MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Jones Harrison Residence
3700 Cedar Lake Road
Minneapolis, MN 55416
Hennepin County

Report #: H5460046

Date: June 7, 2013

Date of Visit: 05/20/13
Time of Visit: 7:10 a.m.

By: Debora Vangsness, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): It is alleged that neglect occurred when a resident received blisters to her left forearm when coffee was spilled.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)

☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☐ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

The preponderance of evidence establishes that neglect is substantiated when the AP gave hot coffee to a resident in a styrofoam cup without a lid and the resident sustained a second-degree burn to the left forearm. The preponderance of evidence also establishes that neglect is substantiated when facility staff failed to notify the physician of the resident's burn, resulting in a delay of medical treatment to the resident for 48 hours.

The resident has left-sided weakness as the result of a stroke. The resident's left hand is contracted and s/he does not have functional use of the left arm. The resident is totally dependent on staff for care but is able to eat independently with the aid of adaptive equipment, such as a divided plate that is placed on a dycem mat and a sippy cup with a lid. Although the resident is cognitively impaired, s/he is very conversant and assertively states his/her preferences. The resident routinely requests coffee and other fluids between meals.

The AP stated s/he was aware that the resident's care plan specified that beverages were to be served to him/her in a sippy cup with a lid. On the afternoon of the incident, the AP poured hot coffee in a styrofoam cup that did not have a lid and placed it in front of the resident. When the resident reached for the coffee, s/he knocked it over and it spilled on the resident's left arm and lap. The AP was several feet away from the resident and saw the incident occurring but could not stop it. The AP gave the resident coffee in a styrofoam cup because there were no extra sippy cups in the unit cupboard. The resident sustained a second-degree burn to the left forearm measuring 17cm x 7cm that had two blisters. In addition, the resident sustained three sites of redness on the left upper thigh measuring 11cm x 3cm, 5cm x 1cm, and 10 cm x 2 cm, and three sites of redness on the lower abdomen measuring 6cm x 4cm, 5cm x 3cm, and 5cm x 2cm. The AP communicated with the House Supervisor about the resident's injuries and was directed to monitor it, which the AP did. Although the AP left a voice mail for the nurse practitioner about the incident and the resident's resultant injuries, the nurse practitioner's office was closed when the AP left the voice mail (Friday evening). The AP did not notify the on-call physician/nurse practitioner of the resident's injuries. Three other nurses who documented that they monitored the resident's burn during the weekend also failed to inform the physician/nurse practitioner of the resident's injury. As a result, the resident's burn went untreated for 48 hours, until the nurse manager followed up with the nurse practitioner the following Monday morning. The nurse practitioner directed staff to apply a topical remedy for burns to the resident's left forearm. The areas of redness on the resident's left thigh and abdomen had resolved by this time.

Observations and staff interviews indicated that extra sippy cups are available in the unit cupboard and the main kitchen.

Management staff stated that all staff are to adhere to each resident's plan of care. If no sippy cups were available on the unit, the AP should have obtained one from the kitchen prior to serving the resident coffee. Management staff also stated that nursing staff who worked the weekend (from Friday afternoon through Monday morning) should have notified the on-call physician regarding the resident's burn. It was not acceptable practice to simply leave a voice mail for the nurse practitioner.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The AP is responsible for the neglect related to giving the resident hot coffee in a regular styrofoam cup without a lid, instead of a sippy cup with a lid. The AP acknowledged that the resident's adaptive eating equipment has been an established care intervention for two years, which the AP failed to follow. The AP has functioned as the Charge Nurse on the resident's unit for 8 years. The AP was provided with a written job description for Charge nurses, denoting responsibilities for accurate resident care and the supervision of ancillary staff on the unit.

