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- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 20, 2019 be rescinded as of March 21, 2019.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 Therefore, the NATCEP prohibition is rescinded.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.

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,

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

DEPARTMENT OF HEALTH

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,

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

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 Tamika.Brown@cms.hhs.gov.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

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

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 01/30/2019

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 1/28/19 through 1/30/19, to investigate complaints #H5460051 and # H5460054C Jones Harrison Residence was not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities for F689. The non compliance resulted in actual harm. Additionally complaints #H5460053C and H5460052C were investigated. The facility was found not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities for F607, and F609. The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 607		3/15/19

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

Electronically 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.

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F 607	Continued From page 1 Based on interview and document review, the facility failed to develop policies and procedures for reporting all suspected or alleged allegations of abuse, neglect, exploitation of residents, and misappropriation of resident property to the State Agency (SA) within 2 hours. This had the potential to affect all resident in the facility. Findings include: The policy, Resident Grievances, revised 11/2016, indicated all alleged violations involving neglect, abuse and or misappropriation of resident property would be reported immediately according to facility policy and as required by law. The policy lacked specific timelines for reporting. On further investigation, the policy Investigation and Report of Suspected Abuse/Neglect, revised January, 2019, indicated allegations related to abuse would be reported within 2 hours if the allegation of abuse resulted in serious bodily injury. If the allegation of abuse did not result in serious bodily injury, the facility had 24 hours to make a report to the SA. The policy was lacking direction to report any allegation concerning abuse to be reported within 2 hours, not just for those resulting in serious injury. A separate policy, Compliance with Elder Justice Act, dated 10/1/11, defined serious bodily injury as an injury involving extreme pain; substantial risk of death; protracted loss or impairment of function or an organ, body member or mental faculty, or requiring medical intervention. On 1/30/19, at 3:00 p.m. the DON verified it was the policy to write complaints using the grievance form and procedure. The DON verified the	F 607	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. It is the policy of Jones Harrison to report any allegations of a crime, abuse, neglect, exploitation of residents, and misappropriation of resident property to the Administrator, State Agency and local authorities when appropriate based on the facilities policy and as required by law. Upon notification, the facility did update the Abuse and Neglect polices to include specific time lines for reporting abuse and/or a crime. Under the direction on the Campus Administrator all facility staff will receive re-education related to the policy updates, including the specific timing and guidelines for reporting and investigation. 5 random staff will be interviewed by the Campus Administrator or their designee weekly for four weeks following the training to ensure staff are competent on the facility's Abuse and Neglect policy and the proper reporting timelines. The Campus Administrator will monitor all reports of alleged abuse, neglect, exploitation, and misappropriation of resident property to ensure the proper time lines for reporting are followed. Audits will be done after each report made and the results of these audits will be brought to the quarterly QAPI meeting for	

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F 607	Continued From page 2 grievance form lacked direction for staff to determine if the allegation was concerning possible abuse and lacked directions for staff to report immediately to the administrator any suspected or alleged abuse.	F 607	discussion. The Facility will be in compliance by 03/15/2019.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		3/15/19

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F 609	Continued From page 3 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). Findings include: A grievance report dated 1/21/19, indicated R1 had alleged being sexually assaulted after bedtime on 1/19/19. R1's family member (FM)-A was present during the reporting of the allegation, per the grievance report. The report was dated at the top of the page as received on 1/22/19, and signed by the director of nurses (DON) as the responsible individual for reviewing the grievance. Corrective action taken indicated an investigation started on 1/22/19, and a Vulnerable Adult (VA) report was submitted to the SA on 1/23/19 (2 days after later). The administrator was interviewed on 1/29/19, at 9:15 a.m. The administrator verified allegation should have been reported immediately to the administrator and the SA. On 1/30/19, at 3:00 p.m. the DON verified the house supervisor had placed the grievance report under the office door where it was discovered by the DON on 1/22/19. The DON verified the grievance form lacked direction for staff to determine if the allegation was concerning possible abuse and did not give direction on how or what to report. The grievance form indicated, "Please submit this form to the assistant administrator/grievance official." There was no indication on proper timelines for reporting	F 609	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. It is the policy of Jones Harrison to report any allegations of a crime, abuse, neglect, exploitation of residents, and misappropriation of resident property to the Administrator, State Agency and local authorities when appropriate based on the facilities policy and as required by law. Upon notification, the facility did update the Abuse and Neglect polices to include specific time lines for reporting abuse and/or a crime. Under the direction on the Campus Administrator all facility staff will receive re-education related to the policy updates, including the specific timing and guidelines for reporting and investigation. 5 random staff will be interviewed by the Campus Administrator or their designee weekly for four weeks following the training to ensure staff are competent on the facility's Abuse and Neglect policy and the proper reporting timelines. The Campus Administrator will monitor all reports of alleged abuse, neglect, exploitation, and misappropriation of resident property to ensure the proper time lines for reporting are followed. Audits will be done after each report made and the results of these audits will be brought to the quarterly QAPI meeting for	

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F 609	Continued From page 4 The policy, Resident Grievances, revised 11/2016, indicated all alleged violations involving neglect, abuse and or misappropriation of resident property would be reported immediately according to facility policy and as required by law. The policy lacked specific timelines for reporting. However, the policy Investigation and Report of Suspected Abuse/Neglect, revised January, 2019, indicated allegations related to abuse would be reported within 2 hours if the allegation of abuse resulted in serious bodily injury. If the allegation of abuse did not result in serious bodily injury, the facility had 24 hours to make a report to the SA.	F 609	discussion. The Facility will be in compliance by 03/15/2019.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)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 assess and evaluate causal factors for falls, and failed to ensure adequate interventions were implemented to reduce falls, for 2 of 3 residents (R4 and R3) reviewed who both sustained falls resulting in actual harm. Findings include:	F 689	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. It is the policy of Jones Harrison to assess	3/21/19

