

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 19, 2019

Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, MN 55416

RE: Project Number H5460051, H5460052C, H5460053C, and H5460054C

Dear Administrator:

On February 21, 2019, we informed you that the following enforcement remedy was being imposed:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 20, 2019.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on January 30, 2019. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 17, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on January 30, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2019. We have determined, based on our visit, that your facility has corrected as of March 21, 2019.

As a result of the revisit findings:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 20, 2019 be rescinded as of March 21, 2019. (42 CFR 488.417 (b))

In our letter of February 21, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 20, 2019, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 21, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

Jones Harrison Residence April 19, 2019 Page 2

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

Feel free to contact me if you have questions.

Sincerely,

Doubles Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 19, 2019

Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, MN 55416

Re: Reinspection Results - Project Number H5460051, H5460052C, H5460053C, and H5460054C

Dear Administrator:

On April 17, 2019 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 April 17, 2019, with orders received by you on February 22, 2019. At this time these correction orders were found corrected.

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,

Doverte Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 21, 2019

Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, MN 55416

RE: Project Numbers H5460051, H5460052C, H5460053C, and H5460054C

Dear Administrator:

On January 30, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 20, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 20, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 20, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits

approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 20, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Jones Harrison Residence will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 20, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Eva Loch, Unit Supervisor

> Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: eva.loch@state.mn.us Phone: (651) 201-3792 Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

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 30, 2019 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov.</u>

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Dovernes Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	`´CO№	E SURVEY IPLETED
		245460	B. WING _				C / 30/2019
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		00/2013
JONES H	IARRISON RESIDEN	CF			00 CEDAR LAKE AVENUE		
				MI	NNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00			
F 607 SS=C	1/28/19 through 1/3 complaints #H5460 Harrison Residence 42 CFR Part 483, s Long Term Care Fa compliance resulted Additionally compla H5460052C were in found not in complia subpart B, requirem Facilities for F607, if The facility is enroll Correction (ePOC) not required at the I CMS-2567 form. Al required, it is requir receipt of the electr Develop/Implement CFR(s): 483.12(b)(§483.12(b)(1) Prohi neglect, and exploit misappropriation of §483.12(b)(2) Estat to investigate any s §483.12(b)(3) Inclu- paragraph §483.95	2051 and # H5460054C Jones e was not in compliance with ubpart B, requirements for acilities for F689. The non d in actual harm. aints #H5460053C and hvestigated. The facility was ance with 42 CFR Part 483, hents for Long Term Care and F609. ed in the electronic Plan of and therefore a signature is bottom of the first page of the though no plan of correction is red that you acknowledge onic documents. t Abuse/Neglect Policies 1)-(3) ility must develop and policies and procedures that: ibit and prevent abuse, tation of residents and resident property, blish policies and procedures uch allegations, and de training as required at	F 60)7			3/15/19
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						03/03/2019

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.

PRINTED: 03/06/2019

		AND HUMAN SERVICES			0		APPROVE 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES F	ARRISON RESIDEN	CE			3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
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F 607	facility failed to dev for reporting all sus of abuse, neglect, misappropriation of Agency (SA) within potential to affect a Findings include: The policy, Resider 11/2016, indicated neglect, abuse and resident property w according to facility The policy lacked s On further investiga and Report of Susp January, 2019, indi abuse would be rep allegation of abuse injury. If the allegat serious bodily injury make a report to th direction to report a abuse to be reported those resulting in su	v and document review, the elop policies and procedures spected or alleged allegations exploitation of residents, and f resident property to the State 2 hours. This had the II resident in the facility. At Grievances, revised all alleged violations involving or misappropriation of rould be reported immediately policy and as required by law. specific timelines for reporting. ation, the policy Investigation bected Abuse/Neglect, revised cated allegations related to borted within 2 hours if the resulted in serious bodily ion of abuse did not result in y, the facility had 24 hours to e SA. The policy was lacking any allegation concerning ed within 2 hours, not just for	F 6	507	This plan of correction constitutes written allegation of compliance for deficiencies cited. Submission of this plan of correction an admission that the deficiency ex- that it is cited accurately. This plan correction is submitted to meet star federal requirements. It is the policy of Jones Harrison to any allegations of a crime, abuse, exploitation of residents, and misappropriation of resident prope the Administrator, State Agency ar authorities when appropriate based facilities policy and as required by Upon notification, the facility did up the Abuse and Neglect polices to in specific time lines for reporting abu and/or a crime. Under the direction on the Campus Administrator all facility staff will re re-education related to the policy u including the specific timing and guidelines for reporting and investi 5 random staff will be interviewed I Campus Administrator or their des weekly for four weeks following the training to ensure staff are compet the facility's Abuse and Neglect polices	r the on is not xists or of te and report neglect, rty to nd local d on the law. odate nclude use s ceive pdates, gation. by the ignee e ent on	
	as an injury involvir risk of death; protra function or an orga faculty, or requiring	defined serious bodily injury ng extreme pain; substantial acted loss or impairment of n, body member or mental medical intervention.			the proper reporting timelines. The Campus Administrator will mo reports of alleged abuse, neglect, exploitation, and misappropriation resident property to ensure the pro time lines for reporting are followed Audits will be done after each repo	of per d.	
	the policy to write c) p.m. the DON verified it was complaints using the grievance e. The DON verified the			and the results of these audits will brought to the quarterly QAPI mee	be	

Facility ID: 00216

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED C
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NAME OF F	PROVIDER OR SUPPLIER		<u>ا</u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES H	ARRISON RESIDEN	CE		3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
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F 607	determine if the alle possible abuse and	ked direction for staff to egation was concerning I lacked directions for staff to to the administrator any	F 607	discussion. The Facility will be in complianc 03/15/2019.	e by	
F 609 SS=D	CFR(s): 483.12(c)(§483.12(c) In respo		F 609			3/15/19
	involving abuse, ne mistreatment, inclu source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not re the administrator of officials (including t and adult protective provides for jurisdic	are that all alleged violations eglect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other o the State Survey Agency e services where state law ction in long-term care ance with State law through ures.				
	designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		245460	B. WING		C 01/30/2019	
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				3700 CEDAR LAKE AVENUE		
JONES H	ARRISON RESIDEN	CE		MINNEAPOLIS, MN 55416		
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F 609	Continued From pa	une 3	F 60	00		
1 000		•	FUL			
		v and document review, the ort an allegation of sexual		This plan of correction consti written allegation of compliance		
		to the administrator and within		deficiencies cited.		
		the report to the State		Submission of this plan of cor	rection is not	
	Agency (SA) for 1 c			an admission that the deficien		
	5 5 7 7			that it is cited accurately. This		
	Findings include:			correction is submitted to mee		
	-			federal requirements.		
		dated 1/21/19, indicated R1		It is the policy of Jones Harris		
		sexually assaulted after		any allegations of a crime, ab	use, neglect,	
		. R1's family member (FM)-A		exploitation of residents, and		
		the reporting of the allegation,		misappropriation of resident p		
	per the grievance re	eport.		the Administrator, State Agen		
	The report was date	ed at the top of the page as		authorities when appropriate the facilities policy and as required		
		9, and signed by the director of		Upon notification, the facility d		
		ne responsible individual for		the Abuse and Neglect polices		
		ance. Corrective action taken		specific time lines for reporting		
		gation started on 1/22/19, and		and/or a crime.	5	
	a Vulnerable Adult	(VA) report was submitted to		Under the direction on the Ca	mpus	
	the SA on 1/23/19 ((2 days after later).		Administrator all facility staff w	/ill receive	
				re-education related to the po		
		vas interviewed on 1/29/19, at		including the specific timing a		
		inistrator verified allegation		guidelines for reporting and in	vestigation.	
		eported immediately to the		E random atoff will be intension	und by the	
	administrator and the	IIE SA.		5 random staff will be interview Campus Administrator or their		
	On 1/30/10 at 3.00	p.m. the DON verified the		weekly for four weeks followin		
		ad placed the grievance report		training to ensure staff are co		
		or where it was discovered by		the facility's Abuse and Negle		
		9. The DON verified the		the proper reporting timelines.		
		ked direction for staff to		The Campus Administrator wi		
		egation was concerning		reports of alleged abuse, negl	ect,	
		I did not give direction on how		exploitation, and misappropria		
		he grievance form indicated,		resident property to ensure the		
		form to the assistant		time lines for reporting are foll		
		ance official." There was no		Audits will be done after each		
	indication on prope	r timelines for reporting		and the results of these audits		
				brought to the quarterly QAPI	meeting for	