The facility is responsible for the neglect related to the resident's delay in medical treatment. The facility's system for prompt physician notification of significant resident problems was insufficient. The resident sustained several reddened areas from spilled hot coffee as well as a second-degree burn. The incident occurred at 4:00 p.m. on a Friday. The nurse practitioner/physician was not contacted by facility staff until 9:00 a.m. the following Monday, at which time medical treatment was initiated. None of the facility staff, who had worked the weekend (from 4:00 p.m. Friday to 9:00 a.m. Monday), informed the nurse practitioner/physician of the resident's burn.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):
The facility re-educated the AP regarding accurate care plan implementation, the importance of resident safety, how to minimize risk for resident injury, and the process for contacting the nurse practitioner for acute problems.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Medication Administration Records
- ☒ Facility Incident Reports
- ☐ ADL (Activities of Daily Living) Flow Sheets
- ☒ Physician Orders
- ☒ Nurses Notes
- ☐ Activities Reports
- ☐ Therapy and/or Ancillary Services Records
- ☒ Skin Assessments
- ☒ Care Guide
- ☒ Treatment Sheets
- ☒ Physician Progress Notes
- ☐ Laboratory and X-ray Reports
- ☐ Social Service Notes
- ☐ Meal Intake Records
- ☐ Weight Records
- ☒ Assessments
- ☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

- ☐ Resident/Family Council Minutes
- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Personnel Records/Background Check, etc.
- ☒ Facility In-service Records
- ☒ Facility Policies and Procedures

☐ Call Light Audits ☒ Other, specify: Resident Meal Tickets

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 4

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 10

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ◉ Yes ○ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☒ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☒ Infection Control	☐ Cleanliness	☒ Injury
☒ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Nursing Home Administrators
Minnesota Board of Nursing
Minneapolis City Police Department
Hennepin County Attorney
Minneapolis City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING _____ B. WING _____	C 06/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint #H5460046. The following deficiencies are issued:	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	It is Jones-Harrison's policy that the physician is notified when an accident involving the resident results in injury and has the potential for requiring physician intervention. This policy has been reviewed and revised. The licensed nurses involved have been retrained on June 28th and July 2nd. All accident and incident reports will be reviewed by the DON and Administrator to ensure that proper notification to the physicians has occurred on a weekly basis. This plan will be corrected by July 12, 2013.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 7-1-13

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

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F 157	Continued From page 1	F 157		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure that the physician was immediately contacted for 1 of 1 residents reviewed (R1), who sustained a second-degree burn from spilled coffee. Findings include:

R1's care plan, dated 02/15/13, established that R1 has left-sided weakness as the result of a stroke. R1's left hand is contracted and s/he does not have functional use of the left arm. R1 is totally dependent on staff for care but is able to eat independently with the aid of adaptive equipment. R1 drinks all fluids from a sippy cup with a lid. This information was consistent with the investigator's observations conducted on 05/20/13 at 7:20 a.m. and 8:10 a.m. in the Cedar Bay Memory Care dining room, where R1 was observed drinking fluids independently from a sippy cup with a lid.

An Incident Report, dated 04/26/13 at 4:00 p.m., indicated that RN/(D) gave R1 a cup of coffee and when R1 reached for the coffee, it spilled on R1's left arm and lap. R1 sustained a second-degree burn to the left lower arm measuring 17cm x 7 cm. The area of burn also contained two small blisters (size not documented). In addition, R1 sustained three sites of redness on the left upper thigh measuring 11cm x 3cm, 5cm x 1cm, and 10 cm x 2 cm, and three sites of redness on the lower abdomen measuring 6cm x 4cm, 5cm x 3cm, and 5cm x 2cm.

The progress notes, dated 04/26/13 at 9:06 p.m.

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F 157	Continued From page 2	F 157		

(a Friday night), indicated that RN/(D) left a "voice message" for the nurse practitioner regarding R1's skin and condition.