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F 689	Continued From page 5 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. The care plan, dated 10/24/18, indicated a problem for falls and safety related to: a history of falls, impaired mobility, debility, self transfers, cognitive deficits and medications. The goal was for R4 to have minimal falls or fall related injuries. Interventions listed were low bed with mat, anticipate toileting needs and assist as needed, observe for medication side effects, physical therapy (PT) for strengthening and endurance to improve mobility. The care plan had one hand-written comment dated 1/17/19, indicating, "Fall - unsafe with transfers". There were no additional interventions written on the care plan to correspond to the comment. Progress notes on 10/8/18, indicated R4 had a fall at 5:00 p.m. while trying to get up to the bathroom. R4 had not used the call light. R4 was found sitting in front of the recliner. R4 agreed to use the call light in the future. The record lacked evidence of any other immediate actions or	F 689	and evaluate causal factors for falls to ensure adequate interventions are implemented to reduce all falls, including falls with actual harm. The resident (s) cited have been evaluated and assessed to minimize risk for falls prior to, but upon notification, the residents were re-assessed and re-evaluated for causal factors for their falls and their plan of care was updated to include specific interventions to reduce further falls. The Bowel and Bladder Evaluation and Falls Risk Data Collection policies have been reviewed and revised. The IDT process has been enhanced, including the reporting process and individualized interventions to ensure that all residents have appropriate interventions implemented after each fall to minimize risk for further falls. The Director of Nursing is responsible for ensuring this process is sustained. The nursing staff and IDT members will receive education under the direction of the Director of Nursing; reviewing assessment and evaluation of causal factors for falls, including individualized interventions to reduce falls at Jones Harrison. Audits will be completed for residents who have fallen daily, for four weeks and then weekly for three months and then as needed with results reported to the QAPI	

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 01/30/2019

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 689	Continued From page 6 interventions at the time of the fall. On 10/9/18, progress notes indicated R4 was found at 6:45 a.m. lying next to the bed and stated she was trying to go to the bathroom. The right leg appeared shorter than the left and the foot was turned in. A low bed with floor mat was initiated and was reminded to use the call light. 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. On 10/11/18, (two/three days post falls) the IDT met to review R4's falls. Documentation indicated R4 had post operative delirium following hip surgery. R4 was independent at home and not accustomed to needing to ask for help and believed she was still able to to to the bathroom independently. R4 was in a room near a nursing office. The plan was to make frequent checks and remind to use the call light. PT was consulted, a low bed was initiated, continue therapy to strengthening. The note indicated the care plan was reviewed and current. However, there was no indication toileting needs were evaluated at the time of the fall, even though R4's two falls on 10/8/18 and 10/9/18 were related to her needing to use the bathroom. A fall risk data collection was completed on 10/24/18. The data indicated R4 had a fall related fracture, was unsteady, used a diuretic (medicine to reduce fluid in the body). The record lacked an assessment of the data. A bowel and bladder evaluation (BBE) was competed on 10/28/18. The BBE indicated R4 was continent of bowel and bladder, and woke in the night to use the toilet. R4 was able to identify	F 689	committee meeting for further review and recommendations. The Director of Nursing will oversee the audit process. The facility will be in compliance by 03/21/2019.	

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the need to toilet and was able to use the call light. The BBE had no written summary of findings or interventions indicated. The toileting care plan dated 10/31/18, indicated a goal to maintain level of continence. The interventions were to provide pericare after each incontinent episode, provide assistance with toileting, toilet per facility protocol, offer assist to the toiled at night if awake, administer medications and observe for signs or symptoms of urinary tract infection. The toileting care plan made no reference to R4's risk for falls.

On 11/19/18, at 10:29 a.m. documentation indicated R4 was found on the floor in a kneeling position with top half of body on the bed and knees on the floor mat. R4 had a laceration above the eye due to the fall. R4 stated a need to use the bathroom and could not wait for help. R4 had not put the call light on. At 8:26 p.m. documentation indicated R4 had been in bed all day with a headache rated a pain level of 8 out of 10. The record lacked indication any new or revised interventions had been initiated related to self toileting.

The IDT reviewed the fall on 11/22/18 (three days post fall). The documentation indicated R4 was forgetful of limitations, tends to be "fiercely" independent, low hemoglobin, declined in therapy and was placed on hospice. Additionally noted was R2's feeling of not being able to wait for help. Interventions were unchanged with low bed and floor mat, frequent safety checks (no frequency parameter indicated). However, there was no evidence resident's bathroom use needs were re-assessed, and related interventions developed and implemented.

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On 12/4/18 at 10:23 p.m., it was noted R4 tried to self-transfer from unlocked wheelchair to the toilet, was too weak to accomplish the task and fell to the floor. At the time of the fall R4 stated had hit head on the floor.

The IDT reviewed the fall on 12/6/18 (two days later). Documentation indicated the call light was on at the time of the fall, desired to be independent, had weakness, used wheelchair in room, had low bed with mat, continue to encourage call light use, hit head on the floor and ice was applied, care plan reviewed and revised. However, the toileting care plan lacked evidence any revisions had been made. The falls and safety care plan also lacked evidence new or revised interventions had been implemented.

On 12/15/18, R4 had been caught self-transferring to toilet three times and said the urgency to go was so strong and could not wait. The record lacked evidence of any new or revised interventions related to R4 self-transferring.

A fall risk data was collected on 1/9/19. The summary indicated R4 was at risk for falls, was fiercely independent and attempted to do as much for self as possible, used the call light to get help for toileting, and mostly continent of bowel and bladder. Physical and occupational therapy were requested for strengthening and mobility. Additionally noted was R4 had begun to attempt to self-transfer and continued to be weak. Plan was to have staff check frequently for any needs.

On 1/17/19, a nursing note indicated R4 had an unwitnessed fall. The falls/safety care plan up-dated on 1/17/19, indicated a fall occurred due

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to unsafe transfers. There were no additional interventions added to the care plan to correspond with the fall notation. On 1/22/19 at 11:24 p.m., a nurse progress indicated R4 had been exhibiting confusion and hallucinations related to family members in the room and mother in the bed. The nurse practitioner was notified and felt the confusion could be related to dementia and not a urinary tract infection. Later, a loud noise was heard and R4 was found on the roommates side of the room wedged between the wall and roommates night stand. R4 had a skin tear on left wrist, pain in both hips and left arm. The fall happened at 10:40 p.m. R4 left the facility by ambulance. R4 was admitted to the hospital with a left femoral fracture, per nursing note dated 1/23/19. R4 returned to the facility from the hospital on 1/23/19, at 7:10 p.m., per nursing documentation. The IDT reviewed this fall on 1/23/19. The IDT documentation indicated R4 had a history of falls, was having unusual behavior, was self-transferring. R4 sustained a left femoral fracture and was sent to the hospital but no surgery performed. R4 spent the night in the emergency room and returned to the facility the next day with pain medication. The documentation noted "comfort is the goal".