Facility ID: 00216

If continuation sheet Page 4 of 20

PRINTED: 03/06/2019

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/06/2019 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED C
		245460	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
JONES H	ARRISON RESIDENC)E			00 CEDAR LAKE AVENUE INNEAPOLIS, MN 55416		
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F 609 F 689 SS=G	11/2016, indicated neglect, abuse and resident property we according to facility The policy lacked si However, the policy Suspected Abuse/N 2019, indicated alle would be reported w of abuse resulted in allegation of abuse injury, the facility hat to the SA. Free of Accident Hat CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must en §483.25(d)(1) The r as free of accident H Supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa causal factors for fa adequate intervention	all alleged violations involving or misappropriation of ould be reported immediately policy and as required by law. pecific timelines for reporting. Investigation and Report of Neglect, revised January, gations related to abuse within 2 hours if the allegation of serious bodily injury. If the did not result in serious bodily ad 24 hours to make a report azards/Supervision/Devices 1)(2)	Fé	609	discussion. The Facility will be in compliance by 03/15/2019. This plan of correction constitutes of written allegation of compliance for deficiencies cited. Submission of this plan of correction an admission that the deficiency ex- that it is cited accurately. This plan of correction is submitted to meet state federal requirements. It is the policy of Jones Harrison to	our the n is not ists or of e and	3/21/19

Event ID:0PIB11

Facility ID: 00216

If continuation sheet Page 5 of 20

TATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _			PLETED
		045400					C
		245460	B. WING			01/:	30/2019
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
JONES I	ARRISON RESIDEN	CE			700 CEDAR LAKE AVENUE IINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 689	Continued From pa	age 5	F 6	89			
	R4's nursing note dated 10/8/18, indicated R4 was admitted on 10/8/18, from the hospital with a right hip fracture from a fall at home. R4 had a 14 day admission Minimum Data Set MDS completed on 10/15/18. The MDS indicated R4 had a score of 9 on a cognitive assessment (BIMS) indicating moderate cognitive impairment. Section V of the MDS, CAA and care planning, indicated R4 triggered the following areas for development of a care plan: Cognitive loss, rehab, urinary incontinence and catheter, psychosocial well being, activities, falls, pressure ulcer and pain. CAA for falls dated 10/24/18, indicated R4 was at risk for falls related to impaired mobility, was continent of bowel and able to summon staff and wait for assistance. The goal was to be free from falls.				and evaluate causal factors for fall ensure adequate interventions are implemented to reduce all falls, ind falls with actual harm. The resident (s) cited have been evaluated and assessed to minimiz for falls prior to, but upon notification residents were re-assessed and re-evaluated for causal factors for falls and their plan of care was upon include specific interventions to red further falls. The Bowel and Bladder Evaluation Falls Risk Data Collection policies been reviewed and revised.	cluding ze risk on, the their lated to duce and	
	problem for falls ar falls, impaired mob cognitive deficits ar for R4 to have min Interventions listed anticipate toileting observe for medica therapy (PT) for str improve mobility. T hand-written comm "Fall - unsafe with additional intervent correspond to the o Progress notes on fall at 5:00 p.m. wh bathroom. R4 had found sitting in from	ed 10/24/18, indicated a nd safety related to: a history of bility, debility, self transfers, nd medications. The goal was imal falls or fall related injuries. were low bed with mat, needs and assist as needed, ation side effects, physical rengthening and endurance to the care plan had one nent dated 1/17/19, indicating, transfers". There were no ions written on the care plan to comment. 10/8/18, indicated R4 had a ille trying to get up to the not used the call light. R4 was at of the recliner. R4 agreed to the future. The record lacked			The IDT process has been enhance including the reporting process and individualized interventions to ensu- all residents have appropriate interventions implemented after ea- to minimize risk for further falls. The Director of Nursing is responsible f ensuring this process is sustained. The nursing staff and IDT member receive education under the directi- the Director of Nursing; reviewing assessment and evaluation of caus factors for falls, including individua interventions to reduce falls at Jon- Harrison. Audits will be completed for resider have fallen daily, for four weeks an weekly for three months and then a	een enhanced, process and ions to ensure that opriate nted after each fall her falls. The esponsible for s sustained. DT members will er the direction of ; reviewing ation of causal ng individualized falls at Jones ed for residents who ur weeks and then	

Facility ID: 00216

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		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MLII T		E CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
				-			C
		245460	B. WING			01/:	30/2019
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
JONES F	IARRISON RESIDEN	CE			700 CEDAR LAKE AVENUE INNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 689	Continued From pa	age 6	F 68	89			
	interventions at the	e time of the fall.			committee meeting for further revie		
	0 40/0/40	0/9/18, progress notes indicated R4 was I at 6:45 a.m. lying next to the bed and			recommendations. The Director of		
					Nursing will oversee the audit proc	ess.	
stated she was trying to go to the ba right leg appeared shorter than the l					The facility will be in compliance by	y	
					03/21/2019.		
		A low bed with floor mat was eminded to use the call light.					
		ints of pain. A right hip X-ray					
	was ordered and s	howed no evidence of fracture,					
	per physician note	s dated 10/17/18.					
	On 10/11/18. (two/	three days post falls) the IDT					
	met to review R4's	falls. Documentation indicated					
		tive delirium following hip					
		dependent at home and not eding to ask for help and					
		still able to to to the bathroom					
		was in a room near a nursing					
		as to make frequent checks the call light. PT was					
		ed was initiated, continue					
	therapy to strength	ening. The note indicated the					
		ewed and current. However,					
		ation toileting needs were ne of the fall, even though R4's					
		8 and 10/9/18 were related to					
	her needing to use	e the bathroom.					
	A fall risk data coll	ection was completed on					
	10/24/18. The data	a indicated R4 had a fall related					
		eady, used a diuretic (medicine					
	assessment of the	ne body). The record lacked an data.					
	A h						
		er evaluation (BBE) was 8/18. The BBE indicated R4					
		owel and bladder, and woke in					
		e toilet. R4 was able to identify					

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DEPARTMENT OF HEALTH AND I CENTERS FOR MEDICARE & MEI					FORM	03/06/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245460	B. WING				C 30/2019
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES HARRISON RESIDENCE				700 CEDAR LAKE AVENUE /INNEAPOLIS, MN 55416		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 F 689 Continued From page 7 the need to toilet and was light. The BBE had no writ findings or interventions in care plan dated 10/31/18, maintain level of continent were to provide pericare a episode, provide assistant per facility protocol, offer a night if awake, administer observe for signs or symp infection. The toileting car reference to R4's risk for f On 11/19/18, at 10:29 a.m indicated R4 was found or position with top half of bo knees on the floor mat. R4 above the eye due to the f use the bathroom and cou had not put the call light of documentation indicated F day with a headache rated 10. The record lacked indi- revised interventions had self toileting. The IDT reviewed the fall post fall). The documentat forgetful of limitations, ten- independent, low hemoglo and was placed on hospic was R2's feeling of not be Interventions were unchar floor mat, frequent safety op parameter indicated). How evidence resident's bathroor re-assessed, and related i and implemented. 	tten summary of ndicated. The toileting indicated a goal to ce. The interventions after each incontinent ce with toileting, toilet assist to the toiled at medications and otoms of urinary tract re plan made no falls. n. documentation n the floor in a kneeling ody on the bed and 4 had a laceration fall. R4 stated a need to uld not wait for help. R4 n. At 8:26 p.m. R4 had been in bed all d a pain level of 8 out of ication any new or been initiated related to on 11/22/18 (three days tion indicated R4 was ds to be "fiercely" obin, declined in therapy ce. Additionally noted ing able to wait for help. nged with low bed and checks (no frequency vever, there was no boom use needs were	F	589			

