



Protecting, Maintaining and Improving the Health of All Minnesotans

August 21, 2023

Licensee
Jones Harrison Assisted Living
3700 Cedar Lake Avenue
Minneapolis, MN 55416

RE: Project Number(s) SL30734015

Dear Licensee:

On August 17, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 26, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 14, 2023

Licensee

Jones Harrison Assisted Living
3700 Cedar Lake Avenue
Minneapolis, MN 55416

RE: Project Number(s) SL30734015

Dear Licensee:

On June 14, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 26, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 26, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on April 26, 2023, found not corrected at the time of the June 14, 2023, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on June 14, 2023, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/14/2023
NAME OF PROVIDER OR SUPPLIER JONES HARRISON ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30734015-0 On June 13, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 26, 2023. At the time of the survey, there were 49 residents receiving services under the Assisted Living Facility with Dementia Care license. As a result of the revisit, the licensee remains in non-compliance and will be reissued 2310 for Appropriate Care and Services related to Bed Rails.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 250}	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}			

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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action required.	{0 250}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 500} SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies	{0 500}			

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{0 500}	Continued From page 3 on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: No further action required.	{0 500}			

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{0 500}	Continued From page 4	{0 500}			
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 510}			
{0 620} SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: No further action required.	{0 620}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	{0 630}			

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{0 630}	Continued From page 5 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action required.	{0 630}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	{0 780}			

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{0 780}	Continued From page 6 operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	{0 810}			

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{0 810}	Continued From page 7 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;	{0 940}			

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{0 940}	Continued From page 8 (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required.	{0 940}			
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	{0 950}			

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{0 950}	Continued From page 9 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: No further action required.	{0 950}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	{01060}			

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{01060}	Continued From page 10 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01060}	Continued From page 11	{01060}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action required.	{01290}			
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by:	{01460}			

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{01460}	Continued From page 12 No further action required.	{01460}			
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}			
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed	{01820}			

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{01820}	Continued From page 13 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: No further action required.	{01820}			
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}			
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action required.	{01970}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment	{02040}			

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{02040}	Continued From page 14 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}			
{02110} SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic	{02110}			

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{02110}	Continued From page 15 medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: No further action required.	{02110}			
{02310} SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for five of eight residents (R3, R4, R6, R10, R11) who utilized consumer bed rails. This resulted in reissuance of the correction order previously issued on April 24,	{02310}			

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{02310}	Continued From page 16 2023, at approximately 5:15 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3 was admitted to the licensee on September 17, 2018. R3's service plan signed on August 16, 2021, indicated they received services for linen changes, safety checks, and showers. R4 R4 was admitted to the licensee on May 4, 2021. R4's service plan signed February 19, 2023, indicated they received services for bathing, activities of daily living (ADLs), and medication management. R6 R6 was admitted to the licensee on July 14, 2015. R6's service plan signed January 18, 2023, indicated they received services for housekeeping and behavior management. R10 R10 was admitted to the licensee on September 15, 2011. R10's services plan signed on January 23, 2023, indicated they received services for bathing and housekeeping. R11	{02310}			

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{02310}	Continued From page 17 R11 was admitted to the licensee on April 19, 2022. R11's service plan signed on February 15, 2023, indicated they received services for bathing, dressing, grooming, and medication management. On June 13, 2023, the licensee provided the surveyor with bed rail assessments, measurements or manufacturer instructions, and risk versus benefits forms for R3, R4, R7, R8 and R9. The licensee provided a bed rail assessment and risk versus benefits form for R6, but no manufacturer instructions. The licensee provided a bed rail assessment, manufacturer's instructions, and risk versus benefits form for R11 but were completed and signed during the revisit survey on June 13, 2023. On June 13, 2023, at 9:35 a.m., assisted living director (ALD)-D stated she would begin gathering documentation but did not have a formal plan of correction to provide to the surveyor. Interim director of nursing (DON)-A from the previous survey no longer worked for the licensee and interim DON-I was hired. On June 13, 2023, at 11:20 a.m., DON-I stated R6 still had their same consumer bed rail identified during the initial survey and immediate order issued on April 24, 2023, and remained on the bed presently. DON-I stated they were trying to find a mesh sleeve which would fit over R6's bed rail to help make it safer. Surveyor questioned how the licensee could determine if it was safe and compatible with the bed rail if they did not know who the manufacturer was. DON-I stated they did not know but were hoping to make	{02310}			