R1's medical record provided no evidence that any facility staff followed up with the nurse practitioner about R1's burn for the remainder of 04/26/13 or during the weekend of 04/27 - 04/28/13. The progress notes and treatment record indicated that RN/(D) and three other unit nurses who worked between 04/26/13 and 04/28/13 all documented that they had monitored the "redness and blisters" on R1's left forearm and none of them informed the nurse practitioner/physician about R1's burn.

The progress notes, dated 04/29/13 at 9:22 a.m., indicated that RN/(J)/Nurse Manager contacted Nurse Practitioner (NP)/(K) about the status of R1's burn and blisters. NP/(K) ordered a Silvadene ointment treatment (a topical antibacterial used to treat burns) to be completed twice daily until the burn resolved. This treatment protocol was initiated on 04/29/13 and ended on 05/19/13, at which time R1's burns were resolved.

RN/(D) was interviewed on 05/23/13 at 10:25 a.m. RN/(D) stated it was her responsibility on 04/26/13 to notify the nurse practitioner or on-call physician about R1's burn. RN/(D) thought she met this obligation by leaving a voice message for the nurse practitioner. RN/(D) also stated that she notified RN/(L)/House Supervisor about R1's burn, right after the incident occurred and again later that same shift.

RN/(L)/House Supervisor was interviewed on 06/06/13 at 10:55 a.m. S/he stated that RN/(D)

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F 157	Continued From page 3	F 157		

first informed him/her about the resident's injury at 9:00 p.m. when s/he was conducting final rounds on the shift. RN/(D) told RN/(L) that the resident had a reddened area on the resident's arm with two small blisters from spilling hot coffee on him/herself. RN/(D) also told RN/(L) that s/he had notified the on-call physician about the resident's burn. RN/(D) did not tell RN/(L) that s/he had only left a voice mail message for the nurse practitioner.

RN/(J)/Nurse Manager was interviewed on 05/30/13 at 11:05 a.m. RN/(J) stated she learned of R1's injury when she returned to work on 04/29/13 (Monday). RN/(J) examined R1's injury, which had two open blisters. RN/(J) immediately contacted the nurse practitioner about the status of R1's burn because it needed medical treatment, which was ordered by the nurse practitioner on 04/29/13.

Nurse Practitioner (NP)/(K) was interviewed on 05/31/13 at 10:35 a.m. S/he stated that s/he did not receive RN/(D)'s voice message from 04/26/13 until 04/29/13. NP/(K)'s hours of business end at 4:00 p.m. on Friday and NP/(K) does not resume business hours until 7:00 a.m. on Monday. NP/(K)'s pager message includes these hours of availability and that messages should only be left for "non-urgent" issues. For acute problems, the message directs callers to notify the on-call nurse practitioner via a stat page. R1's burn required medical attention and orders should have been obtained and initiated over the weekend (04/27 - 04/28/13).

The facility's policy on Change In Status - Physician Notification indicated that the physician

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F 157	Continued From page 4 is to be notified when "There is an accident involving the resident which results in injury and has the potential for requiring physician intervention."	F 157		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that each resident was provided with the necessary adaptive eating equipment, to maintain safety and prevent avoidable accidents, in 1 of 3 residents reviewed (R1), who sustained a second-degree burn when staff gave the resident hot coffee in a regular styrofoam cup, instead of a sippy cup with a lid. Findings include: R1's care plan, dated 02/15/13, established that R1 has left-sided weakness as the result of a stroke. R1's left hand is contracted and s/he does not have functional use of the left arm. R1 is totally dependent on staff for care but is able to eat independently with the aid of adaptive equipment. R1 drinks all fluids from a sippy cup with a lid. This information was consistent with the investigator's observations conducted on 05/20/13 at 7:20 a.m. and 8:10 a.m. in the Cedar	F 323	It is Jones-Harrison's policy to provide proper adaptive equipment as indicated on the resident's care plan for all meals. The adaptive equipment policy was reviewed and revised on June 26th. The dietary staff are responsible for ensuring that the proper adaptive equipment is available for all meals and that an extra supply of sippy cups are located in the kitchenette.	