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		I AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245460	B. WING				C 30/2019
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES H	IARRISON RESIDENC)E			3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	self-transfer from u toilet, was too weak fell to the floor. At th had hit head on the The IDT reviewed t later). Documentatio on at the time of the independent, had w room, had low bed encourage call light ice was applied, can However, the toileti any revisions had b safety care plan als revised intervention On 12/15/18, R4 ha self-transferring to t urgency to go was a The record lacked of interventions related A fall risk data was summary indicated fiercely independen much for self as po get help for toileting bowel and bladder. therapy were reque mobility. Additionall attempt to self-trans Plan was to have st needs. On 1/17/19, a nursi	 ³ p.m., it was noted R4 tried to nlocked wheelchair to the control of the fall R4 stated in the time of the fall R4 stated if floor. ⁴ he fall on 12/6/18 (two days on indicated the call light was e fall, desired to be veakness, used wheelchair in with mat, continue to to true, hit head on the floor and re plan reviewed and revised. Ing care plan lacked evidence even made. The falls and to lacked evidence new or is had been implemented. ⁴ ad been caught toilet three times and said the so strong and could not wait. evidence of any new or revised d to R4 self-transferring. ⁴ collected on 1/9/19. The R4 was at risk for falls, was at and attempted to do as ssible, used the call light to g, and mostly continent of Physical and occupational ested for strengthening and y noted was R4 had begun to sfer and continued to be weak. taff check frequently for any 	F	589			
	On 1/17/19, a nursi unwitnessed fall. Th	ng note indicated R4 had an ne falls/safety care plan 9, indicated a fall occurred due					

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		AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245460	B. WING				C 30/2019
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
		~ E		3	3700 CEDAR LAKE AVENUE		
JUNES	HARRISON RESIDEN	, E		Ν	MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	to unsafe transfers. interventions added correspond with the 11:24 p.m., a nurse been exhibiting con- related to family me mother in the bed. notified and felt the dementia and not a loud noise was hea roommates side of wall and roommate tear on left wrist, pa The fall happened a by ambulance. R4 with a left femoral fi dated 1/23/19. R4 hospital on 1/23/19 documentation. The 1/23/19. The IDT of had a history of falls behavior, was self-ti left femoral fracture but no surgery perfet the emergency root the next day with pa documentation note A temporary care p for alteration in motifall in room. The go mobility skills with a increased independent of daily living (ADL) without infection an interventions develop mobility and transfer independent as pos	. There were no additional	F	589			

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		AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245460	B. WING	i			C 30/2019
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
JONES H	ARRISON RESIDEN	CE			3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	and family notified; incision site; implemented were on 1/29/19, at 1:20 in a low bed. The n interview and stated since hurting her hi Registered Nurse (was interviewed on verified R4 had bee and did have a fall in tried to get up on here NA-I was interviewed NA-I verified she were protocol and had ch would be back in to hour. NA-I verified I The Fall Risk Asset 7/2016, indicated far admission, quarter The assessor would hazards and risks a minimal, moderate care plan would be interventions, and t monitored for effect R3 had a significan (MDS) comprehens 10/24/2018. The M	therapy as ordered' monitor ment safety measures as cifics of the safety measures to ere noted. 9 p.m. R4 was observed lying ursing assistant (NA)-H was d R4 no longer tried to get up p. RN)-E (also nurse manager) 1/30/19 at 10:30 a.m. and en admitted with a hip fracture injuring the other hip when R4 er own during the night, ed on 1/30/19 at 10: 45 a.m. ould check and change and y 2 hours which was standard hanged R4 about hour ago and o care for R4 in about and R4 no longer used the toilet. ssment (FSA) policy, revised all risk data was collected on y and after 3 consecutive falls. d evaluate and analyze the and assign a risk range of or high risk. Additionally, the	F	589			

						0.0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			AL BOILDING			С
		245460	B. WING		01	/30/2019
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CO		
JONES I	ARRISON RESIDEN	CE		3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	admission and 2 fa admission. The Ca summary, listed ca from the MDS for in MDS indicated R3 abilities test (BIMS decline. The CAA s areas of: Cognition daily living, urinary symptoms, falls an worksheet also ind factors to increase impairment, depres and impaired balar The care plan for fa developed on 7/17, during the months November of 2018 December dated 1 and floor mat. A ha plan indicated a fall but lacked new inte fall. Listed interven place; monitor falls free environment; o anticipate needs for floor. The care plan for b dated 4/18/19, indi- challenging behavid depression. R3 had irritable, anxious, m confusion, verbal a resistive behaviors respond to behavid	Ills without injury since ire Area Assessment (CAA) ire areas that had triggered inclusion in the care plan. The scored a 5 on a cognitive) indicating significant cognitive summary identified problem a, communication, activity of incontinence, and behavioral d nutritional status. The icated possible contributing the risk for falls of: cognitive ssion, incontinence, anemia, nee during transitions. alls and safety, initially (17, showed no up-dates of September, October and , and one update for 2/31/18, to initiate a low bed and written notation on the care I had occurred on 11/27/18, erventions to correspond to the tions included roam alert in a per protocol; maintain clutter observe for changes in gait; or safety; grip tape to bathroom we havior/dementia had a goal cated R3 was at risk for ors related to dementia and d a history of wandering, epetitive, restless, compulsive, iggression, forgetfulness, and . The goal was for R3 to	F 689			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245460	B. WING				C 30/2019
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES F	ARRISON RESIDENC	E			3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
				IV	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa firm approach, expl comprehension and reassurance and va wandering and guid received an antidep plan lacked persona all the specific prob for falls was not add behavior/dementia Nursing progress no medical record india - On 9/5/18, R3 was p.m. with a large bo floor. - On 9/6/18, R3 was the bed at 2:45 p.m (IDT) meeting docu indicated R3 appea pull pants down to u independent with to The documentation been updated. - On 9/12/18, R3 st No injuries were no - On 9/30/18, R3 was in pad, on carpet ar documentation on 1 from the falls, but d from a previous fall ambulation and trar times and move at a	ge 12 ain procedures, allow time for d response and offer alidation. Also to monitor for le to specific destination. R3 pressant medication. The care alized interventions to address lem areas indicated. High risk dressed on the care plan. ote documentation in R3's cated: s found on the floor at 3:15 wel movement (BM) on the s found on the floor in front of . The interdisciplinary team mentation, dated 9/6 /18 red to fall related to trying to use the toilet. R3 was ileting and often refused care. indicated the care plan had ood up, took one step and fell. ted. as found on the floor with BM nd in bathroom. IDT 10/1/18, indicated no injuries id have a left knee abrasion . R3 was independent with hsfers, but can be unsteady at a fast pace. Staff assist as	1	589	DEFICIENCY)		
	and staff were to re and toileting. R3 ha gripper strips to bat support bars to toile	ill allow. R3 often refused care -approach to assist with cares d BM incontinence. Will add hroom floor and additional et. A bowel and bladder ated 10/18/18, indicated R3 continent of bowel.					