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{02310}	Continued From page 18 it safer for R6 until it could be figured out. They were having their maintenance staff look at R6's bed today, June 13, 2023, to see if a Halo (style of consumer bed rail/grab bar) would be safe to attach to the bed and replace R6's current bed rail. On June 13, 2023, at 11:24 a.m., regional registered nurse (RN)-J stated R6 still had the same bed rail on their bed as was identified during the immediate order issued on April 24, 2023. R6 was open to safety checks and had been stuffing a pillow between the bed rail and themselves to prevent R6 from sliding between it and the bed. R6 was open to a new bed rail so long as they had one as it helped R6 maintain independence. RN-J stated they were looking into getting R6 a Halo and their maintenance director was going to look at R6's bed today, June 13, 2023. RN-J stated they would try and find documentation of the challenges they were having with R6. On June 13, 2023, at 12:09 p.m., the surveyor observed RN-J trying to find a manufacturer name on R6's bed rail which was a white upside-down U shape. The bed rail pulled out without resistance and was not anchored to the bed in any way. RN-J stated they found the name of the manufacturer and would search for the manual online. RN-J stated there was nothing holding the bed rail in place. On June 13, 2023, at 12:12 p.m., R6 stated they had the same bed rail in place for approximately eight years when they were admitted to the facility. It was provided by the facility but R6 was responsible to pay for it. R6 stated no one had ever assessed or looked at the bed rail until DON-A did approximately one month ago. R6	{02310}			

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{02310}	Continued From page 19 stated they were using a pillow to put between themselves and the bed rail, so they didn't roll toward it. R6 stated their neighbor, R10, had a bed rail as well. On June 13, 2023, at 12:17 p.m., the surveyor observed R10's bed rail which was a black upside-down U-shape with a black mesh sleeve over it. Surveyor pulled on the bed rail, and it was firmly attached to the box spring. R10 stated they have had a bed rail since they moved into the facility over 10 years ago. R10 stated no one had ever come to assess or check to make sure it was installed correctly. On June 13, 2023, at 12:40 p.m., DON-I provided the installation manual for R6's bed rail and were in the process of making sure it was installed correctly. DON-I stated they were not aware R10 had a bed rail until the surveyor brought it to their attention today, June 13, 2023. On June 13, 2023, at 1:03 p.m., RN-J stated they were trying to get information and answers from DON-A but since they were no longer employed by the licensee, they weren't helpful in getting answers. On June 13, 2023, at 1:25 p.m., DON-I stated R11 had returned to the facility on May 18, 2023, after a stay at a transitional care unit (TCU). DON-A had uploaded bed rail manufacturer instructions to PointClickCare (charting and medical record software) for R11 on May 19, 2023, but had not performed an assessment, obtain a signed risk versus benefits form, or documented proper installation per manufacturer instructions. DON-I stated they completed R11's bed rail assessment, manufacturer installation instructions, and risk versus benefits form today,	{02310}			

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{02310}	Continued From page 20 June 13, 2023, as they were not aware of the bed rail. DON-I and RN-J acknowledged the risk versus benefits forms signed on April 24, 2023, for R3, R4 and R6 were not valid since they were signed prior to completed bed rail assessments on May 1, 2023, and/or before the bed rails were assessed for proper installation per the manufacturer instructions. RN-J stated they thought the correction process had been completed by DON-A prior to their departure, but it became clear it wasn't the case. RN-J stated a complete audit of the facility was required to check for any further missed bed rails and would conduct the audit immediately. DON-I and RN-J stated they would review DON-A's work to ensure documentation was completed properly. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether	{02310}			