A temporary care plan was developed on 1/22/19, for alteration in mobility related to fracture from fall in room. The goal was for R4 to participate in mobility skills with assistance and regain increased independence; participate in activities of daily living (ADL), incisional area will heal without infection and will remain comfortable. The interventions developed were: assist with ADL, mobility and transfers; encourage to be as independent as possible; praise efforts; observe for changes in range of motion; keep physician

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and family notified; therapy as ordered' monitor incision site; implement safety measures as necessary. No specifics of the safety measures to be implemented were noted.

On 1/29/19, at 1:20 p.m. R4 was observed lying in a low bed. The nursing assistant (NA)-H was interview and stated R4 no longer tried to get up since hurting her hip.

Registered Nurse (RN)-E (also nurse manager) was interviewed on 1/30/19 at 10:30 a.m. and verified R4 had been admitted with a hip fracture and did have a fall injuring the other hip when R4 tried to get up on her own during the night,

NA-I was interviewed on 1/30/19 at 10: 45 a.m. NA-I verified she would check and change and re-position R4 every 2 hours which was standard protocol and had changed R4 about hour ago and would be back in to care for R4 in about and hour. NA-I verified R4 no longer used the toilet.

The Fall Risk Assessment (FSA) policy, revised 7/2016, indicated fall risk data was collected on admission, quarterly and after 3 consecutive falls. The assessor would evaluate and analyze the hazards and risks and assign a risk range of minimal, moderate or high risk. Additionally, the care plan would be updated to reflect interventions, and the interventions would be monitored for effectiveness and modified by IDT.

R3 had a significant change Minimum Data Set (MDS) comprehensive assessment completed 10/24/2018. The MDS, dated 10/24/18, indicated R3 had experienced 2 falls with injury since

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admission and 2 falls without injury since admission. The Care Area Assessment (CAA) summary, listed care areas that had triggered from the MDS for inclusion in the care plan. The MDS indicated R3 scored a 5 on a cognitive abilities test (BIMS) indicating significant cognitive decline. The CAA summary identified problem areas of: Cognition, communication, activity of daily living, urinary incontinence, and behavioral symptoms, falls and nutritional status. The worksheet also indicated possible contributing factors to increase the risk for falls of: cognitive impairment, depression, incontinence, anemia, and impaired balance during transitions.

The care plan for falls and safety, initially developed on 7/17/17, showed no up-dates during the months of September, October and November of 2018, and one update for December dated 12/31/18, to initiate a low bed and floor mat. A hand written notation on the care plan indicated a fall had occurred on 11/27/18, but lacked new interventions to correspond to the fall. Listed interventions included roam alert in place; monitor falls per protocol; maintain clutter free environment; observe for changes in gait; anticipate needs for safety; grip tape to bathroom floor.

The care plan for behavior/dementia had a goal dated 4/18/19, indicated R3 was at risk for challenging behaviors related to dementia and depression. R3 had a history of wandering, irritable, anxious, repetitive, restless, compulsive, confusion, verbal aggression, forgetfulness, and resistive behaviors. The goal was for R3 to respond to behavior approaches. The approaches listed were to: evaluate effectiveness of medications, administer medications, use calm

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firm approach, explain procedures, allow time for comprehension and response and offer reassurance and validation. Also to monitor for wandering and guide to specific destination. R3 received an antidepressant medication. The care plan lacked personalized interventions to address all the specific problem areas indicated. High risk for falls was not addressed on the behavior/dementia care plan.

Nursing progress note documentation in R3's medical record indicated:
- On 9/5/18, R3 was found on the floor at 3:15 p.m. with a large bowel movement (BM) on the floor.
- On 9/6/18, R3 was found on the floor in front of the bed at 2:45 p.m. The interdisciplinary team (IDT) meeting documentation, dated 9/6 /18 indicated R3 appeared to fall related to trying to pull pants down to use the toilet. R3 was independent with toileting and often refused care. The documentation indicated the care plan had been updated.
- On 9/12/18, R3 stood up, took one step and fell. No injuries were noted.
- On 9/30/18, R3 was found on the floor with BM in pad, on carpet and in bathroom. IDT documentation on 10/1/18, indicated no injuries from the falls, but did have a left knee abrasion from a previous fall. R3 was independent with ambulation and transfers, but can be unsteady at times and move at a fast pace. Staff assist as needed an as R3 will allow. R3 often refused care and staff were to re-approach to assist with cares and toileting. R3 had BM incontinence. Will add gripper strips to bathroom floor and additional support bars to toilet. A bowel and bladder evaluation (BBE) dated 10/18/18, indicated R3 had dementia, was continent of bowel,

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incontinent of bladder with one continent episode each shift. Was able to identify the need to toilet, was resistive to cares. The approach was to toilet per facility protocol and as needed to promote continence. However, there was no evidence the facility assessed causal factors related to toileting needs to develop individualized interventions.

- On 11/27/18, R3 was seen getting up from the wheelchair and starting to walk. A staff went to assist, R3 pulled away and fell. No injuries were noted, R3 was helped back into the wheelchair and monitored. The IDT documentation, dated 11/28/18, at 9:31 a.m., indicated R3 was receiving physical therapy (PT), had improved mobility, pain was managed medically, and wore a knee brace on right knee. Additionally, R3 could not remember to wait for assistance due to dementia. There was no evidence of root-cause analysis of contributing factors and the documentation did not address specific interventions initiated to reduce the risk for falls other than PT.
- On 12/2/18, at 8:12 a.m., a bruise was reported on R3's left hip and buttock down the side of thigh measuring 17 centimeters (cm). The medical doctor (MD) was notified and an X-ray taken. The X-ray results showed non-displaced pelvic fractures. The IDT met on 12/3/18, at 10:00 a.m. to discuss the bruising. The documentation indicated the following: R3 was getting PT, would refuse cares and ice packs; Due to cognitive impairment does not ask for assistance and was resistive; attempts to walk unattended; fracture may have been from fall on 11/27/18. R3 was placed on non-weight bearing on left leg. The record lacked evidence causal factors had been assessed by the facility to develop individualized interventions to reduce the risk for further falls.

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A progress note dated 12/3/18, at 9:36 p.m., indicated R3 continued to self-transfer and walk from bed to bathroom. R3 was instructed to use the call light for help. The documentation noted at 9:00 p.m. R3 was seen walking from bedroom to dining room with a walker. R3 was re-directed back to bedroom. R3 was offered juice.