		I AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245460	B. WING				C 30/2019
NAME OF F	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				3	3700 CEDAR LAKE AVENUE		
JONES F	ARRISON RESIDENC	CE		N	MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	each shift. Was abl was resistive to car per facility protocol continence. However facility assessed ca needs to develop in - On 11/27/18, R3 w wheelchair and star assist, R3 pulled av noted, R3 was help and monitored. The 11/28/18, at 9:31 a. receiving physical th mobility, pain was n a knee brace on rig could not remembe dementia. There wa analysis of contribu documentation did interventions initiate other than PT. - On 12/2/18, at 8:1 on R3's left hip and measuring 17 centi doctor (MD) was no The X-ray results sl fractures. The IDT is to discuss the bruis indicated the follow refuse cares and ic impairment does no resistive; attempts to may have been from	ler with one continent episode e to identify the need to toilet, es. The approach was to toilet and as needed to promote er, there was no evidence the usal factors related to toileting idividualized interventions. was seen getting up from the tring to walk. A staff went to vay and fell. No injuries were ed back into the wheelchair e IDT documentation, dated m., indicated R3 was herapy (PT), had improved nanaged medically, and wore ht knee. Additionally, R3 er to wait for assistance due to as no evidence of root-cause	F	589			
	assessed by the fac	ence causal factors had been cility to develop individualized uce the risk for further falls.					

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		I AND HUMAN SERVICES						FORM	03/06/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			NSTRUCTION	0	(X3) DAT COM	E SURVEY PLETED
		245460	B. WING	;					C 30/2019
NAME OF	PROVIDER OR SUPPLIER				STREE	T ADDRESS, CITY, STATE, ZIP	CODE		
					3700 C	EDAR LAKE AVENUE			
JONES	HARRISON RESIDEN	CE			MINN	EAPOLIS, MN 55416			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 14	F6	689	9				
	indicated R3 contin from bed to bathroo the call light for hely 9:00 p.m. R3 was s dining room with a back to bedroom. F A progress note da was found sitting or door. R3 had a skir no other sources of 12/20/18, at 10:51 a tear to left knee and fall on 12/18/18. Th had been reviewed care plan for falls a lacked evidence ad added on 12/20/18. A progress note da indicated R3 was so no complaints of pa it was noted the hou from R3's room and with pants down. At was found on the fl and trying to get up transferred into the bathroom, but fell a wheelchair to get in bringing in medicati and found R3 on th term memory loss a indicated R3 was e and staff would com	ted 12/3/18, at 9:36 p.m., ued to self-transfer and walk om. R3 was instructed to use b. The documentation noted at een walking from bedroom to walker. R3 was re-directed R3 was offered juice. ted, 12/18/18, at 3:30 p.m., R3 in the floor by the bathroom in tear below the left knee but injury. The IDT note dated a.m., indicated R3 had a skin d bruising to buttocks after the e note indicated the care plan and revised. However the nd safety, dated 7/17/18, ditional interventions had been ted 12/29/18, at 8:41 p.m., een falling to the floor, but had ain. On 12/30/18, at 9:35 p.m. usekeeper heard a loud noise d found R3 sitting on the floor t 11:00 p.m. on 12/30/18, R3 oor by the bed lying on left hip . R3 explained he had wheelchair to use the t back to bed after using the s he walked around the to bed. The nurse was ion and hot tea for a cough e floor. Although R3 had short and dementia, the note ncouraged to use the call light tinue to monitor and check on ghout the night. The IDT met							

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		AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI COM	E SURVEY PLETED
		245460	B. WING	i			C 30/2019
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES H	ARRISON RESIDEN	CE		-	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	on 12/31/18, to revi occurred between 1 documentation indi- transfer or ambulat did not remember to healing pelvic fractul lower extremity ede unsteady gait. The low bed and floor m self-transfers. The monitoring of R3 in lacked evidence the discussed intervent use the bathroom. A progress note, da indicated R3 was for to the bathroom. Th sitting in bed when said he lowered him A progress note, da indicated R3 was for bathroom at 9:30 p documentation from R3 had fallen on 12 crawling to the bath use the call light for forgetful related to a mat were initiated. A progress note, da indicated R3 was for bathroother at 9:30 p documentation from R3 had fallen on 12 crawling to the bath use the call light for forgetful related to a mat were initiated. A progress note, da indicated R3 was for R3 said he was cra asleep. Documenta indicated R3 was for IDT met on 1/7/19, on 1/5/19. The doct	iew the three falls that 12/29/18 and 12/30/18. The cated R3 was unsafe to e per self, but due to dementia o ask for assistance. R3 had a ure from a previous fall and ema that contributed to an IDT decided to implement a nat to minimize attempts of staff were to increase the great room. The record e IDT had reviewed or tions related to R3's need to ated, 12/31/18, at 9:20 p.m., bund on bedside mat crawling he note indicated R3 had been checked 15 minutes prior. R3 nself to the mat.	F	589			

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		AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DAT COM	E SURVEY PLETED
		245460	B. WING				C 30/2019
NAME OF	PROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES H	ARRISON RESIDEN	CE			3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	unsafe transfers, w continue current pla indicated the additional and attempt to keep possible on 1/7/19. A progress note, da indicated R3 was for on the floor at the end 1/12/19, at 5:57 a.m the bed, resident has last rounds. IDT me discuss fall on 1/8/2 bruise on left side of was in low bed with unsafely. Had a pel and did not rememi mobility. No further A progress note, da indicate R3 was for bathroom. The note sleepy, tired and we 12:00 p.m., to discu	hich was in place Will an of care." The care plan did on of a tilt back wheelchair, p in dining room as much as	F	589			
	current intervention Additionally, the nor and did not ask for required assistance interventions would plan was reviewed A quarterly bowel a completed on 1/16/ the bowel and blad	ow bed with mat in place as a due to history of falls. te indicated R3 was impulsive assistance with mobility, e with mobility, current I be continued, and the care and revised. and bladder review was (19. The document indicated der management program was ced by the goal effective and					

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		AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245460	B. WING				30/2019
NAME OF F	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
JONES HARRISON RESIDENCE					700 CEDAR LAKE AVENUE /INNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	no skin breakdown. was blank for interv bowel and bladder had one hand-writte supervision to assis The goal was for R3 free. The intervention pericare, encourage 1 with toileting, toile re-approach calmly evidence the facility toileting intervention toileting. R3 was observed of was in a tilt back wh rests and pedals. F attendant present. If pleasant mood, but to cognitive disabilit attendant (PCA) hir works 4-6 times per 11:30 a.m. The PCA attempting to get up During interview on Licensed Practical current intervention matt, frequent chec LPN-B said R3 had R3 did not have stre before. Additionally and put in bed when resistive with cares Nursing Assistant ((interviewed on 1/29 the unit R3 resides	Additionally the document ventions implemented. The care plan, reviewed on 1/18/19 en update of a change from stance with pericare (undated). 3 to be clean dry and odor ons were to assist with e fluids, monitor BM's assist of et per facility protocol, the care plan lacked y had developed individualized ns beyond facility protocol for on 1/30/19, at 10:30 a.m. R3 heelchair with head rest, leg R3 had a paid personal care R3 was talkative and in to could not be interviewed due ties. The personal care red by R3's family said he r week between 9:30 a.m. to A stated R3 was not p as before. 1/29/19, at 11:25 a.m. Nurse (LPN)-B explained the stated R3 were a low bed with cks and anticipate needs. I not fallen for a while now as ength to self-transfer as the stated R3 could be	F	589			