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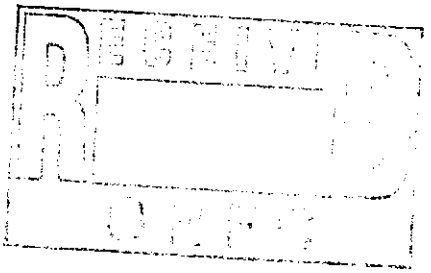
F 323	Continued From page 5 Bay Memory Care dining room, where R1 was observed drinking fluids independently from a sippy cup with a lid. An Incident Report, dated 04/26/13 at 4:00 p.m., indicated that RN/(D) gave R1 a cup of coffee and when R1 reached for the coffee, it spilled on R1's left arm and lap. R1 sustained a second-degree burn to the left lower arm measuring 17cm x 7 cm. The area of burn also contained two small blisters (size not documented). In addition, R1 sustained three sites of redness on the left upper thigh measuring 11cm x 3cm, 5cm x 1cm, and 10 cm x 2 cm, and three sites of redness on the lower abdomen measuring 6cm x 4cm, 5cm x 3cm, and 5cm x 2cm. The progress notes, dated 04/29/13 at 9:22 a.m., indicated that Nurse Practitioner (NP)/(K) ordered application of Silvadene cream to R1's left arm wound twice daily with a nonstick dressing wrapped in kerlix. This treatment protocol was initiated on 04/29/13. RN/(D) was interviewed on 05/23/13 at 10:25 a.m. RN/(D) stated that R1 has used adaptive eating equipment for approximately two years. R1 consumes all fluids from a sippy cup with a lid, due to his/her physical limitations. R1 likes to have coffee in the afternoon. On the day of the incident, RN/(D) was in the dining room with several residents, including R1, who requested a cup of coffee. RN/(D) poured hot coffee in a styrofoam cup that did not have a lid and placed it in front of R1. When R1 reached for the coffee cup, s/he knocked it over and it spilled on his/her arm and lap. RN/(D) was several feet away from	F 323	The licensed nurses are responsible to ensure that the care plan is being followed. The dietary staff was retrained on the policy on June 28th and July 2nd. The licensed nurses were retrained on June 28th and July 2nd. Both the dietary department and the nursing department will audit the kitchenettes weekly all residents who have adaptive equipment listed on their care plans to ensure compliance. This plan will be corrected by July 12, 2013	



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F 323	Continued From page 6	F 323		

R1 and saw the incident occurring but could not stop it. RN/(D) stated she gave R1 coffee in a styrofoam cup because there were no extra sippy cups in the unit cupboard. R1 had large areas of redness on his/her lap, leg, and left forearm. The left forearm also had "two or three blisters." R1 complained of discomfort in the areas of redness on his/her leg and lap area, but R1 had no complaints of discomfort in the reddened area on his/her left arm. RN/(D) applied ice to all the reddened areas and placed a nonstick dressing on the area of blistering. Afterward, RN/(D) left a voice-mail message for the Nurse Practitioner (NP) about R1's injuries.

Dietary Technician/(C) was interviewed on 05/20/13 at 9:10 a.m. S/he explained that dietary staff are responsible for setting the resident tables prior to the meal. Dietary staff utilize a seating map for each dining room, which designates all adaptive equipment required for each individual. The adaptive equipment is set up at each resident's place setting before the meal is served. When the steam table arrives in the dining room, each resident has a computer-generated meal ticket that identifies the type of diet to be served and any speical equipment the resident utilizes during the meal. Extra sippy cups are avialble in dining room cupboards on the units, if needed throughout the day. In the event that the unit supply of sippy cups is depleted, more sippy cups are available in the main kitchen.