A progress note dated, 12/18/18, at 3:30 p.m., R3 was found sitting on the floor by the bathroom door. R3 had a skin tear below the left knee but no other sources of injury. The IDT note dated 12/20/18, at 10:51 a.m., indicated R3 had a skin tear to left knee and bruising to buttocks after the fall on 12/18/18. The note indicated the care plan 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.

A progress note dated 12/29/18, at 8:41 p.m., indicated R3 was seen falling to the floor, but had no complaints of pain. On 12/30/18, at 9:35 p.m. it was noted the housekeeper heard a loud noise from R3's room and found R3 sitting on the floor with pants down. At 11:00 p.m. on 12/30/18, R3 was found on the floor by the bed lying on left hip and trying to get up. R3 explained he had transferred into the wheelchair to use the bathroom. R3 went back to bed after using the bathroom, but fell as he walked around the wheelchair to get into bed. The nurse was bringing in medication and hot tea for a cough and found R3 on the floor. Although R3 had short term memory loss and dementia, the note indicated R3 was encouraged to use the call light and staff would continue to monitor and check on R3 frequently throughout the night. The IDT met

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on 12/31/18, to review the three falls that occurred between 12/29/18 and 12/30/18. The documentation indicated R3 was unsafe to transfer or ambulate per self, but due to dementia did not remember to ask for assistance. R3 had a healing pelvic fracture from a previous fall and lower extremity edema that contributed to an unsteady gait. The IDT decided to implement a low bed and floor mat to minimize attempts of self-transfers. The staff were to increase monitoring of R3 in the great room. The record lacked evidence the IDT had reviewed or discussed interventions related to R3's need to use the bathroom.

A progress note, dated, 12/31/18, at 9:20 p.m., indicated R3 was found on bedside mat crawling to the bathroom. The note indicated R3 had been sitting in bed when checked 15 minutes prior. R3 said he lowered himself to the mat.

A progress note, dated 1/2/19, at 8:30 p.m., indicated R3 was found crawling from bed to bathroom at 9:30 p.m. on 1/1/19. IDT documentation from 1/2/19, at 2:54 p.m. indicated R3 had fallen on 12/31/18 and 1/2/18. R3 was crawling to the bathroom. R3 was encouraged to use the call light for assistance, but was very forgetful related to dementia. A low bed and floor mat were initiated.

A progress note, dated 1/6/19, at 10:15 p.m.,. indicated R3 was found lying on floor off the mat. R3 said he was crawling to the bathroom and fell asleep. Documentation on 1/5/19, at 19:16 p.m. indicated R3 was found on the floor mat sleeping. IDT met on 1/7/19, at 11:00 a.m. to discuss fall on 1/5/19. The documentation indicated, "current intervention is low bed with floor mat due to

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unsafe transfers, which was in place... Will continue current plan of care." The care plan did indicated the addition of a tilt back wheelchair, and attempt to keep in dining room as much as possible on 1/7/19.

A progress note, dated 1/8/19, at 5:20 a.m, indicated R3 was found on his knees and hands on the floor at the entrance to the bathroom. On 1/12/19, at 5:57 a.m. R3 was found lying next to the bed, resident had been with a staff prior to last rounds. IDT met on 1/9/19, at 11:00 a.m. to discuss fall on 1/8/19. It was noted R3 had a bruise on left side of back, was on blood thinners, was in low bed with mat but can self-transfer unsafely. Had a pelvis fracture from previous fall, and did not remember to ask for assistance with mobility. No further interventions were mentioned.

A progress note, dated 1/14/19, at 2:50 p.m., indicate R3 was found sitting on the floor in the bathroom and said he was trying to use the bathroom. The note indicated R3 appeared sleepy, tired and weak. IDT met on 1/14/19 at 12:00 p.m., to discuss the fall that occurred on 1/12/19. The documentation indicated R3 was found on the floor 20 minutes after a previous check, and had a low bed with mat in place as current intervention due to history of falls. Additionally, the note indicated R3 was impulsive and did not ask for assistance with mobility, required assistance with mobility, current interventions would be continued, and the care plan was reviewed and revised.

A quarterly bowel and bladder review was completed on 1/16/19. The document indicated the bowel and bladder management program was effective as evidenced by the goal effective and

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no skin breakdown. Additionally the document was blank for interventions implemented. The bowel and bladder care plan, reviewed on 1/18/19 had one hand-written update of a change from supervision to assistance with pericare (undated). The goal was for R3 to be clean dry and odor free. The interventions were to assist with pericare, encourage fluids, monitor BM's assist of 1 with toileting, toilet per facility protocol, re-approach calmly. The care plan lacked evidence the facility had developed individualized toileting interventions beyond facility protocol for toileting.

R3 was observed on 1/30/19, at 10:30 a.m. R3 was in a tilt back wheelchair with head rest, leg rests and pedals. R3 had a paid personal care attendant present. R3 was talkative and in pleasant mood, but could not be interviewed due 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 matt, frequent checks and anticipate needs. LPN-B said R3 had not fallen for a while now as R3 did not have strength to self-transfer as before. Additionally, staff tried to keep R3 in sight and put in bed when tired and R3 could be resistive with cares.

Nursing Assistant (NA)-C and NA-E were interviewed on 1/29/19, at 11:30 a.m. NA-C said the unit R3 resides on is staffed with 2 NA's for 12 residents. NA-C said she was able to get her

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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) COMPLETION DATE
F 689	Continued From page 18	F 689		

work completed and watch over the residents. NA-C said she tries to keep a close eye on R3 and offer to take to the bathroom even thought R3 could also say when he needed to go to the bathroom. NA-C verified R3 could be very resistive to cares and strike out. NA-E said they try to keep R3 in the dining room or where he could be seen. NA-E verified If R3 was left in his room alone, he might try to get up. NA-E thought the night shift also tried to keep R3 in sight in the reclining wheelchair and just do frequent checks when in the bedroom.

The unit nurse manger, registered nurse (RN)-B was interviewed on 12/29/19, at approximately 1:00 p.m. RN-B explained, R3 was walking independently initially and was trying to get up from the bed. R3 declined in mobility and would stand up but was not safe to walk independently. The IDT which included the physical therapist decided a low bed and mat would be a safer option for R3 than risking a fall from a standing position. RN-B said R3 was not safe independently transferring from the bed to a wheelchair. RN-B verified R3 did not know to ask for assistance due to cognitive decline and was not progressing in therapies. When asked about investigation additional interventions for R3 related to toileting or being resistive and impulsive. RN-B said she felt there were not many options for interventions. Concerning interventions related to R3's need for help with toileting, RN-B verified R3 was on a diuretic (a medicine to remove excess fluid from the body) that could cause an increased need for toileting. Additionally, R3 was resistive to help and would attempt to go by himself right after staff offered help. RN-B said staff were to check on the need to go to the toilet per normal protocol. RN-B

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	245460	A. BUILDING _____ B. WING _____	C 01/30/2019

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explained the usual protocol was before and after meals and as needed. During the night shift, the protocol was to check every 2 hours. RN-B said staff were to do "frequent checks" but did not give a specific time line for the frequency. RN-B verified R3 was a very active and independent person, but currently was not attempting to walk.