If continuation sheet Page 18 of 20

		I AND HUMAN SERVICES				FORM	03/06/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COM	E SURVEY PLETED
		245460	B. WING				C 30/2019
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
JONES I	ARRISON RESIDEN	CE			700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	work completed and NA-C said she tries and offer to take to R3 could also say w bathroom. NA-C ver resistive to cares and try to keep R3 in the could be seen. NA- room alone, he mig the night shift also for reclining wheelchai when in the bedroo The unit nurse man was interviewed on 1:00 p.m. RN-B exp independently initia from the bed. R3 do stand up but was no The IDT which includ decided a low bed a option for R3 than r position. RN-B said independently trans wheelchair. RN-B w for assistance due not progressing in t investigation addition related to toileting of impulsive. RN-B said many options for in interventions relate- toileting, RN-B veriff medicine to remove that could cause ar Additionally, R3 wa attempt to go by hir help. RN-B said stat	d watch over the residents. a to keep a close eye on R3 the bathroom even thought when he needed to go to the erified R3 could be very nd strike out. NA-E said they e dining room or where he E verified If R3 was left in his ht try to get up. NA-E thought tried to keep R3 in sight in the r and just do frequent checks m. ager, registered nurse (RN)-B 12/29/19, at approximately blained, R3 was walking lly and was trying to get up eclined in mobility and would ot safe to walk independently. uded the physical therapist and mat would be a safer risking a fall from a standing	F	\$89			

Facility ID: 00216

If continuation sheet Page 19 of 20

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245460	B. WING				
NAME OF F	PROVIDER OR SUPPLIER						
JONES H	ARRISON RESIDENC)E		PRINTED: 03/06/2019 FORM APPROVED OMB NO. 0938-0391 23. WING			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
F 689	meals and as needs protocol was to che staff were to do "fre a specific time line it verified R3 was a ve person, but current! DON was interview and stated if a resid the staff would bring offer food and fluids until they wanted to said one to one inter documented. Additi the fracture, R3 wo independently and ve had left the room. T thorough review of more specific interve The policy, Fall Rist 7/2016, indicated es adequate supervision prevent accidents. A for facility staff to en possible for resident The policy, Compre Planning, revised N comprehensive carr within 7 days of the comprehensive per reviewed throughou The interdisciplinant	I protocol was before and after ed. During the night shift, the eck every 2 hours. RN-B said equent checks" but did not give for the frequency. RN-B ery active and independent ly was not attempting to walk. ed on 1/30/19. at 1:36 p.m. dent was restless or awake, g them to a common area and s and keep an eye on them g back to bed. The DON erventions would be ionally, DON explained, before uld go to his room would get up shortly after staff The DON verified a more R3's falls needed to develop ventions. k Assessment (FSA), revised ach resident was to receive on and assistance devices to Additionally, it was important nsure the safest environment nts.	F 6	\$89	DEFICIENCY)		
	care plan.						

Facility ID: 00216

If continuation sheet Page 20 of 20



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 21, 2019

Administrator Jones Harrison Residence 3700 Cedar Lake Avenue Minneapolis, MN 55416

Re: State Nursing Home Licensing Orders - Project Numbers H5460051, H5460052C, H5460053C, and H5460054C

Dear Administrator:

The above facility was surveyed on January 28, 2019 through January 30, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Eva Loch, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: eva.loch@state.mn.us Phone: (651) 201-3792 Fax: (651) 215-9697

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,

Douter Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit

Jones Harrison Residence February 21, 2019 Page 3 Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	ealth				ATTROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00216	B. WING		C 01/30/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE	-	
		3700 CEI	DAR LAKE A			
JONES H		CE MINNEAF	OLIS, MN 5	5416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of the the Minnesota Dep Determination of w corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff investigate complai H5460052C, H5460 result the following	h 1/30/19, a surveyor of this visited the above provider to				
Minnesota D	epartment of Health					
ABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIC	GNATURE	TITLE		(X6) DATE 03/03/19

Electronically Signed

6899

If continuation sheet 1 of 20

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
						С
		00216	B. WING		01/	30/2019
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
IONES H	ARRISON RESIDEN		DAR LAKE AV POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	original to the Minn Division of Complia	of these orders and return the esota Department of Health, ance Monitoring, Office of aplaints; 85 East Seventh t. Paul, Minnesota,				
	Correction (ePoC) anot required at the State form. Although	led in the electronic Plan of and therefore a signature is bottom of the first page of the gh no plan of correction is red that you acknowledge				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00216	B. WING		C 01/30/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
JONES H	HARRISON RESIDEN	CF	DAR LAKE A POLIS, MN - 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
	receipt of the electr	onic documents.			
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830		3/21/19
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.			
	by: Based on observati review, the facility fa causal factors for fa adequate interventi reduce falls, for 2 o	ent is not met as evidenced on, interview and document ailed to assess and evaluate alls, and failed to ensure ons were implemented to f 3 residents (R4 and R3) sustained falls resulting in		Corrected	
	Findings include:				
	was admitted on 10 right hip fracture fro day admission Mini completed on 10/15 had a score of 9 on	ated 10/8/18, indicated R4 0/8/18, from the hospital with a om a fall at home. R4 had a 14 mum Data Set MDS 5/18. The MDS indicated R4 a cognitive assessment noderate cognitive impairment.			

PRINTED: 03/06/2019 FORM APPROVED

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED
		00216	B. WING			30/2019
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ONES F	ARRISON RESIDEN	CF	DAR LAKE AV POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 3	2 830			
	indicated R4 trigge development of a c rehab, urinary incor psychosocial well b ulcer and pain. CAJ indicated R4 was a impaired mobility, w able to summon sta The goal was to be The care plan, date problem for falls ar falls, impaired mobi cognitive deficits ar for R4 to have mini Interventions listed anticipate toileting observe for medicat therapy (PT) for str improve mobility. T hand-written comm "Fall - unsafe with t additional intervent correspond to the c Progress notes on fall at 5:00 p.m. wh bathroom. R4 had found sitting in from use the call light in evidence of any oth interventions at the On 10/9/18, progree found at 6:45 a.m. stated she was trying	ed 10/24/18, indicated a nd safety related to: a history of ility, debility, self transfers, nd medications. The goal was imal falls or fall related injuries. were low bed with mat, needs and assist as needed, ation side effects, physical rengthening and endurance to 'he care plan had one nent dated 1/17/19, indicating, transfers". There were no ions written on the care plan to comment. 10/8/18, indicated R4 had a ille trying to get up to the not used the call light. R4 was at of the recliner. R4 agreed to the future. The record lacked her immediate actions or				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00216		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		B. WING			01/30/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
JONES H	HARRISON RESIDEN	3E	DAR LAKE AV POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 4	2 830			
	R4 had no complaints of pain. A right hip X-ray was ordered and showed no evidence of fracture, per physician notes dated 10/17/18.					
	met to review R4's R4 had post operat surgery. R4 was ind accustomed to nee believed she was s independently. R4 wo office. The plan wa and remind to use f consulted, a low be therapy to strengthe care plan was revie there was no indicate evaluated at the tim two falls on 10/8/18 her needing to use A fall risk data colle 10/24/18. The data fracture, was unste to reduce fluid in th	ection was completed on indicated R4 had a fall related ady, used a diuretic (medicine e body). The record lacked an				
	competed on 10/28 was continent of bo the night to use the the need to toilet ar light. The BBE had findings or interven care plan dated 10/ maintain level of co were to provide per episode, provide as per facility protocol	er evaluation (BBE) was (18. The BBE indicated R4 wel and bladder, and woke in toilet. R4 was able to identify nd was able to use the call no written summary of tions indicated. The toileting (31/18, indicated a goal to ontinence. The interventions icare after each incontinent sistance with toileting, toilet offer assist to the toiled at inister medications and				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00216	B. WING		01/3	30/2019
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
JONES H	HARRISON RESIDEN	CF	DAR LAKE AV POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 5	2 830			
		r symptoms of urinary tract ting care plan made no sk for falls.				
	indicated R4 was for position with top has knees on the floor r above the eye due use the bathroom a had not put the call documentation indi day with a headach 10. The record lack	29 a.m. documentation bund on the floor in a kneeling of of body on the bed and mat. R4 had a laceration to the fall. R4 stated a need to and could not wait for help. R4 light on. At 8:26 p.m. cated R4 had been in bed all he rated a pain level of 8 out of and indication any new or hs had been initiated related to				
	post fall). The docu forgetful of limitatio independent, low h and was placed on was R2's feeling of Interventions were floor mat, frequent parameter indicated evidence resident's	the fall on 11/22/18 (three days imentation indicated R4 was ns, tends to be "fiercely" emoglobin, declined in therapy hospice. Additionally noted not being able to wait for help unchanged with low bed and safety checks (no frequency d). However, there was no bathroom use needs were elated interventions developed				
	self-transfer from u toilet, was too weal	3 p.m., it was noted R4 tried to nlocked wheelchair to the < to accomplish the task and he time of the fall R4 stated e floor.				
	later). Documentati on at the time of the	he fall on 12/6/18 (two days on indicated the call light was e fall, desired to be veakness, used wheelchair in				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00216	B. WING		C 01/30/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
JONES	HARRISON RESIDEN	3F	DAR LAKE AV POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	room, had low bed encourage call light ice was applied, ca However, the toileti any revisions had b safety care plan als revised intervention On 12/15/18, R4 ha self-transferring to furgency to go was The record lacked of interventions related A fall risk data was summary indicated fiercely independen much for self as po get help for toileting bowel and bladder. therapy were reque mobility. Additionall attempt to self-trans Plan was to have stineeds. On 1/17/19, a nursi unwitnessed fall. Th up-dated on 1/17/19 to unsafe transfers. interventions added correspond with the 11:24 p.m., a nurse been exhibiting con related to family me mother in the bed. notified and felt the dementia and not a	with mat, continue to the use, hit head on the floor and re plan reviewed and revised. Ing care plan lacked evidence leen made. The falls and to lacked evidence new or the had been implemented. The falls and the so lacked evidence new or to lacked three times and said the so strong and could not wait. evidence of any new or revised d to R4 self-transferring. collected on 1/9/19. The R4 was at risk for falls, was thand attempted to do as ssible, used the call light to g, and mostly continent of Physical and occupational sted for strengthening and y noted was R4 had begun to sfer and continued to be weak. taff check frequently for any ng note indicated R4 had an ne falls/safety care plan 9, indicated a fall occurred due There were no additional				