Observations in the Cedar Bay Memory Care dining room on 05/20/13 at 7:20 a.m. revealed that staff had already prepared place settings at tables for ten residents. One of ten place settings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. BUILDING _____ B. WING _____	C 06/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

contained a sippy cup (R1's). LPN/(E) and Nursing Assistants (G and H) stated that the dietary department sets the tables and places any adaptive eating equipment needed by the residents.

RN/(J)/Nurse Manager was interviewed on 05/30/13 at 11:05 a.m. S/he stated that all staff are to adhere to each resident's plan of care. If no sippy cups were available in the unit cupboard on the afternoon of 04/26/13, RN/(D) should have gone to the main kitchen and obtained one, prior to serving R1 coffee. It was not acceptable for RN/(D) or anyone to provide fluids to R1 in the wrong receptacle.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 06/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5332021. The following correction orders are issued:	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 06/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 2 development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that the physician was immediately contacted for 1 of 1 residents reviewed (R1), who sustained a second-degree burn from spilled coffee. Findings include: R1's care plan, dated 02/15/13, established that R1 has left-sided weakness as the result of a stroke. R1's left hand is contracted and s/he does not have functional use of the left arm. R1 is totally dependent on staff for care but is able to eat independently with the aid of adaptive equipment. R1 drinks all fluids from a sippy cup	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 06/07/2013

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

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2 265	Continued From page 3	2 265		

with a lid. This information was consistent with the investigator's observations conducted on 05/20/13 at 7:20 a.m. and 8:10 a.m. in the Cedar Bay Memory Care dining room, where R1 was observed drinking fluids independently from a sippy cup with a lid.

An Incident Report, dated 04/26/13 at 4:00 p.m., indicated that RN/(D) gave R1 a cup of coffee and when R1 reached for the coffee, it spilled on R1's left arm and lap. R1 sustained a second-degree burn to the left lower arm measuring 17cm x 7 cm. The area of burn also contained two small blisters (size not documented). In addition, R1 sustained three sites of redness on the left upper thigh measuring 11cm x 3cm, 5cm x 1cm, and 10 cm x 2 cm, and three sites of redness on the lower abdomen measuring 6cm x 4cm, 5cm x 3cm, and 5cm x 2cm.

The progress notes, dated 04/26/13 at 9:06 p.m. (a Friday night), indicated that RN/(D) left a "voice message" for the nurse practitioner regarding R1's skin and condition.

R1's medical record provided no evidence that any facility staff followed up with the nurse practitioner about R1's burn for the remainder of 04/26/13 or during the weekend of 04/27 - 04/28/13. The progress notes and treatment record indicated that RN/(D) and three other unit nurses who worked between 04/26/13 and 04/28/13 all documented that they had monitored the "redness and blisters" on R1's left forearm and none of them informed the nurse practitioner/physician about R1's burn.

The progress notes, dated 04/29/13 at 9:22 a.m., indicated that RN/(J)/Nurse Manager contacted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 265	Continued From page 4 Nurse Practitioner (NP)/(K) about the status of R1's burn and blisters. NP/(K) ordered a Silvadene ointment treatment (a topical antibacterial used to treat burns) to be completed twice daily until the burn resolved. This treatment protocol was initiated on 04/29/13 and ended on 05/19/13, at which time R1's burns were resolved. RN/(D) was interviewed on 05/23/13 at 10:25 a.m. RN/(D) stated it was her responsibility on 04/26/13 to notify the nurse practitioner or on-call physician about R1's burn. RN/(D) thought she met this obligation by leaving a voice message for the nurse practitioner. RN/(D) also stated that she notified RN/(L)/House Supervisor about R1's burn, right after the incident occurred and again later that same shift. RN/(L)/House Supervisor was interviewed on 06/06/13 at 10:55 a.m. S/he stated that RN/(D) first informed him/her about the resident's injury at 9:00 p.m. when s/he was conducting final rounds on the shift. RN/(D) told RN/(L) that the resident had a reddened area on the resident's arm with two small blisters from spilling hot coffee on him/herself. RN/(D) also told RN/(L) that s/he had notified the on-call physician about the resident's burn. RN/(D) did not tell RN/(L) that s/he had only left a voice mail message for the nurse practitioner. RN/(J)/Nurse Manager was interviewed on 05/30/13 at 11:05 a.m. RN/(J) stated she learned of R1's injury when she returned to work on 04/29/13 (Monday). RN/(J) examined R1's injury, which had two open blisters. RN/(J) immediately contacted the nurse practitioner about the status of R1's burn because it needed medical treatment, which was ordered by the nurse practitioner on 04/29/13.	2 265		