DON was interviewed on 1/30/19. at 1:36 p.m. and stated if a resident was restless or awake, the staff would bring them to a common area and offer food and fluids and keep an eye on them until they wanted to go back to bed. The DON said one to one interventions would be documented. Additionally, DON explained, before the fracture, R3 would go to his room independently and would get up shortly after staff had left the room. The DON verified a more thorough review of R3's falls needed to develop more specific interventions.

The policy, Fall Risk Assessment (FSA), revised 7/2016, indicated each resident was to receive adequate supervision and assistance devices to prevent accidents. Additionally, it was important for facility staff to ensure the safest environment possible for residents.

The policy, Comprehensive and Baseline Care Planning, revised November, 2017, indicated a comprehensive care plan would be developed within 7 days of the completion of the comprehensive person-centered assessment and reviewed throughout the resident's length of stay. The interdisciplinary team prepared the comprehensive individualized person-centered care plan.

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

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

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 01/30/2019

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2 000	Initial Comments	2 000		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
On 1/28/19, through 1/30/19, a surveyor of this Department's staff visited the above provider to investigate complaints #H5460053C, H5460052C, H5460051 and # H5460054C. As a result the following correction orders are issued.

When corrections are completed, please sign and

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2 000	Continued From page 1 date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge	2 000		

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2 000	Continued From page 2 receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate causal factors for falls, and failed to ensure adequate interventions were implemented to reduce falls, for 2 of 3 residents (R4 and R3) reviewed who both sustained falls resulting in actual harm. Findings include: 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.	2 830	Corrected	3/21/19

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2 830	Continued From page 3 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. The care plan, dated 10/24/18, indicated a problem for falls and safety related to: a history of falls, impaired mobility, debility, self transfers, cognitive deficits and medications. The goal was for R4 to have minimal falls or fall related injuries. Interventions listed were low bed with mat, anticipate toileting needs and assist as needed, observe for medication side effects, physical therapy (PT) for strengthening and endurance to improve mobility. The care plan had one hand-written comment dated 1/17/19, indicating, "Fall - unsafe with transfers". There were no additional interventions written on the care plan to correspond to the comment. Progress notes on 10/8/18, indicated R4 had a fall at 5:00 p.m. while trying to get up to the bathroom. R4 had not used the call light. R4 was found sitting in front of the recliner. R4 agreed to use the call light in the future. The record lacked evidence of any other immediate actions or interventions at the time of the fall. On 10/9/18, progress notes indicated R4 was found at 6:45 a.m. lying next to the bed and stated she was trying to go to the bathroom. The right leg appeared shorter than the left and the foot was turned in. A low bed with floor mat was initiated and was reminded to use the call light.	2 830		

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2 830	Continued From page 4 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. On 10/11/18, (two/three days post falls) the IDT met to review R4's falls. Documentation indicated R4 had post operative delirium following hip surgery. R4 was independent at home and not accustomed to needing to ask for help and believed she was still able to to to the bathroom independently. R4 was in a room near a nursing office. The plan was to make frequent checks and remind to use the call light. PT was consulted, a low bed was initiated, continue therapy to strengthening. The note indicated the care plan was reviewed and current. However, there was no indication toileting needs were evaluated at the time of the fall, even though R4's two falls on 10/8/18 and 10/9/18 were related to her needing to use the bathroom. A fall risk data collection was completed on 10/24/18. The data indicated R4 had a fall related fracture, was unsteady, used a diuretic (medicine to reduce fluid in the body). The record lacked an assessment of the data. A bowel and bladder evaluation (BBE) was competed on 10/28/18. The BBE indicated R4 was continent of bowel and bladder, and woke in the night to use the toilet. R4 was able to identify the need to toilet and was able to use the call light. The BBE had no written summary of findings or interventions indicated. The toileting care plan dated 10/31/18, indicated a goal to maintain level of continence. The interventions were to provide pericare after each incontinent episode, provide assistance with toileting, toilet per facility protocol, offer assist to the toiled at night if awake, administer medications and	2 830		

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2 830	Continued From page 5 observe for signs or symptoms of urinary tract infection. The toileting care plan made no reference to R4's risk for falls. On 11/19/18, at 10:29 a.m. documentation indicated R4 was found on the floor in a kneeling position with top half of body on the bed and knees on the floor mat. R4 had a laceration above the eye due to the fall. R4 stated a need to use the bathroom and could not wait for help. R4 had not put the call light on. At 8:26 p.m. documentation indicated R4 had been in bed all day with a headache rated a pain level of 8 out of 10. The record lacked indication any new or revised interventions had been initiated related to self toileting. The IDT reviewed the fall on 11/22/18 (three days post fall). The documentation indicated R4 was forgetful of limitations, tends to be "fiercely" independent, low hemoglobin, declined in therapy and was placed on hospice. Additionally noted was R2's feeling of not being able to wait for help. Interventions were unchanged with low bed and floor mat, frequent safety checks (no frequency parameter indicated). However, there was no evidence resident's bathroom use needs were re-assessed, and related interventions developed and implemented. On 12/4/18 at 10:23 p.m., it was noted R4 tried to self-transfer from unlocked wheelchair to the toilet, was too weak to accomplish the task and fell to the floor. At the time of the fall R4 stated had hit head on the floor. The IDT reviewed the fall on 12/6/18 (two days later). Documentation indicated the call light was on at the time of the fall, desired to be independent, had weakness, used wheelchair in	2 830		

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2 830	Continued From page 6	2 830		

room, had low bed with mat, continue to encourage call light use, hit head on the floor and ice was applied, care plan reviewed and revised. However, the toileting care plan lacked evidence any revisions had been made. The falls and safety care plan also lacked evidence new or revised interventions had been implemented.

On 12/15/18, R4 had been caught self-transferring to toilet three times and said the urgency to go was so strong and could not wait. The record lacked evidence of any new or revised interventions related to R4 self-transferring.