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		A. BUILDING:		C		
	00216	B. WING			01/30/2019	
AME OF PROVIDER OR SUPPLIEF	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ONES HARRISON RESIDEN	ICF	DAR LAKE AV POLIS, MN 55				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830 Continued From p	age 7	2 830				
tear on left wrist, p The fall happened by ambulance. R4 with a left femoral dated 1/23/19. R4 hospital on 1/23/19 documentation. Th 1/23/19. The IDT had a history of fa behavior, was self left femoral fractur but no surgery per the emergency roo the next day with p documentation no	es night stand. R4 had a skin bain in both hips and left arm. at 10:40 p.m. R4 left the facility 4 was admitted to the hospital fracture, per nursing note 4 returned to the facility from the 9, at 7:10 p.m., per nursing ne IDT reviewed this fall on documentation indicated R4 Ils, was having unusual 5-transferring. R4 sustained a re and was sent to the hospital formed. R4 spent the night in om and returned to the facility bain medication. The ted "comfort is the goal".					
for alteration in mo fall in room. The g mobility skills with increased indeper of daily living (ADL without infection a interventions deve mobility and transf independent as po for changes in ran and family notified incision site; imple	plan was developed on 1/22/19 obility related to fracture from oal was for R4 to participate in assistance and regain indence; participate in activities _), incisional area will heal nd will remain comfortable. The eloped were: assist with ADL, fers; encourage to be as ossible; praise efforts; observe ge of motion; keep physician ; therapy as ordered' monitor ement safety measures as ecifics of the safety measures to yere noted.					
in a low bed. The interview and state since hurting her h						
	(RN)-E (also nurse manager)				1	

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUILDING:			
		00216	B. WING		C 01/30/2019	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ONES H	ARRISON RESIDEN	CE 3700 CE	DAR LAKE AV	ENUE		
		MINNEA	POLIS, MN 55	5416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE CO THE APPROPRIATE	(X5) OMPLET DATE
2 830	Continued From pa	age 8	2 830			
	and did have a fall	en admitted with a hip fracture injuring the other hip when R4 er own during the night,				
	NA-I verified she w re-position R4 ever protocol and had c would be back in to	ed on 1/30/19 at 10: 45 a.m. yould check and change and ry 2 hours which was standard hanged R4 about hour ago and o care for R4 in about and R4 no longer used the toilet.	1			
	7/2016, indicated fa admission, quarter The assessor woul hazards and risks a minimal, moderate care plan would be interventions, and t	essment (FSA) policy, revised all risk data was collected on ly and after 3 consecutive falls ld evaluate and analyze the and assign a risk range of or high risk. Additionally, the updated to reflect the interventions would be triveness and modified by IDT.				
	(MDS) comprehensi 10/24/2018. The M R3 had experience admission and 2 fa admission. The Ca summary, listed ca from the MDS for in MDS indicated R3 abilities test (BIMS decline. The CAA s areas of: Cognition	at change Minimum Data Set sive assessment completed IDS, dated 10/24/18, indicated ad 2 falls with injury since alls without injury since are Area Assessment (CAA) are areas that had triggered nclusion in the care plan. The scored a 5 on a cognitive) indicating significant cognitive summary identified problem a, communication, activity of incontinence, and behavioral				
	symptoms, falls an worksheet also ind factors to increase	d nutritional status. The icated possible contributing the risk for falls of: cognitive ssion, incontinence, anemia,				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00216	B. WING			C 01/30/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
JONES H		CE	DAR LAKE AV				
			POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	ige 9	2 830				
	and impaired balan	and impaired balance during transitions.					
	developed on 7/17/ during the months of November of 2018, December dated 12 and floor mat. A ha plan indicated a fall but lacked new inter fall. Listed intervent place; monitor falls free environment; of	alls and safety, initially (17, showed no up-dates of September, October and , and one update for 2/31/18, to initiate a low bed nd written notation on the care I had occurred on 11/27/18, erventions to correspond to the tions included roam alert in per protocol; maintain clutter observe for changes in gait; r safety; grip tape to bathroom					
	dated 4/18/19, indic challenging behavio depression. R3 had irritable, anxious, re confusion, verbal a resistive behaviors, respond to behavio approaches listed v of medications, adr firm approach, expl comprehension and reassurance and va wandering and guid received an antidep plan lacked person	vere to: evaluate effectiveness minister medications, use calm lain procedures, allow time for d response and offer alidation. Also to monitor for de to specific destination. R3 pressant medication. The care alized interventions to address plem areas indicated. High risk dressed on the					
	medical record indi - On 9/5/18, R3 wa	ote documentation in R3's cated: s found on the floor at 3:15 owel movement (BM) on the					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			A. BUILDING:			
		00216			C 01/30/2019	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		CF	DAR LAKE AV			
		MINNEA	POLIS, MN 55	5416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	the bed at 2:45 p.m (IDT) meeting docu indicated R3 appea pull pants down to independent with to The documentation been updated. - On 9/12/18, R3 st No injuries were no - On 9/30/18, R3 w in pad, on carpet at documentation on from the falls, but of from a previous fall ambulation and tra times and move at needed an as R3 w and staff were to re and toileting. R3 ha gripper strips to ba support bars to toile evaluation (BBE) d had dementia, was incontinent of bladd each shift. Was ab was resistive to can per facility protocol continence. Howev facility assessed can needs to develop in - On 11/27/18, R3 w wheelchair and sta assist, R3 pulled av noted, R3 was help and monitored. The 11/28/18, at 9:31 a	s found on the floor in front of h. The interdisciplinary team umentation, dated 9/6 /18 ared to fall related to trying to use the toilet. R3 was bileting and often refused care. h indicated the care plan had tood up, took one step and fell. oted. tas found on the floor with BM nd in bathroom. IDT 10/1/18, indicated no injuries lid have a left knee abrasion I. R3 was independent with nsfers, but can be unsteady at a fast pace. Staff assist as vill allow. R3 often refused cares ad BM incontinence. Will add throom floor and additional et. A bowel and bladder ated 10/18/18, indicated R3 continent of bowel, der with one continent episode le to identify the need to toilet, res. The approach was to toilet and as needed to promote rer, there was no evidence the ausal factors related to toileting ndividualized interventions. was seen getting up from the rting to walk. A staff went to way and fell. No injuries were bed back into the wheelchair e IDT documentation, dated , indicated R3 was therapy (PT), had improved				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/30/2019	
		00216	B. WING			
AME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ONES I	ARRISON RESIDEN	CF	DAR LAKE AV POLIS, MN 55			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
2 830	Continued From pa	ige 11	2 830			
	a knee brace on rig could not remember dementia. There w analysis of contribu- documentation did interventions initiate other than PT. - On 12/2/18, at 8:1 on R3's left hip and measuring 17 centi- doctor (MD) was not The X-ray results s fractures. The IDT to discuss the bruis indicated the follow refuse cares and ic impairment does not resistive; attempts may have been fro- placed on non-weig record lacked evide assessed by the fa- interventions to recor A progress note da indicated R3 contin- from bed to bathroo- the call light for hel 9:00 p.m. R3 was s dining room with a back to bedroom. F A progress note da was found sitting of door. R3 had a skin no other sources of 12/20/18, at 10:51	managed medically, and wore ght knee. Additionally, R3 er to wait for assistance due to as no evidence of root-cause iting factors and the not address specific ed to reduce the risk for falls 2 a.m., a bruise was reported 1 buttock down the side of thigh meters (cm). The medical otified and an X-ray taken. howed non-displaced pelvic met on 12/3/18, at 10:00 a.m. sing. The documentation ring: R3 was getting PT, would be packs; Due to cognitive ot ask for assistance and was to walk unattended; fracture m fall on 11/27/18. R3 was ght bearing on left leg. The ence causal factors had been cility to develop individualized luce the risk for further falls. ted 12/3/18, at 9:36 p.m., ued to self-transfer and walk om. R3 was instructed to use p. The documentation noted at seen walking from bedroom to walker. R3 was re-directed R3 was offered juice. ted, 12/18/18, at 3:30 p.m., R3 in the floor by the bathroom in tear below the left knee but f injury. The IDT note dated a.m., indicated R3 had a skin d bruising to buttocks after the				