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2 265	Continued From page 5 Nurse Practitioner (NP)/(K) was interviewed on 05/31/13 at 10:35 a.m. S/he stated that s/he did not receive RN/(D)'s voice message from 04/26/13 until 04/29/13. NP/(K)'s hours of business end at 4:00 p.m. on Friday and NP/(K) does not resume business hours until 7:00 a.m. on Monday. NP/(K)'s pager message includes these hours of availability and that messages should only be left for "non-urgent" issues. For acute problems, the message directs callers to notify the on-call nurse practitioner via a stat page. R1's burn required medical attention and orders should have been obtained and initiated over the weekend (04/27 - 04/28/13). The facility's policy on Change In Status - Physician Notification indicated that the physician is to be notified when "There is an accident involving the resident which results in injury and has the potential for requiring physician intervention." A Suggested Method of Correction: (1) Develop and implement a system which ensures that each resident receives timely medical intervention during hours when the nurse practitioner/physician's office is closed for business; educate all licensed personnel. (2) Review the facility's policy on Physician Notification with all licensed personnel. (3) Document all corrective action taken. Time Period for Correction: Thirty (30) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		

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2 830	Continued From page 6 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that each resident was provided with the necessary adaptive eating equipment, to maintain safety and prevent avoidable accidents, in 1 of 3 residents reviewed (R1), who sustained a second-degree burn when staff gave the resident hot coffee in a regular styrofoam cup, instead of a sippy cup with a lid. Findings include: R1's care plan, dated 02/15/13, established that R1 has left-sided weakness as the result of a stroke. R1's left hand is contracted and s/he does not have functional use of the left arm. R1 is totally dependent on staff for care but is able to eat independently with the aid of adaptive equipment. R1 drinks all fluids from a sippy cup with a lid. This information was consistent with the investigator's observations conducted on 05/20/13 at 7:20 a.m. and 8:10 a.m. in the Cedar Bay Memory Care dining room, where R1 was observed drinking fluids independently from a sippy cup with a lid. An Incident Report, dated 04/26/13 at 4:00 p.m.,	2 830		