A fall risk data was collected on 1/9/19. The summary indicated R4 was at risk for falls, was fiercely independent and attempted to do as much for self as possible, used the call light to get help for toileting, and mostly continent of bowel and bladder. Physical and occupational therapy were requested for strengthening and mobility. Additionally noted was R4 had begun to attempt to self-transfer and continued to be weak. Plan was to have staff check frequently for any needs.

On 1/17/19, a nursing note indicated R4 had an unwitnessed fall. The falls/safety care plan up-dated on 1/17/19, indicated a fall occurred due to unsafe transfers. There were no additional interventions added to the care plan to correspond with the fall notation. On 1/22/19 at 11:24 p.m., a nurse progress indicated R4 had been exhibiting confusion and hallucinations related to family members in the room and mother in the bed. The nurse practitioner was notified and felt the confusion could be related to dementia and not a urinary tract infection. Later, a loud noise was heard and R4 was found on the roommates side of the room wedged between the

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2 830	Continued From page 7	2 830		

wall and roommates night stand. R4 had a skin tear on left wrist, pain in both hips and left arm. The fall happened at 10:40 p.m. R4 left the facility by ambulance. R4 was admitted to the hospital with a left femoral fracture, per nursing note dated 1/23/19. R4 returned to the facility from the hospital on 1/23/19, at 7:10 p.m., per nursing documentation. The IDT reviewed this fall on 1/23/19. The IDT documentation indicated R4 had a history of falls, was having unusual behavior, was self-transferring. R4 sustained a left femoral fracture and was sent to the hospital but no surgery performed. R4 spent the night in the emergency room and returned to the facility the next day with pain medication. The documentation noted "comfort is the goal".

A temporary care plan was developed on 1/22/19, for alteration in mobility related to fracture from fall in room. The goal was for R4 to participate in mobility skills with assistance and regain increased independence; participate in activities of daily living (ADL), incisional area will heal without infection and will remain comfortable. The interventions developed were: assist with ADL, mobility and transfers; encourage to be as independent as possible; praise efforts; observe for changes in range of motion; keep physician and family notified; therapy as ordered' monitor incision site; implement safety measures as necessary. No specifics of the safety measures to be implemented were noted.

On 1/29/19, at 1:20 p.m. R4 was observed lying in a low bed. The nursing assistant (NA)-H was interview and stated R4 no longer tried to get up since hurting her hip.

Registered Nurse (RN)-E (also nurse manager) was interviewed on 1/30/19 at 10:30 a.m. and

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2 830	Continued From page 8 verified R4 had been admitted with a hip fracture and did have a fall injuring the other hip when R4 tried to get up on her own during the night, NA-I was interviewed on 1/30/19 at 10: 45 a.m. NA-I verified she would check and change and re-position R4 every 2 hours which was standard protocol and had changed R4 about hour ago and would be back in to care for R4 in about and hour. NA-I verified R4 no longer used the toilet. The Fall Risk Assessment (FSA) policy, revised 7/2016, indicated fall risk data was collected on admission, quarterly and after 3 consecutive falls. The assessor would evaluate and analyze the hazards and risks and assign a risk range of minimal, moderate or high risk. Additionally, the care plan would be updated to reflect interventions, and the interventions would be monitored for effectiveness and modified by IDT. R3 had a significant change Minimum Data Set (MDS) comprehensive assessment completed 10/24/2018. The MDS, dated 10/24/18, indicated R3 had experienced 2 falls with injury since admission and 2 falls without injury since admission. The Care Area Assessment (CAA) summary, listed care areas that had triggered from the MDS for inclusion in the care plan. The MDS indicated R3 scored a 5 on a cognitive abilities test (BIMS) indicating significant cognitive decline. The CAA summary identified problem areas of: Cognition, communication, activity of daily living, urinary incontinence, and behavioral symptoms, falls and nutritional status. The worksheet also indicated possible contributing factors to increase the risk for falls of: cognitive impairment, depression, incontinence, anemia,	2 830		

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2 830	Continued From page 9 and impaired balance during transitions. The care plan for falls and safety, initially developed on 7/17/17, showed no up-dates during the months of September, October and November of 2018, and one update for December dated 12/31/18, to initiate a low bed and floor mat. A hand written notation on the care plan indicated a fall had occurred on 11/27/18, but lacked new interventions to correspond to the fall. Listed interventions included roam alert in place; monitor falls per protocol; maintain clutter free environment; observe for changes in gait; anticipate needs for safety; grip tape to bathroom floor. The care plan for behavior/dementia had a goal dated 4/18/19, indicated R3 was at risk for challenging behaviors related to dementia and depression. R3 had a history of wandering, irritable, anxious, repetitive, restless, compulsive, confusion, verbal aggression, forgetfulness, and resistive behaviors. The goal was for R3 to respond to behavior approaches. The approaches listed were to: evaluate effectiveness of medications, administer medications, use calm firm approach, explain procedures, allow time for comprehension and response and offer reassurance and validation. Also to monitor for wandering and guide to specific destination. R3 received an antidepressant medication. The care plan lacked personalized interventions to address all the specific problem areas indicated. High risk for falls was not addressed on the behavior/dementia care plan. Nursing progress note documentation in R3's medical record indicated: - On 9/5/18, R3 was found on the floor at 3:15 p.m. with a large bowel movement (BM) on the	2 830		

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2 830	Continued From page 10 floor. - On 9/6/18, R3 was found on the floor in front of the bed at 2:45 p.m. The interdisciplinary team (IDT) meeting documentation, dated 9/6 /18 indicated R3 appeared to fall related to trying to pull pants down to use the toilet. R3 was independent with toileting and often refused care. The documentation indicated the care plan had been updated. - On 9/12/18, R3 stood up, took one step and fell. No injuries were noted. - On 9/30/18, R3 was found on the floor with BM in pad, on carpet and in bathroom. IDT documentation on 10/1/18, indicated no injuries from the falls, but did have a left knee abrasion from a previous fall. R3 was independent with ambulation and transfers, but can be unsteady at times and move at a fast pace. Staff assist as needed an as R3 will allow. R3 often refused care and staff were to re-approach to assist with cares and toileting. R3 had BM incontinence. Will add gripper strips to bathroom floor and additional support bars to toilet. A bowel and bladder evaluation (BBE) dated 10/18/18, indicated R3 had dementia, was continent of bowel, incontinent of bladder with one continent episode each shift. Was able to identify the need to toilet, was resistive to cares. The approach was to toilet per facility protocol and as needed to promote continence. However, there was no evidence the facility assessed causal factors related to toileting needs to develop individualized interventions. - On 11/27/18, R3 was seen getting up from the wheelchair and starting to walk. A staff went to assist, R3 pulled away and fell. No injuries were noted, R3 was helped back into the wheelchair and monitored. The IDT documentation, dated 11/28/18, at 9:31 a.m., indicated R3 was receiving physical therapy (PT), had improved	2 830		

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2 830	Continued From page 11	2 830		

mobility, pain was managed medically, and wore a knee brace on right knee. Additionally, R3 could not remember to wait for assistance due to dementia. There was no evidence of root-cause analysis of contributing factors and the documentation did not address specific interventions initiated to reduce the risk for falls other than PT.
- On 12/2/18, at 8:12 a.m., a bruise was reported on R3's left hip and buttock down the side of thigh measuring 17 centimeters (cm). The medical doctor (MD) was notified and an X-ray taken. The X-ray results showed non-displaced pelvic fractures. The IDT met on 12/3/18, at 10:00 a.m. to discuss the bruising. The documentation indicated the following: R3 was getting PT, would refuse cares and ice packs; Due to cognitive impairment does not ask for assistance and was resistive; attempts to walk unattended; fracture may have been from fall on 11/27/18. R3 was placed on non-weight bearing on left leg. The record lacked evidence causal factors had been assessed by the facility to develop individualized interventions to reduce the risk for further falls.

A progress note dated 12/3/18, at 9:36 p.m., indicated R3 continued to self-transfer and walk from bed to bathroom. R3 was instructed to use the call light for help. The documentation noted at 9:00 p.m. R3 was seen walking from bedroom to dining room with a walker. R3 was re-directed back to bedroom. R3 was offered juice.

A progress note dated, 12/18/18, at 3:30 p.m., R3 was found sitting on the floor by the bathroom door. R3 had a skin tear below the left knee but no other sources of injury. The IDT note dated 12/20/18, at 10:51 a.m., indicated R3 had a skin tear to left knee and bruising to buttocks after the fall on 12/18/18. The note indicated the care plan

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2 830	Continued From page 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.

A progress note dated 12/29/18, at 8:41 p.m., indicated R3 was seen falling to the floor, but had no complaints of pain. On 12/30/18, at 9:35 p.m. it was noted the housekeeper heard a loud noise from R3's room and found R3 sitting on the floor with pants down. At 11:00 p.m. on 12/30/18, R3 was found on the floor by the bed lying on left hip and trying to get up. R3 explained he had transferred into the wheelchair to use the bathroom. R3 went back to bed after using the bathroom, but fell as he walked around the wheelchair to get into bed. The nurse was bringing in medication and hot tea for a cough and found R3 on the floor. Although R3 had short term memory loss and dementia, the note indicated R3 was encouraged to use the call light and staff would continue to monitor and check on R3 frequently throughout the night. The IDT met on 12/31/18, to review the three falls that occurred between 12/29/18 and 12/30/18. The documentation indicated R3 was unsafe to transfer or ambulate per self, but due to dementia did not remember to ask for assistance. R3 had a healing pelvic fracture from a previous fall and lower extremity edema that contributed to an unsteady gait. The IDT decided to implement a low bed and floor mat to minimize attempts of self-transfers. The staff were to increase monitoring of R3 in the great room. The record lacked evidence the IDT had reviewed or discussed interventions related to R3's need to use the bathroom.

A progress note, dated, 12/31/18, at 9:20 p.m., indicated R3 was found on bedside mat crawling

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2 830	Continued From page 13 to the bathroom. The note indicated R3 had been sitting in bed when checked 15 minutes prior. R3 said he lowered himself to the mat. A progress note, dated 1/2/19, at 8:30 p.m., indicated R3 was found crawling from bed to bathroom at 9:30 p.m. on 1/1/19. IDT documentation from 1/2/19, at 2:54 p.m. indicated R3 had fallen on 12/31/18 and 1/2/18. R3 was crawling to the bathroom. R3 was encouraged to use the call light for assistance, but was very forgetful related to dementia. A low bed and floor mat were initiated. A progress note, dated 1/6/19, at 10:15 p.m.,. indicated R3 was found lying on floor off the mat. R3 said he was crawling to the bathroom and fell asleep. Documentation on 1/5/19, at 19:16 p.m. indicated R3 was found on the floor mat sleeping. IDT met on 1/7/19, at 11:00 a.m. to discuss fall on 1/5/19. The documentation indicated, "current intervention is low bed with floor mat due to unsafe transfers, which was in place... Will continue current plan of care." The care plan did indicated the addition of a tilt back wheelchair, and attempt to keep in dining room as much as possible on 1/7/19. A progress note, dated 1/8/19, at 5:20 a.m, indicated R3 was found on his knees and hands on the floor at the entrance to the bathroom. On 1/12/19, at 5:57 a.m. R3 was found lying next to the bed, resident had been with a staff prior to last rounds. IDT met on 1/9/19, at 11:00 a.m. to discuss fall on 1/8/19. It was noted R3 had a bruise on left side of back, was on blood thinners, was in low bed with mat but can self-transfer unsafely. Had a pelvis fracture from previous fall, and did not remember to ask for assistance with mobility. No further interventions were mentioned.	2 830		

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2 830	Continued From page 14 A progress note, dated 1/14/19, at 2:50 p.m., indicate R3 was found sitting on the floor in the bathroom and said he was trying to use the bathroom. The note indicated R3 appeared sleepy, tired and weak. IDT met on 1/14/19 at 12:00 p.m., to discuss the fall that occurred on 1/12/19. The documentation indicated R3 was found on the floor 20 minutes after a previous check, and had a low bed with mat in place as current intervention due to history of falls. Additionally, the note indicated R3 was impulsive and did not ask for assistance with mobility, required assistance with mobility, current interventions would be continued, and the care plan was reviewed and revised. A quarterly bowel and bladder review was completed on 1/16/19. The document indicated the bowel and bladder management program was effective as evidenced by the goal effective and no skin breakdown. Additionally the document was blank for interventions implemented. The bowel and bladder care plan, reviewed on 1/18/19 had one hand-written update of a change from supervision to assistance with pericare (undated). The goal was for R3 to be clean dry and odor free. The interventions were to assist with pericare, encourage fluids, monitor BM's assist of 1 with toileting, toilet per facility protocol, re-approach calmly. The care plan lacked evidence the facility had developed individualized toileting interventions beyond facility protocol for toileting. R3 was observed on 1/30/19, at 10:30 a.m. R3 was in a tilt back wheelchair with head rest, leg rests and pedals. R3 had a paid personal care attendant present. R3 was talkative and in pleasant mood, but could not be interviewed due	2 830		

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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 matt, frequent checks and anticipate needs. LPN-B said R3 had not fallen for a while now as R3 did not have strength to self-transfer as before. Additionally, staff tried to keep R3 in sight and put in bed when tired and R3 could be resistive with cares.

Nursing Assistant (NA)-C and NA-E were interviewed on 1/29/19, at 11:30 a.m. NA-C said the unit R3 resides on is staffed with 2 NA's for 12 residents. NA-C said she was able to get her work completed and watch over the residents. NA-C said she tries to keep a close eye on R3 and offer to take to the bathroom even thought R3 could also say when he needed to go to the bathroom. NA-C verified R3 could be very resistive to cares and strike out. NA-E said they try to keep R3 in the dining room or where he could be seen. NA-E verified If R3 was left in his room alone, he might try to get up. NA-E thought the night shift also tried to keep R3 in sight in the reclining wheelchair and just do frequent checks when in the bedroom.

The unit nurse manger, registered nurse (RN)-B was interviewed on 12/29/19, at approximately 1:00 p.m. RN-B explained, R3 was walking independently initially and was trying to get up from the bed. R3 declined in mobility and would stand up but was not safe to walk independently. The IDT which included the physical therapist

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2 830	Continued From page 16 decided a low bed and mat would be a safer option for R3 than risking a fall from a standing position. RN-B said R3 was not safe independently transferring from the bed to a wheelchair. RN-B verified R3 did not know to ask for assistance due to cognitive decline and was not progressing in therapies. When asked about investigation additional interventions for R3 related to toileting or being resistive and impulsive. RN-B said she felt there were not many options for interventions. Concerning interventions related to R3's need for help with toileting, RN-B verified R3 was on a diuretic (a medicine to remove excess fluid from the body) that could cause an increased need for toileting. Additionally, R3 was resistive to help and would attempt to go by himself right after staff offered help. RN-B said staff were to check on the need to go to the toilet per normal protocol. RN-B explained the usual protocol was before and after meals and as needed. During the night shift, the protocol was to check every 2 hours. RN-B said staff were to do "frequent checks" but did not give a specific time line for the frequency. RN-B verified R3 was a very active and independent person, but currently was not attempting to walk. DON was interviewed on 1/30/19. at 1:36 p.m. and stated if a resident was restless or awake, the staff would bring them to a common area and offer food and fluids and keep an eye on them until they wanted to go back to bed. The DON said one to one interventions would be documented. Additionally, DON explained, before the fracture, R3 would go to his room independently and would get up shortly after staff had left the room. The DON verified a more thorough review of R3's falls needed to develop more specific interventions.	2 830		

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2 830	Continued From page 17 The policy, Fall Risk Assessment (FSA), revised 7/2016, indicated each resident was to receive adequate supervision and assistance devices to prevent accidents. Additionally, it was important for facility staff to ensure the safest environment possible for residents. The policy, Comprehensive and Baseline Care Planning, revised November, 2017, indicated a comprehensive care plan would be developed within 7 days of the completion of the comprehensive person-centered assessment and reviewed throughout the resident's length of stay. The interdisciplinary team prepared the comprehensive individualized person-centered care plan. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to the assessing the causal factors related to falls, and revise the care plans as needed. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 830		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a	21995		3/21/19

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21995	Continued From page 18 mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements 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). Findings include: A grievance report dated 1/21/19, indicated R1 had alleged being sexually assaulted after bedtime on 1/19/19. R1's family member (FM)-A was present during the reporting of the allegation, per the grievance report. The report was dated at the top of the page as received on 1/22/19, and signed by the director of nurses (DON) as the responsible individual for reviewing the grievance. Corrective action taken indicated an investigation started on 1/22/19, and a Vulnerable Adult (VA) report was submitted to the SA on 1/23/19 (2 days after later). The administrator was interviewed on 1/29/19, at 9:15 a.m. The administrator verified allegation should have been reported immediately to the administrator and the SA. On 1/30/19, at 3:00 p.m. the DON verified the house supervisor had placed the grievance report under the office door where it was discovered by the DON on 1/22/19. The DON verified the grievance form lacked direction for staff to	21995	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. It is the policy of Jones Harrison to assess and evaluate causal factors for falls to ensure adequate interventions are implemented to reduce all falls, including falls with actual harm. The resident (s) cited have been evaluated and assessed to minimize risk for falls prior to, but upon notification, the residents were re-assessed and re-evaluated for causal factors for their falls and their plan of care was updated to include specific interventions to reduce further falls. The Bowel and Bladder Evaluation and Falls Risk Data Collection policies have been reviewed and revised. The IDT process has been enhanced, including the reporting process and individualized interventions to ensure that all residents have appropriate interventions implemented after each fall to minimize risk for further falls. The Director of Nursing is responsible for ensuring this process is sustained.	

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21995	Continued From page 19 determine if the allegation was concerning possible abuse and did not give direction on how or what to report. The grievance form indicated, "Please submit this form to the assistant administrator/grievance official." There was no indication on proper timelines for reporting The policy, Resident Grievances, revised 11/2016, indicated all alleged violations involving neglect, abuse and or misappropriation of resident property would be reported immediately according to facility policy and as required by law. The policy lacked specific timelines for reporting. However, the policy Investigation and Report of Suspected Abuse/Neglect, revised January, 2019, indicated allegations related to abuse would be reported within 2 hours if the allegation of abuse resulted in serious bodily injury. If the allegation of abuse did not result in serious bodily injury, the facility had 24 hours to make a report to the SA. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on the facility's abuse and neglect policies and procedures to ensure staff immediately report any allegation of resident abuse. The director of nursing or designee could randomly audit reports to ensure compliance. The results of the audits could be reported to the facility's quality assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995	The nursing staff and IDT members will receive education under the direction of the Director of Nursing; reviewing assessment and evaluation of causal factors for falls, including individualized interventions to reduce falls at Jones Harrison. Audits will be completed for residents who have fallen daily, for four weeks and then weekly for three months and then as needed with results reported to the QAPI committee meeting for further review and recommendations. The Director of Nursing will oversee the audit process. The facility will be in compliance by 03/21/2019.	