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{02310}	Continued From page 21 that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rails/Assist Bars policy dated October 2022, indicated, "All residents of [Licensee] will be assessed for appropriateness of side rail use, family will be informed of the risk and benefits associated with side rail risk." Further, "Upon admission and annually or the implementation of a new device, the resident will be assessed for physical devices. The	{02310}			

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{02310}	Continued From page 22 assessment will be reviewed quarterly." No further information provided.	{02310}			
{03000} SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	{03000}			

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{03000}	Continued From page 23 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: No further action required.	{03000}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 16, 2023

Licensee

Jones Harrison Assisted Living
3700 Cedar Lake Avenue
Minneapolis, MN 55416

RE: Project Number(s) SL30734015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

The total amount you are assessed is \$3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER JONES HARRISON ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30734015-0 On April 24, through April 26, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 44 residents; all of whom received services under the provider's Assisted Living with Dementia Care license. On April 24, 2023, an immediate order was issued for 2310. The immediacy was not removed prior to the time of exit on April 26, 2023.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 24, 2023, at 10:15 a.m., assisted living director (ALD)-D	0 250		

Minnesota Department of Health

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0 250	Continued From page 3 and director of nursing (DON)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page Seven was electronically signed by Authorized Agent/ALD-D on March 1, 2023. The licensee had an Assisted Living with Dementia Care license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - staff orientation and training; - infection control practices; - nursing assessments; - contract content; - appropriate cares and services; - background checks; - abuse prevention and Minnesota Adult Abuse Reporting Center (MAARC) notification; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On April 26, 2023, at 1:00 p.m., ALD-D confirmed the licensee provided Assisted Living with Dementia Care services but failed to develop and implement corresponding policies and	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 procedures, as required. As a result of this survey, the following orders were issued 0250, 0480, 0500, 0510, 0620, 0630, 0780, 0810, 0940, 0950, 0970, 1060, 1290, 1460, 1620, 1820, 1880, 1970, 2040, 2110, 2310, 3000 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 480		

Minnesota Department of Health

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0 480	Continued From page 7 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated April 25, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the	0 500			

Minnesota Department of Health

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0 500	Continued From page 8 assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 24, 2023, at 8:11 a.m., the surveyor emailed the licensee that an onsite assisted living	0 500			

Minnesota Department of Health

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0 500	Continued From page 9 facility with dementia care survey would be initiated on April 24, 2023, at approximately 10:00 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey process: -orientation and training. On April 26, 2023, at 11:00 a.m., surveyor requested employee orientation and training policies and procedures from assisted living director (ALD)-D. On April 26, 2023, at 3:07 p.m., the survey was exited via email to ALD-D and director of nursing (DON)-A. On April 28, 2023, at 4:56 p.m., ALD-D sent policies via email, over 48 hours after the survey exit. The email included a Microsoft Word document file named, "Orientation Policy," but when opened was a Documentation of Medication, Treatment and Therapy Management Services policy. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 10 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 25, 2023, at 8:02 a.m., the surveyor observed ULP-B enter R2's room without performing hand hygiene. ULP-B donned clean gloves and assisted R2 out of bed and into a wheelchair. ULP-B transferred R2 onto the toilet and assisted with washing and dressing the top half of R2. ULP-B then provided peri care and finished dressing the bottom half of R2. Without	0 510			

Minnesota Department of Health

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0 510	Continued From page 11 removing gloves or performing hand hygiene, ULP-B transferred R2 into the wheelchair and placed toothpaste on a toothbrush and assisted R2 with oral cares. ULP-B then removed gloves and performed hand hygiene and escorted R2 out of the bathroom and completed blood glucose monitoring for R2. ULP-B removed gloves and without performing hand hygiene made R2's bed and escorted R2 to the dining room where they performed hand hygiene. On April 25, 2023, at 8:35 a.m., ULP-B stated they were trained to, "wash our hands after we touch anything, and you should change your gloves after you touch anything soiled and wash your hands." On April 26, 2023, at 9:23 a.m., director of nursing (DON)-A stated, "Staff are trained initially at orientation by the education nurse at the nursing home, I don't do any of that training." The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensees Hand Washing policy dated November 2022 read, "Hand-washing, which is the single most effective way of controlling the spread of infection will be performed by staff routinely and thoroughly to protect residents from the spread of infection. When Hands Should be Washed. Hand washing shall be performed between resident cares and whenever direct physical contact with a resident	0 510			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER JONES HARRISON ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
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0 510	Continued From page 12 takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a resident b. If moving from a contaminated-body site to a clean-body site during resident care c. After contact with environmental surfaces or equipment in the immediate vicinity of the resident d. After removing gloves or gown e. Before eating and after using a restroom." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of five residents (R7). The licensee was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Center (MAARC). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 620		

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0 620	Continued From page 13 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R7's diagnoses included hypothyroidism, major depressive disorder, urinary tract infection, and unspecified pain. R7's service plan dated February 1, 2023, indicated R7 received services for bathing, dressing, grooming, transfers, mobility, toileting, medication administration, and housekeeping. R7's progress note dated April 11, 2023, at 9:48 a.m., indicated a late entry was made for R7's suspected fall the previous night. The note indicated the fall was unwitnessed and R7 was transferred to the hospital that morning due to severe pain. R7's progress note dated April 17, 2023, at 3:57 p.m., indicated R7 had returned to the community from the hospital and was enrolled with hospice. On April 26, 2023, at 9:21 a.m., the surveyor requested to review an incident report or MAARC report related to R7's fall. Director of nursing (DON)-A located one progress note dated April 11, 2023, which indicated R7 had a sustained a fall that was not witnessed. No incident report, fall follow up report, or MAARC report was located or provided to the surveyor, and DON-A stated, "I thought the MAARC report is for abuse, not a fall, and we didn't get the info from the hospital that	0 620			

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0 620	Continued From page 14 there was a hip fracture until the next day, so we never reported that. We never report a basic fall with injury." On April 26, 2023, at 11:30 a.m., DON-A filled a MAARC report for R7 for the above listed incident. The licensee's Abuse, Neglect, Mistreatment, Misappropriation of Resident Property policy dated, June 5, 2019, read, "Any staff person whom [sic] witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to the administrator/DON and that person will complete an incident report. a. if the incident appears to be suspected abuse, neglect or financial exploitation, The Director of Nursing (DON) or designee will immediately make a report no more than 2 hours after receiving notification. a. "Immediately" means as soon as possible from the time the Director of Nursing/Designee received initial knowledge that the incident occurred. b. If it is unclear based whether maltreatment has occurred, an investigation into the incident will begin immediately. c. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to the CEP. d. If it appears that a crime may have been committed, the Director of Nursing/ Designee will immediately contact the police if the witness has not already done so." Additionally, the licensee's Abuse, Neglect, Mistreatment, Misappropriation of Resident Property policy dated, June 5, 2019, read, "The Nursing Home Administrator/Director of Nursing	0 620			

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0 620	Continued From page 15 or designee will report abuse to the state agency per State and Federal requirements as stated in the final paragraphs of this policy. Other definitions of abuse: 12. Injuries of unknown origin: -The source of the injury was not observed by any person or the source of the injury could not be explained by the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have completed an individual abuse prevention plan (IAPP) with identified vulnerabilities and interventions for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a	0 630		

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0 630	Continued From page 16 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, and hyperlipidemia (high cholesterol). R1's service plan dated January 27, 2023, indicated R1 received services for bathing, cueing with dressing, cueing with grooming, medication administration, escorts to meals, standby assist with toileting, and housekeeping. R1's record contained an Individual Abuse Prevention Assessment and Plan dated December 5, 2022. The assessment identified areas of vulnerability, however, lacked interventions for abuse prevention and assessment of the following: -susceptibility to abuse others; -susceptibility to abuse self; -susceptibility to be abused by others; and -statements of specific measure to be taken to minimize the risk of abuse. R2 R2's diagnoses included unspecified dementia without behavioral disturbances, type 2 diabetes mellitus, hyperlipidemia, anxiety disorder, and gastro-esophageal reflux disease.	0 630			