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2 830	Continued From page 7 indicated that RN/(D) gave R1 a cup of coffee and when R1 reached for the coffee, it spilled on R1's left arm and lap. R1 sustained a second-degree burn to the left lower arm measuring 17cm x 7 cm. The area of burn also contained two small blisters (size not documented). In addition, R1 sustained three sites of redness on the left upper thigh measuring 11cm x 3cm, 5cm x 1cm, and 10 cm x 2 cm, and three sites of redness on the lower abdomen measuring 6cm x 4cm, 5cm x 3cm, and 5cm x 2cm. The progress notes, dated 04/29/13 at 9:22 a.m., indicated that Nurse Practitioner (NP)/(K) ordered application of Silvadene cream to R1's left arm wound twice daily with a nonstick dressing wrapped in kerlix. This treatment protocol was initiated on 04/29/13. RN/(D) was interviewed on 05/23/13 at 10:25 a.m. RN/(D) stated that R1 has used adaptive eating equipment for approximately two years. R1 consumes all fluids from a sippy cup with a lid, due to his/her physical limitations. R1 likes to have coffee in the afternoon. On the day of the incident, RN/(D) was in the dining room with several residents, including R1, who requested a cup of coffee. RN/(D) poured hot coffee in a styrofoam cup that did not have a lid and placed it in front of R1. When R1 reached for the coffee cup, s/he knocked it over and it spilled on his/her arm and lap. RN/(D) was several feet away from R1 and saw the incident occurring but could not stop it. RN/(D) stated she gave R1 coffee in a styrofoam cup because there were no extra sippy cups in the unit cupboard. R1 had large areas of redness on his/her lap, leg, and left forearm. The left forearm also had "two or three blisters." R1 complained of discomfort in the areas of redness	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 8 on his/her leg and lap area, but R1 had no complaints of discomfort in the reddened area on his/her left arm. RN/(D) applied ice to all the reddened areas and placed a nonstick dressing on the area of blistering. Afterward, RN/(D) left a voice-mail message for the Nurse Practitioner (NP) about R1's injuries. Dietary Technician/(C) was interviewed on 05/20/13 at 9:10 a.m. S/he explained that dietary staff are responsible for setting the resident tables prior to the meal. Dietary staff utilize a seating map for each dining room, which designates all adaptive equipment required for each individual. The adaptive equipment is set up at each resident's place setting before the meal is served. When the steam table arrives in the dining room, each resident has a computer-generated meal ticket that identifies the type of diet to be served and any speical equipment the resident utilizes during the meal. Extra sippy cups are avialble in dining room cupboards on the units, if needed throughout the day. In the event that the unit supply of sippy cups is depleted, more sippy cups are available in the main kitchen. Observations in the Cedar Bay Memory Care dining room on 05/20/13 at 7:20 a.m. revealed that staff had already prepared place settings at tables for ten residents. One of ten place settings contained a sippy cup (R1's). LPN/(E) and Nursing Assistants (G and H) stated that the dietary department sets the tables and places any adaptive eating equipment needed by the residents. RN/(J)/Nurse Manager was interviewed on 05/30/13 at 11:05 a.m. S/he stated that all staff are to adhere to each resident's plan of care. If no	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00216	A. BUILDING: _____ B. WING _____	C 06/07/2013

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

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2 830	Continued From page 9 sippy cups were available in the unit cupboard on the afternoon of 04/26/13, RN/(D) should have gone to the main kitchen and obtained one, prior to serving R1 coffee. It was not acceptable for RN/(D) or anyone to provide fluids to R1 in the wrong receptacle. A Suggested Method of Correction: (1) Conduct routine audits to ensure resident care plans are being implemented accurately by staff. (2) Document all corective action taken. Time Period for Correction: Thirty (30) days.	2 830		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
Jones Harrison Residence
3700 Cedar Lake Avenue
Minneapolis, MN 55416
Hennepin County

Report #: H5460046

Date: July 22, 2013

Date of Visit: July 19, 2013
Time of Visit: 6:50 a.m.

By: Deb Vangsness, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up two federal deficiencies and two state licensing orders which were issued on June 18, 2013, as the result of an investigation which had been completed on June 7, 2013.

The status of each order is as follow:
1 MN Rule 4658.0085 – Corrected
2 MN Rule 4658.0520 Subp. 1 - Corrected

See Attached 2567B for status of federal deficiencies.

xc: Minnesota Department of Health -Licensing & Certification Division

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245460	A. Building B. Wing	7/19/2013

Name of Facility	Street Address, City, State, Zip Code
JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	07/12/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	07/12/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KL/CBL	Date: 7/23/13	Signature of Surveyor: 05455	Date: 7/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/7/2013				

AH Form Approved
7/23/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00216	A. Building B. Wing	7/19/2013

Name of Facility	Street Address, City, State, Zip Code
JONES HARRISON RESIDENCE	3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20265 Reg. # MN Rule 4658.0085 LSC	07/12/2013	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. LSC	07/12/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By kl / Cbl	Date: 7/23/13	Signature of Surveyor: 05455	Date: 7/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/7/2013			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO