on both arms. The assessment on 11/21/11, indicated there was bruising on the back of the left hand. The assessment dated 11/14/11, indicated there was bruising on the back of the right hand. Registered nurse (RN)-A was interviewed at 1:00 p.m. on 1/11/12. RN-A indicated anyone on blood thinners would be at risk for bruising.	F 274	revised to add risk factors for bruising. Licensed nursing staff has been in serviced on identification of those at risk for bruising. Audits will be performed by nurse managers for identification of risk factors for bruising with appropriate interventions identified. Reports of audits will be reported to facility QA meeting for review.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	DON/designee will be responsible for overall compliance. Completion date: February 21, 2012		

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F 279	Continued From page 5 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan related to an abrasion and wound treatment for 1 of 4 residents (R170) identified with a current non-pressure related skin condition. Findings include: R170 lacked care plan interventions related to an abrasion and wound treatment. An incident report was completed on 12/3/11, when an abrasion was observed on R170's left calf behind the knee. R170 had bumped the toilet seat when sitting on the toilet. The area was assessed and found to be 1.5 cm long and 3.0 cm wide. The abrasion was due to "fragile skin" and "bruises easily." The next nurse's note that addressed the abrasion was documented on 1/5/11, and described the abrasion as an open area on outer, lower leg, below the knee. Measures 1.0 cm by 4.5 cm with wound bed that was beefy red, edges pink, and wound bed moist. Treatment: areas cleansed with DWC (Dermal Wound Cleaner),	F 279	It is the policy and procedure of Jones Harrison Residence to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Resident #170 care plan has been reviewed and revised for problem, goal and interventions related to skin integrity. All residents with an alteration in skin integrity have been reviewed for temporary care plan with applicable interventions Policy and procedure for Skin Breakdown-Non Pressure Related Skin Conditions has been reviewed and		

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F 279	Continued From page 6 and hydrocolloid dressing applied per wound care standing orders. The care plan dated 11/11/11, did not address R170's skin being fragile; that the skin bruised easily nor interventions to prevent abrasions from re-occurring. On 12/31/11, the care plan had a handwritten addition "small abrasion noted behind left knee." No specific interventions, treatments or a measurable goal were addressed on the care plan. On 1/12/12 at 9:20 a.m. R170 was observed to have a dressing over area on the left calf. Licensed practical nurse (LPN)-A checked the condition of the dressing which was due to be changed that day. LPN-A cleansed wound with DWC (dermal wound cleaner), dried the area, and measured area (1 x 4 cm) with granulation. No redness of skin was noted around the wound. The wound was then covered with the hydrocolloid dressing. Registered nurse manager-A, when interviewed on 1/12/12 at 10:00 a.m., stated the care plan should have listed the wound, the treatment used, and instruction to treat the wound until healed.	F 279	revised. A new temporary care plan for Non Pressure Skin Conditions has been implemented. Licensed nursing staff has been in-serviced on policy and procedure for Skin Breakdown-Non Pressure Related Skin Conditions. Non- licensed staff has been re-in serviced on reporting of any alterations in skin integrity. Audits of care plans will be performed by Nurse Manager and MDS nurses. Reports of audits will be reported to facility QA meeting for review. DON/designee is responsible for overall compliance.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate interventions related to ongoing skin bruising were in place to minimize further bruising or to adequately monitor a skin wound for 2 of 4 residents (R184, R170) reviewed for non-pressure related skin conditions. Findings include: R184's significant change Minimum Data Set assessment (MDS) dated 12/9/11, indicated R184 had no cognition issues and had pressure related skin breakdown. R184 was observed at 4:15 p.m. on 1/09/12, with a purple discoloration covering the top of the left hand. R184 stated that the area was the result of a blood thinning medication. The resident indicated that there had been no incident that caused the discoloration, but that due to the medication a discoloration could develop just from mild straining, such as pulling on a pair of pants. R184's current physician orders dated 12/12/11, indicated R184 had received 325 milligrams (mg) of aspirin (a platelet aggregation inhibitor/blood thinner) daily since 11/1/11. R184's care plan last updated 12/26/11, indicated impaired skin integrity related to pressure ulcers, but did not indicate R184 was at risk for bruising. The care plan goals were to observe R184's skin daily during cares and to have a nurse complete		F 309	It is the policy and procedure of Jones Harrison Residence that each resident receives the necessary care and services to attain or maintain the highest practicable well-being. Resident #184's has had a new Skin Evaluation/Comprehensive Skin Risk Data Collection and resident care plan has been reviewed and revised. Resident#170's has had a new Skin Evaluation/Comprehensive Skin Risk Data Collection and resident care plan has been reviewed and revised. The Skin Evaluation/Comprehensive Skin Risk Data Collection and the policy and procedure have been			

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F 309	Continued From page 8 a body audit assessment weekly. R184's Skin Evaluation and Comprehensive Risk Data Collection Assessment dated 12/15/11, indicated R184 was at risk for impaired skin integrity related to decreased activity and poor skin turgor. The assessment did not indicate the resident was on medications that may pose a risk for bruising. The assessment summary indicated R184 had old bruises on both arms. An incident report dated 10/28/11, related to a fall, indicated R184 had fragile skin and bruised easily. Nursing notes reviewed for the past 30 days did not identify any injury or skin discoloration that affected the left hand. Weekly body audit forms for R184 were reviewed. The most recent assessment available dated 12/19/11, indicated R184 had no bruising present. The assessment on 12/5/11, indicated R184 had old bruises present on both arms. The assessment on 11/21/11, indicated there was bruising on the back of the left hand. The assessment dated 11/14/11, indicated there was bruising on the back of the right hand. Registered nurse (RN)-A was interviewed at 1:00 p.m. on 1/11/12. RN-A indicated she was not aware of the discoloration on R184's hand. RN-A indicated she was surprised that this was not on the resident's care plan. She added that anyone on blood thinners would be at risk for bruising. RN-A indicated this was something that should have been seen by staff during cares or on bath days.	F 309	reviewed and revised to add risk factors for bruising. Interdisciplinary team members review residents with bruising for potential causal factors and for interventions. Licensed nursing staff has been in serviced on identification of those at risk for bruising, and for interventions to prevent and treat non-pressure related skin conditions. Audits will be performed by nurse managers for identification of risk factors for bruising as well as residents with identified bruising for appropriate interventions. Interdisciplinary team members review residents with bruising for potential causal		

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F 309	Continued From page 9 The director of nursing (DON) was interviewed at 1:30 p.m. on 1/11/12. The DON indicated she was not aware of R184's bruising, and stated that there should have been an incident report and investigation completed. R170 lacked adequate monitoring of a skin wound abrasion of the left calf and interventions to try minimize further abrasions. An incident report was completed on 12/3/11, when an abrasion was observed on R170's left calf behind the knee. R170 had bumped the toilet seat when sitting on the toilet. The area was assessed and found to be 1.5 cm long and 3.0 cm wide. The abrasion was due to "fragile skin" and "bruises easily." The follow-up on 1/3/12, by the nurse manager documented R170 had a personal alarm placed on the wheelchair to alert staff so they could assist her to the toilet. The toilet seat was checked and no rough or sharp edges were found. The staff were to observe the abrasion until healed. The nurse's note on 12/3/11 reflected the information as described on the incident report. The next nurse's note that addressed the abrasion was documented on 1/5/11, and described the abrasion as an open area on outer, lower leg, below the knee and measured 1.0 cm by 4.5 cm with wound bed that was beefy red, edges pink, and wound bed moist. Treatment areas were cleansed with DWC (Dermal Wound Cleaner), and hydrocolloid dressing applied per	F 309	factors and for interventions. Reports of audits will be reported to facility QA meeting for review. DON/designee will be responsible for overall compliance. Completion date: February 21, 2012		