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		00216	B. WING		01/3	30/2019
NAME OF	PROVIDER OR SUPPLIER					
JONES H	HARRISON RESIDEN	CE	AR LAKE AV OLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	had been reviewed and revised. However the care plan for falls and safety, dated 7/17/18, lacked evidence additional interventions had been added on 12/20/18.					
	indicated R3 was s no complaints of pa it was noted the ho from R3's room and with pants down. A' was found on the fl and trying to get up transferred into the bathroom. R3 wen bathroom, but fell a wheelchair to get in bringing in medicat and found R3 on th term memory loss a indicated R3 was e and staff would cor R3 frequently throu on 12/31/18, to rev occurred between documentation indi transfer or ambulat did not remember t healing pelvic fract lower extremity ede unsteady gait. The low bed and floor m self-transfers. The monitoring of R3 in lacked evidence the	ted 12/29/18, at 8:41 p.m., een falling to the floor, but had ain. On 12/30/18, at 9:35 p.m. usekeeper heard a loud noise d found R3 sitting on the floor t 11:00 p.m. on 12/30/18, R3 oor by the bed lying on left hip b. R3 explained he had wheelchair to use the t back to bed after using the as he walked around the to bed. The nurse was ion and hot tea for a cough the floor. Although R3 had short and dementia, the note ncouraged to use the call light ntinue to monitor and check on ighout the night. The IDT met iew the three falls that 12/29/18 and 12/30/18. The cated R3 was unsafe to the per self, but due to dementia to ask for assistance. R3 had a ure from a previous fall and ema that contributed to an IDT decided to implement a nat to minimize attempts of staff were to increase the great room. The record to re tions related to R3's need to				
innesota D		ated, 12/31/18, at 9:20 p.m., ound on bedside mat crawling				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00216	B. WING	B. WING		C 01/30/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
JONES H		CF	DAR LAKE AV POLIS, MN 55				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	nge 13	2 830				
		ne note indicated R3 had been checked 15 minutes prior. R3 nself to the mat.					
	indicated R3 was for bathroom at 9:30 p documentation from R3 had fallen on 12 crawling to the bath use the call light for	ated 1/2/19, at 8:30 p.m., bund crawling from bed to .m. on 1/1/19. IDT n 1/2/19, at 2:54 p.m. indicated 2/31/18 and 1/2/18. R3 was proom. R3 was encouraged to r assistance, but was very dementia. A low bed and floor					
	indicated R3 was for R3 said he was cra asleep. Documenta indicated R3 was for IDT met on 1/7/19, on 1/5/19. The docu intervention is low b unsafe transfers, w continue current pla indicated the addition	ated 1/6/19, at 10:15 p.m.,. bund lying on floor off the mat. wiling to the bathroom and fell ation on 1/5/19, at 19:16 p.m. bund on the floor mat sleeping. at 11:00 a.m. to discuss fall umentation indicated, "current bed with floor mat due to which was in place Will an of care." The care plan did on of a tilt back wheelchair, p in dining room as much as					
	indicated R3 was f on the floor at the e 1/12/19, at 5:57 a.n the bed, resident ha last rounds. IDT me discuss fall on 1/8/ ² bruise on left side c was in low bed with unsafely. Had a pel and did not remem	ated 1/8/19, at 5:20 a.m, found on his knees and hands entrance to the bathroom. On n. R3 was found lying next to ad been with a staff prior to et on 1/9/19, at 11:00 a.m. to 19. It was noted R3 had a of back, was on blood thinners, n mat but can self-transfer lvis fracture from previous fall, ber to ask for assistance with interventions were mentioned.					

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		с	
		00216	B. WING		01/30/2019	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ONES H	ARRISON RESIDEN	CE	AR LAKE AV			
			POLIS, MN 55			(1-1-1)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 14	2 830			
	indicate R3 was fou bathroom and said bathroom. The note sleepy, tired and we 12:00 p.m., to discu 1/12/19. The docur found on the floor 2 check, and had a lo current intervention Additionally, the no and did not ask for required assistance interventions would plan was reviewed A quarterly bowel a completed on 1/16/ the bowel and blad effective as eviden no skin breakdown was blank for interv bowel and bladder had one hand-writte supervision to assis The goal was for R free. The intervention	ated 1/14/19, at 2:50 p.m., und sitting on the floor in the he was trying to use the e indicated R3 appeared eak. IDT met on 1/14/19 at uss the fall that occurred on mentation indicated R3 was 20 minutes after a previous bw bed with mat in place as a due to history of falls. te indicated R3 was impulsive assistance with mobility, e with mobility, current I be continued, and the care and revised. and bladder review was (19. The document indicated der management program was ced by the goal effective and . Additionally the document ventions implemented. The care plan, reviewed on 1/18/19 en update of a change from stance with pericare (undated). 3 to be clean dry and odor ons were to assist with e fluids, monitor BM's assist of				
	1 with toileting, toile re-approach calmly evidence the facility	et per facility protocol, v. The care plan lacked y had developed individualized ns beyond facility protocol for				
	was in a tilt back w rests and pedals. F attendant present.	on 1/30/19, at 10:30 a.m. R3 heelchair with head rest, leg R3 had a paid personal care R3 was talkative and in t could not be interviewed due				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00216	B. WING		01/30/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
JONES H		CE	DAR LAKE AV POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	to cognitive disabilities. The personal care attendant (PCA) hired by R3's family said he works 4-6 times per week between 9:30 a.m. to 11:30 a.m. The PCA stated R3 was not attempting to get up as before. During interview on 1/29/19, at 11:25 a.m. Licensed Practical Nurse (LPN)-B explained the current interventions for R3 were a low bed with					
	LPN-B said R3 had R3 did not have str before. Additionally	cks and anticipate needs. I not fallen for a while now as ength to self-transfer as r, staff tried to keep R3 in sight n tired and R3 could be				
	interviewed on 1/29 the unit R3 resides 12 residents. NA-C work completed an NA-C said she tries and offer to take to R3 could also say w bathroom. NA-C ver resistive to cares a try to keep R3 in th could be seen. NA- room alone, he mig the night shift also	NA)-C and NA-E were 9/19, at 11:30 a.m. NA-C said on is staffed with 2 NA's for said she was able to get her d watch over the residents. to keep a close eye on R3 the bathroom even thought when he needed to go to the erified R3 could be very nd strike out. NA-E said they e dining room or where he E verified If R3 was left in his ght try to get up. NA-E thought tried to keep R3 in sight in the r and just do frequent checks m.				
	was interviewed on 1:00 p.m. RN-B exp independently initia from the bed. R3 do stand up but was n	nger, registered nurse (RN)-B 12/29/19, at approximately plained, R3 was walking Illy and was trying to get up eclined in mobility and would ot safe to walk independently. uded the physical therapist				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED C
	00216		B. WING			30/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
JONES I	ARRISON RESIDENC	3F	DAR LAKE AV POLIS, MN 55			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	option for R3 than r position. RN-B said independently trans wheelchair. RN-B v for assistance due to not progressing in to investigation addition related to toileting of impulsive. RN-B said many options for interventions related toileting, RN-B veriff medicine to remove that could cause an Additionally, R3 was attempt to go by him help. RN-B said stat to go to the toilet per explained the usual meals and as needed protocol was to che staff were to do "fre a specific time line for verified R3 was a ver person, but currentl DON was interviewed and stated if a resid the staff would bring offer food and fluids until they wanted to said one to one inter documented. Additi the fracture, R3 wor independently and v had left the room. T	and mat would be a safer isking a fall from a standing R3 was not safe ferring from the bed to a erified R3 did not know to ask to cognitive decline and was herapies. When asked about onal interventions for R3 or being resistive and id she felt there were not terventions. Concerning d to R3's need for help with ied R3 was on a diuretic (a e excess fluid from the body) increased need for toileting. is resistive to help and would nself right after staff offered ff were to check on the need er normal protocol. RN-B protocol was before and after ed. During the night shift, the ck every 2 hours. RN-B said quent checks" but did not give for the frequency. RN-B ery active and independent y was not attempting to walk. ed on 1/30/19. at 1:36 p.m. lent was restless or awake, g them to a common area and a and keep an eye on them go back to bed. The DON orventions would be onally, DON explained, before uld go to his room would get up shortly after staff the DON verified a more R3's falls needed to develop				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 01/30/2019	
		00216				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
JONES H		CE	DAR LAKE AV POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From page 17		2 830			
	7/2016, indicated e adequate supervisi prevent accidents. for facility staff to e possible for resider The policy, Compre Planning, revised N comprehensive car within 7 days of the comprehensive per reviewed throughou The interdisciplinar	ehensive and Baseline Care lovember, 2017, indicated a e plan would be developed				
	The administrator of develop/revise and procedures related factors related to fa as needed. The qua assurance committa audits to ensure co	implement policies and to the assessing the causal ills, and revise the care plans ality assessment and ee could perform random				
21995	Maltreatment of Vu Subd. 4a. Interna (a) Each facility sh ongoing written pro applicable licensing of suspected maltre	.557 Subd. 4a Reporting - Inerable Adults I reporting of maltreatment. all establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a	21995			3/21/19

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED C	
		00216	B. WING		01/30/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
JONES H		CE	OAR LAKE A POLIS, MN			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		(X5) SE COMPLE	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
21995	Continued From pa	age 18	21995			
	requirements of this internally. Howeve	may meet the reporting s section by reporting r, the facility remains nplying with the immediate ents of this section.				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of sexual abuse immediately to the administrator and within 2 hours of receiving the report to the State Agency (SA) for 1 of 3 residents (R1).			This plan of correction constitutes ou written allegation of compliance for th deficiencies cited. Submission of this plan of correction an admission that the deficiency exis	ne is not	
	Findings include:			that it is cited accurately. This plan of correction is submitted to meet state	f	
	had alleged being s bedtime on 1/19/19	dated 1/21/19, indicated R1 sexually assaulted after 9. R1's family member (FM)-A the reporting of the allegation, eport.		federal requirements. It is the policy of Jones Harrison to a and evaluate causal factors for falls t ensure adequate interventions are implemented to reduce all falls, inclu falls with actual harm. The resident (s) cited have been	to	
	received on 1/22/19 nurses (DON) as th reviewing the grieva indicated an investi	ed at the top of the page as 9, and signed by the director of he responsible individual for ance. Corrective action taken igation started on 1/22/19, and (VA) report was submitted to (2 days after later).		evaluated and assessed to minimize for falls prior to, but upon notification residents were re-assessed and re-evaluated for causal factors for the falls and their plan of care was updat include specific interventions to redu- further falls.	, the eir ted to ce	
	9:15 a.m. The adm	vas interviewed on 1/29/19, at inistrator verified allegation reported immediately to the he SA.		The Bowel and Bladder Evaluation a Falls Risk Data Collection policies ha been reviewed and revised. The IDT process has been enhanced including the reporting process and individualized interventions to ensure	ave d,	
	house supervisor h under the office do the DON on 1/22/1	p.m. the DON verified the ad placed the grievance report or where it was discovered by 9. The DON verified the ked direction for staff to		all residents have appropriate interventions implemented after each to minimize risk for further falls. The Director of Nursing is responsible for ensuring this process is sustained.	n fall	

STATE FORM

0PIB11

If continuation sheet 19 of 20

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C 01/30/2019	
		00216	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
JONES	HARRISON RESIDEN	?F	AR LAKE A OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	ge 19	21995			
	possible abuse and or what to report. T "Please submit this administrator/grieva indication on prope The policy, Resider 11/2016, indicated neglect, abuse and resident property w according to facility The policy lacked s However, the policy Suspected Abuse/N 2019, indicated alle would be reported w of abuse resulted in allegation of abuse injury, the facility hat to the SA. SUGGESTED MET The director of nurs staff on the facility's and procedures to ere port any allegatio director of nursing of audit reports to ens the audits could be assurance committ	egation was concerning I did not give direction on how he grievance form indicated, form to the assistant ance official." There was no r timelines for reporting at Grievances, revised all alleged violations involving or misappropriation of ould be reported immediately policy and as required by law. pecific timelines for reporting. I Investigation and Report of Neglect, revised January, gations related to abuse within 2 hours if the allegation n serious bodily injury. If the did not result in serious bodily ad 24 hours to make a report FHOD OF CORRECTION: sing or designee could educate a buse and neglect policies ensure staff immediately n of resident abuse. The pr designee could randomly ure compliance. The results of reported to the facility's quality ee. R CORRECTION: Fourteen		The nursing staff and IDT n receive education under the the Director of Nursing; rev assessment and evaluation factors for falls, including in interventions to reduce falls Harrison. Audits will be completed for have fallen daily, for four we weekly for three months an needed with results reporte committee meeting for furth recommendations. The Dire Nursing will oversee the au The facility will be in compli 03/21/2019.	e direction of iewing of causal dividualized at Jones r residents who eeks and then d then as d to the QAPI her review and ector of dit process.	