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F 309	Continued From page 10 wound care standing orders. The care plan dated 11/11/11, had addressed risk of skin impairment due to decreased mobility, resistive behavior and incontinence. Interventions included: observe skin with daily cares for signs of irritation/breakdown, a complete body audit by licensed nurse done weekly on bath day, staff to offload resident every 2 hours (make sure resident has stood), pressure relief mattress and wheelchair, and topical treatments as doctor ordered. On 12/31/11, the care plan had a handwritten addition "small abrasion noted behind left knee". No specific interventions, treatments or a measurable goal were addressed on the care plan. In addition, the care plan did not address R170's skin being fragile; that the skin bruised easily nor interventions to prevent abrasions from re-occurring. Review of the weekly complete body skin audits from 12/31/11 to 1/2/12 (the most current audit) did not address the abrasion on the left calf. On 1/12/12 at 9:20 a.m. R170 was observed to have a dressing over area on the left calf. Licensed practical nurse (LPN)-A checked the condition of the dressing which was due to be changed that day. LPN-A cleansed wound with DWC (dermal wound cleaner), dried the area, and measured the area (1 x 4 cm) with granulation. No redness of skin was noted around the wound. The wound was then covered with the hydrocolloid dressing. On 1/9/12 at 7:00 p.m., LPN-B, when queried, stated this abrasion was from R170's wheelchair	F 309			

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F 309	Continued From page 11 and the leg got scraped on the wheelchair. On 1/11/12 at 1:30 p.m., LPN-A was interviewed and explained the abrasion occurred when R170 rubbed the area of the leg on the toilet seat when getting off the toilet and added area is treated with a hydrocolloid dressing which is changed as needed and checked every day. LPN-A said the tracking is documented on the electronic medication/treatment sheet. The information from the treatments are documented in the nurses notes. RN/Manager-A, when interviewed on 1/12/12 at 10:00 a.m., stated the wound protocol was followed and should be documented either in the nurses notes or on the medication/treatment record.	F 309			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure palatable food was provided for 2 of 3 residents (R83, R184) in the sample who reported complaints of food quality. Findings include: R83's reported concerns related to the overall	F 364	It is the practice of Jones-Harrison to ensure that palatable food is offered to meet resident's satisfaction of quality of food. RD met with R83 and R184. Completed Nutrition Follow-Up Assessments on the noted issues and updated care plan 2/9/2012.		

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F 364	Continued From page 12 quality of meals had not been resolved. On 1/9/12, at 4:20 p.m. R83 stated the meat was tough, the hamburger was terrible and he was not satisfied with the meals. R83 had been admitted into the facility on 8/17/11, with diagnoses which included depressive disorder, Parkinson's disease, and iron deficiency anemia. The nutritional assessment and care screening dated 11/18/11, indicated that R83 was on a regular diet. He was offered nutritious juice supplement to promote healing of an open area on his back along the spine. He consumed 100% of his supplement. Risks included: anemia, dehydration, vitamin mineral deficiency, weight loss and increased risk for skin breakdown. A review of R83's weight record revealed a stable weight between 156-158 pounds from admit until 11/28/11. He currently weighed 146 pounds. During interview on 1/12/12, at 10:00 a.m., R83 indicated that he believed he had lost weight as a result of not liking the meals. He stated, "I eat it, but I don't like it." He indicated that he felt "not much" had been done to help improve his satisfaction with the meals. He said his son would bring him a steak once in a while. On 1/11/12, at 11:30 am, the registered dietician (RD) indicated that R83 did not like the food at the facility. She explained that he was used to eating out and was a bit of a "foodie." He enjoyed eating steaks. The RD had tried various supplements with R83, but he would accept only the fruit type and then just once per day. Various meal extras and snacks had also been tried. The	F 364	RD/DTR will review food preferences and alternative menu items per MDS schedule or as needed to ensure satisfaction of quality of food effective 2/1/12. FSD and RD will review menu products and preparation methods with menu cycle changes and as concerns arise effective 2/1/12. RD/DTR will encourage participation in monthly Food Council, restaurant outings with Therapeutic Recreation Department and other facility food events effective 2/1/12.		

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F 364	Continued From page 13 RD stated that she had visited with R83's son who said that R83 had a hard time during his life to gain weight. The RD explained that R83 had recently lost his wife and believed his intake dropped a bit as a result of feeling sad and he exhibited a weight loss. The nutritional care plan for R83 indicated a potential for altered nutrition related to Parkinson's disease. Other diagnoses included iron deficiency anemia, gastro-esophageal reflux disease (heartburn), osteoarthritis. The problem statement indicated that R83 consumed 50-75% at breakfast and lunch and 75-100% at dinner and that he consumed a supplement to promote skin healing. The goal for R83 was to maintain weight at 158 pounds +/- 5 pounds. The interventions listed were: regular diet, medications and labs as ordered, monitor weight weekly, record and monitor food and fluid intake at each meal and document any difficulties with chewing and swallowing. The care plan lacked development of R83's problem of not liking the food with resultant poor intake. R184's reported concerns related to the overall quality of meals had not been resolved. On 1/9/12, at 3:50 p.m., R184 stated that he felt the food quality was poor, was not cooked properly and done in a microwave. He pointed to fruit and other snacks in his room and stated, "That's why I have all this food here."	F 364	Monitoring Monthly Food Council meetings will be conducted by FSD effective 2/1/12. Dining Room Assessment form will be completed in each dining room weekly for 90 days and one dining room weekly thereafter effective 2/13/12. <i>redacted per admin. 2/17/12</i> registered dietitian , Food Service Director will be responsible for compliance.		

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F 364	Continued From page 14 R184 was admitted to the facility on 3/6/11. A comprehensive health assessment was completed by the certified nurse practitioner on 1/12/12. The assessment indicated that R184 had poor appetite, weight loss and weight gain, loose fitting dentures, dysphagia, abdominal pain, diarrhea, nausea and occasional constipation. The nutritional summary for nutrition, from the resident assessment and care screening dated 12/9/11, indicated a diet of 3-4 gram sodium related to diagnoses. He had a usual body weight of 151-160 pounds, had an open area on left buttock, was offered large portion of egg at breakfast to promote healing. Risks included: anemia, dehydration, vitamin mineral deficiency, weight loss and increased risk for skin breakdown. R184 was 5 feet 6 inches and weighed 149 pounds at the time of the assessment. A review of the weight record showed that R184 had fluctuated in weight between approximately 150 and 160 pounds for the past six months. The RD was interviewed on 1/12/12, at 10:30 a.m. concerning R184. She indicated that R184 did complain about the food. She explained that R184 used to live in the facility's assisted living (AL) and thought the food was good. The RD stated the AL food comes from the same kitchen and was the same food as served in the nursing facility, but R184's perception was that it was not as good. In the AL dining room he was able to get his soft cooked egg. With transport times to the nursing facility dining room it was not possible to get the egg to him soft. The RD had worked with him to find an egg preference that he would accept. The RD had also worked with him on	F 364			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
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F 364	Continued From page 15 snack items and meal extras that he would accept. The care plan last updated on 12/26/11, indicated R184 had a potential for altered nutrition related to congestive heart failure, high blood pressure, edema, renal disease, a history of weight fluctuations, consumed 50-75% of meals and had no chewing or swallowing difficulties. The goal for R184 was to remain in a weight range of 153 pounds +/- 5 pounds. Interventions were to provide a regular 3-4 gm sodium diet, provide medications and review labs per MD order, monitor weights, record and monitor food and fluid intake and to document difficulties chewing or swallowing. The care plan lacked development of R184's main concern of dissatisfaction with the quality of the food, and therefore lacked the development of specific interventions that may have improved R184's satisfaction and meal intake. A review of the facility policy for nutritional assessment revealed that the plan of care would be realistic and establish measurable goals for the resident in accordance with the problems, risk factors, and strengths identified in the assessment process or prior to the initial care planning session.	F 364			
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	F 371			

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, 2 of 2 can openers in the dietary kitchen were not maintained in sanitary manner. This practice had the potential to affect all of the 152 residents residing in the facility. Findings include: Two of 2 manual can openers were observed to be soiled. During a kitchen tour on 1/9/12, at 12:30 p.m., and 1/12/12, at 10:00 a.m., two manual can openers were observed. The can opener in the cook's area had considerable food soil covering the blade. The soil was dark in color and dried on to the blade. The can opener in the salad preparation area also had some dried on debris and had metal flakes present in the gear cogs. Both observations were verified by the dietary supervisor (DS) and the dietary director (DD) at that time. The DS demonstrated how the blade unit and blade could be easily removed for cleaning. The DS indicated that the can opener in the salad prep area had been giving them some problems with skipping and not cutting well. The DS stated that the can openers were thoroughly cleaned weekly. Review of the cleaning schedule for the kitchen			F 371	It is the policy of Jones-Harrison to store, prepare, distribute and serve food under sanitary conditions. The 2 manual can openers found in the cook's area and salad preparation area were disassembled and cleaned thoroughly on 1/12/12. A policy and procedure was written to prevent the build up of food debris, metal shavings and to maintain sanitary can openers on 1/12/12. The dietary staff was trained on the new policy and procedure regarding can openers on 1/12/12. The [redacted] <i>df</i> Food Service Director will conduct random sanitation audits through the kitchen to ensure compliance effective 2/12/12.		

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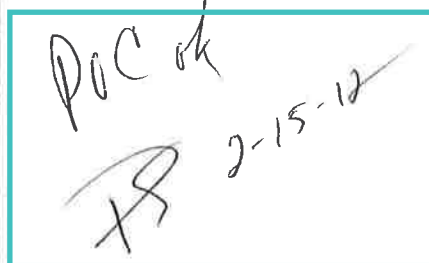
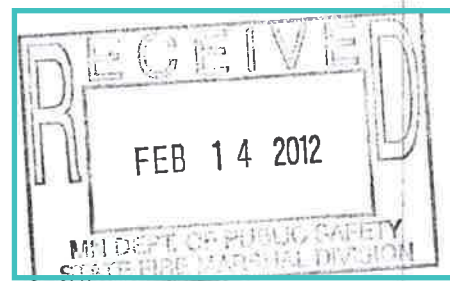
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NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
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F 371	Continued From page 17 revealed that each day any equipment used was to been cleaned and sanitized. Can opener cutting blades were a potential source for food contamination as the blade comes in contact with the food.	F 371			

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FS460021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2012
NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
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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: PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Pat.Sheehan@state.mn.us	K 000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joan Snyder</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2-9-12</i>
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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 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 150 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056			

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NAME OF PROVIDER OR SUPPLIER

JONES HARRISON RESIDENCE

STREET ADDRESS, CITY, STATE, ZIP CODE

**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
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K 056

Continued From page 2
supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:
Based on observations and document review, the automatic sprinkler system is not installed in accordance with NFPA 13. This deficient practice could affect some residents.

Findings include:

During facility tour between 9:00 AM and 11:30 AM on 01/10/2012, observation revealed that the fire sprinkler heads in the main fire alarm panel rooms are missing.

This deficient practice was verified by the administrator at the time of the inspection.

K 056

The sprinkler heads in the fire alarm panel room were replaced by Olsen Fire on 1/12/12.

An audit of every room was conducted by the maintenance dept. on 1/23/12 and no other sprinkler heads were found to be missing.

Scheduled maintenance audits of rooms to verify sprinkler heads are in place.

Ron Carlson, Director of Facilities is responsible for Life Safety Compliance.

1-23-12