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0 630	Continued From page 17 R2's service plan dated February 2, 2023, indicated R2 received services for bathing, dressing, grooming, escorts, toileting, medication administration, and housekeeping. R2's record contained an Individual Abuse Prevention Assessment and Plan dated December 29, 2022. The assessment identified areas of vulnerability, however, lacked interventions for abuse prevention and assessment of the following: -susceptibility to abuse others; -susceptibility to abuse self; -susceptibility to be abused by others; and -statements of specific measure to be taken to minimize the risk of abuse. R3 R3's diagnoses included cervicalgia, mild cognitive impairment, muscle weakness, anemia, and shortness of breath. R3's service plan dated January 2, 2023, indicated R3 received services for bathing and housekeeping. R3's record contained an Individual Abuse Prevention Assessment and Plan dated October 21, 2020. The assessment identified areas of vulnerability, however, lacked interventions for abuse prevention and assessment of the following: -susceptibility to abuse others; -susceptibility to abuse self; -susceptibility to be abused by others; and -statements of specific measure to be taken to minimize the risk of abuse. R4 R4's diagnoses included sepsis, abdominal pain,	0 630			

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0 630	Continued From page 18 and hyperlipidemia. R4's service plan dated January 2, 2023, indicated R4 received services for bathing and housekeeping. R4's record contained an Individual Abuse Prevention Assessment and Plan dated January 2, 2023. The assessment identified areas of vulnerability, however, lacked interventions for abuse prevention and assessment of the following: -susceptibility to abuse others; -susceptibility to abuse self; -susceptibility to be abused by others; and -statements of specific measure to be taken to minimize the risk of abuse. On April 26, 2023, at 9:25 a.m., director of nursing (DON)-A stated, "I don't think Point Click Care (a computer charting software system) has that in their system with how they set it up, so we don't have that IAPP with the required content for anyone, but I will look at it and see what we can do going forward." The licensee's Individual Abuse Prevention Plans policy dated November 2022, indicated an IAPP is developed for each assisted living resident and would include a review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults, and the resident's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 630			

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0 780	Continued From page 19	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in all sleeping rooms and failed to provide smoke alarms outside and in the immediate vicinity of all sleeping. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 20 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 25, 2023, at approximately 10:00 a.m. with the Director of Facilities (DF)- H, it was observed that in all assisted living resident units on the fourth floor, the required smoke alarms were not provided in any of the sleeping rooms. It was also observed that one smoke alarm was installed outside of the sleeping room, but it did not work when tested. During the interview, DF-H confirmed these deficient conditions consistent in every resident unit on the fourth floor in the assisted living program wing. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 21 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based interview and record review, the licensee failed to develop and maintain a fire safety and evacuation plan that shows the number and location of resident rooms, failed to develop a fire protection procedure necessary for residents and procedures necessary for resident movement, evacuation, or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 22 violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on April 25, 2023, at approximately 11:00 a.m. with the Assisted Living Director (ALD)-D and Director of Facilities (DF)- H on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of available documentation indicated that the fire safety and evacuation plan did not show the location and number of resident rooms. Further observation identified that the fire safety and evacuation plan did not identify emergency exit and evacuation routes. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, ALD-D indicated that she was not aware of the location of these provisions and was not able to be provide. Records provided by email the following day by ALD-D indicated the fire safety and evacuation plan lacked fire protection procedures for resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			

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0 940	Continued From page 23	0 940			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940			

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0 940	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, R3 and R4's records included a signed Resident Contract for Assisted Living. The licensee also provided a blank copy of their current Resident Contract for Assisted Living. All contracts lacked the following content: -the toll-free phone number for the MAARC (Minnesota Adult Abuse Reporting Center). On April 25, 2023, at 1:20 p.m., surveyor asked assisted living director (ALD)-D and leasing and communication director (CC)-G where they could find the MAARC reporting information in the resident contracts. Both asked for clarification on what the difference was between the Office of Health Facility Complaints (OHFC) and MAARC. Surveyor stated the difference between the two, ALD-D stated, "so they are basically the same thing." Surveyor stated they were different, and both were required to be in the contract with the contact information. ALD-D stated they would look through the contract to try and find it.	0 940			

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0 940	Continued From page 25 On April 26, 2023, at 12:29 p.m., ALD-D's email indicated they did not have a policy which addressed contract content. On April 26, 2023, at 1:00 p.m., ALD-D stated they were unable to locate MAARC reporting information in their contract and would have it added. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the	0 950			

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0 950	Continued From page 26 designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R3 and R4's records included a signed Resident Contract For Assisted Living. The licensee also provided a blank copy of their current Resident Contract For Assisted Living. All contracts lacked the required verbatim, "right to designate a representative for certain purposes" notice. On April 25, 2023, at 12:52 p.m., assisted living director (ALD)-D stated, "We have something in our contract about the designate representative, but I see that it doesn't have that exact wording". No further information was provided.	0 950			

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0 950	Continued From page 27	0 950			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 24, 2023, at approximately 11:54 a.m., assisted living director (ALD)-D provided the surveyor with a blank Assisted Living Contract:	0 970			

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0 970	Continued From page 28 Summary and Contract Information and indicated the contract was used by licensee for all residents who received services. The contract included the following three sections: -Personal Property which read, "Resident agrees that Provider is not responsible for any loss or damage or Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to Resident's personal property due to fire, water, tornado or other acts of nature and events beyond Providers Control. Resident is strongly encouraged to obtain renter's insurance."; -Indemnification which read, "As an occupant of JH Assisted Living, Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents."; -Liability which read, "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Providers premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners, and agents. Provider is also not liable for any injury, death or damage occurring as the result of Residence receipt of health-related, supportive, or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Residents	0 970			

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0 970	Continued From page 29 agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises." On April 25, 2023, at 12:56 p.m., ALD-D acknowledged that all residents receive the same assisted living contract and stated, "So if we can't have liability in there how do we protect ourselves? Because without that then we are liable." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060			

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01060	Continued From page 30 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care of the emergency relocation greater than four days for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01060			

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01060	Continued From page 31 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R7's service plan dated February 1, 2023, indicated R7 received services for bathing, dressing, grooming, transfers, mobility, toileting, medication administration, and housekeeping. R7's progress note dated April 11, 2023, at 9:48 a.m., indicated a late entry was made for R7's fall the previous night, and they were transferred to the hospital that morning due to severe pain. R7's progress note dated April 17, 2023, at 3:57 p.m., indicated R7 returned to the licensee from the hospital and had been admitted to hospice. R7's record lacked a written notice with the required statutory content provided to resident or resident representative of emergency relocation. On April 26, 2023, director of nursing (DON)-A stated, "That form (indicating a written notice with the required statutory content provided to resident or resident representative of emergency relocation) was never sent as I didn't know about that form, so I can tell you that we have not ever sent that form out for anyone who has gone to the hospital." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01290	Continued From page 32	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and cleared in affiliation with the licensee's HFID number (facility identification number) for two of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01290		

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01290	Continued From page 33 The licensee shared an address with a skilled nursing facility (SNF) owned by the same parent company. ULP-B On April 25, 2023, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-C provide care to R1 including blood glucose monitoring. ULP-B's employee record included a Background Study Notice completed on March 8, 2023. The background check was not completed under the licensee's HFID number, rather under the SNF located in the same building. RN-F RN-F was hired on March 16, 2023, and was observed providing cares to the licensee's residents on April 25, 2023. RN-F's employee record included a Background Study Notice completed on March 6, 2023. The background check was not completed under the licensee's HFID number, rather under the SNF located in the same building. On April 26, 2023, at 1:00 p.m., assisted living director (ALD)-D stated they had recently discovered they completed background checks incorrectly for their staff under their SNF but were correcting the process going forward. The licensee's Abuse, Neglect, Mistreatment, Misappropriation of Resident Property policy dated September 16, 2022, indicated, "After being extended the job offer, the prospective employee will be required to complete the necessary forms to initiate both the OHS Background Study and the independent agency study (Informed Consent Form)."	01290		

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01290	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.		01290		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-C, registered nurse (RN)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:		01460		

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01460	Continued From page 35 ULP-B On April 25, 2023, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-C provide care to R1 including blood glucose monitoring. ULP-B was hired on February 28, 2023. ULP-B's employee record lacked documentation of required orientation to include: -assisted living facility licensing requirements and regulations before providing assisted living services to residents. RN-F RN-F was hired on March 16, 2023, and was observed providing cares to the licensee's residents on April 25, 2023. RN-F's employee record lacked documentation of required orientation to include: -assisted living facility licensing requirements and regulations before providing assisted living services to residents. On April 27th, 2023, at 10:23 a.m., assisted living director (ALD)-D's email to the surveyor indicated they did not have orientation to assisted living facility licensing requirements and regulations. At 5:57 p.m., ALD-D's email indicated no staff received the training. The surveyor made multiple requests for the licensee's staff orientation policies on April 25 and 26, 2023, but none were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		

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01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted assessments within 14-days following a residents admission date and ongoing nursing assessments not to exceed every 90-days thereafter for three of four residents (R1, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620			

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01620	Continued From page 37 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee and began receiving services on January 2, 2023. R1's record contained two AL (assisted living) Assessments dated December 5, 2022, and January 2, 2023, that had been completed by DON-A indicating 28 days between assessments, which exceeded 14 days since admission date. No other assessments had been completed at the time of the survey indicating 112 days had passed from previous assessment, which exceeded 90 days since the previous RN assessment. R3 R3 was admitted to the licensee and began receiving services on September 17, 2018. R3's record lacked timely 90-day nursing assessments. R3 had an AL Assessment dated June 2, 2022, and October 11, 2022, which were 131 days apart. Assessments were also completed on January 2, 2023, and April 6, 2023, which were 94 days apart. R4 R4 was admitted to the licensee and began receiving services on May 4, 2021.	01620			

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01620	Continued From page 38 R4's record lacked timely 90-day nursing assessments. R4 had an AL Assessment dated June 30, 2022, and October 7, 2022, which were 99 days apart. On April 24, 2023, at 10:15 a.m., during the entrance conference, assisted living director (ALD)-D identified director of nursing (DON)-A as the primary nurse responsible for completion of documentation and assessments of residents residing in the facility. DON-A indicated licensee's expectation were: -an initial assessment upon admission, another within 14 days of the initial assessment, every 90 days, or with any change of condition. On April 24, 2023, at 2:20 p.m., DON-A stated the 90-day nursing assessments were not done timely for R3 and R4 and was aware of the 90-day nursing assessment requirements. On April 24, 2023, at 2:26 p.m., DON-A stated, "They did not do a pre-admission assessment for him [R1]. They did these wrong, the first one (12-5-23) is the admission assessment and the other (1-2-23) is the 14-day assessment. It was completed late because I am the only one doing them and I am trying to get everything around here fixed." The licensees Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency dated November 2022 read, "A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days	01620			

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01620	Continued From page 39 after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee and began receiving services on January 2, 2023.	01820			

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01820	Continued From page 40 R1's diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, and hyperlipidemia (high cholesterol). R1's service plan dated January 27, 2023, indicated R1 received services for bathing, cueing with dressing, cueing with grooming, medication administration, escorts to meals, standby assist with toileting, and housekeeping. R1's Medication Administration Record (MAR), dated April 1, 2023, through April 30, 2023, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that donepezil hydrochloride 5 milligram (mg) was administered one time a day on April 2-13, and 15-23. Ketoconazole external cream 2 percent (%) was applied to peri rectal area topically at 9:00 a.m., on April 7-11, 17, 20, and 23, at 3:00 p.m., on April 8, 10, 11, 14, 15, 18, 19, and 20, and at 8:00 p.m., on April 7-13, 15-19. Melatonin 3 mg two tablets by mouth was administered one time a day on April 2-13, and 15-23. Metformin hydrochloride 1000 mg one tablet by mouth was administered at 10:30 a.m., on April 1-24, and at 5:00 p.m., on April 1-23. Neurontin 300 mg one capsule by mouth was administered one time a day on April 2-13, and 15-20, 22, and 23. Calcium/vitamin D 500 mg-200 mg one tablet by mouth was administered at 10:30 a.m., on April 2-24, and at 5:00 p.m., on April 1-23. On April 25, 2023, at 10:36 a.m., director of nursing (DON)-A provided the surveyor with a medication administration record (MAR) dated April 1, 2023, through April 20, 2023, and signed doctor orders for three of the medications listed on the MAR and stated, "this is all we have for	01820			

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01820	Continued From page 41 MD signed orders, the rest of the medications came with him when he moved in and we do not have a signed order for them." The surveyor did not receive signed orders for the following medication prior to survey completion: -donepezil hydrochloride 5 milligram (mg) one tablet by mouth daily; -ketoconazole external cream 2 percent (%) apply to peri rectal area topically three times a day; -melatonin 3 mg two tablets by mouth in the evening; -metformin hydrochloride 1000 mg one tablet by mouth two times a day; -Neurontin 300 mg one capsule by mouth daily; and, -calcium/vitamin D 500 mg-200 mg one tablet by mouth two times a day. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access for one of seven memory care residents.	01880		

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01880	Continued From page 42 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 25, 2023, at 7:55 a.m., the surveyor observed a bottle of Fluticasone nasal spray 50 micrograms (mcg) located on R2's bedside table. On April 25, 2023, at 8:11 a.m., unlicensed personnel (ULP)-B stated, "I will have to ask the nurse why that is in here because that nasal spray should be kept on the cart, so I am not sure why it is in her room." On April 26, 2023, at 9:27 a.m., director of nursing (DON)-A stated, "all meds should be stored in the cart someone forgot and left the nasal spray on the dresser, they told me about that, but they all know they are supposed to only be kept in the medication cart." The licensee's Medication Storage policy dated November 2022, indicated "All medications that are distributed by JH personnel will be kept in the med cart." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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01970	Continued From page 43	01970			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded treatment orders were maintained for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 24, 2023, at approximately 10:15 a.m., director of nursing (DON)-A stated the licensee provided treatment or therapy management services for their residents. R1 admitted to the licensee and began receiving assisted living services on January 2, 2023.	01970			

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01970	Continued From page 44 R1's diagnoses included Alzheimer's disease, type 2 diabetes mellitus with diabetic neuropathy, and hyperlipidemia (high cholesterol). R1's service plan dated January 27, 2023, indicated R1 received services for bathing, cueing with dressing, cueing with grooming, medication administration, escorts to meals, standby assist with toileting, and housekeeping. On April 25, 2023, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-C provide care to R1 including blood glucose monitoring. R1's signed provider order dated January 12, 2023, at 12:27 p.m., ordered blood glucose monitoring once daily. R1's Medication Administration Record (MAR) dated April 1, 2023, through April 30, 2023, included "BG [blood glucose] checks three times a day before meals report to nurse if under 100 three times a day -start date- 02/06/2023 1130." On April 26, 2023, at 9:29 a.m., DON-A acknowledged R1's MAR indicated three times a day blood glucose monitoring and stated, "We are doing it three times a day and I followed up with primary to see about clarification. Because I thought he was supposed to do blood sugar checks three times a day." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

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02040	Continued From page 45	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of the available documentation and an interview was conducted on April 25, 2023, at approximately 11:00 a.m. with the	02040		

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02040	Continued From page 46 Assisted Living Director (ALD)- D and Director of Facilities (DF)- H on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had a disaster plan with identified hazards, but not performed a hazard vulnerability assessment or safety risk assessment on and around the property, nor prescribed any mitigation factors for any of the hazards associated with the physical environment. During interview, DF-H stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an	02110		

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02110	Continued From page 47 assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for four of four residents (R1, R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	02110		

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02110	Continued From page 48 R1 was admitted to the licensee on January 2, 2023. R2 was admitted to the licensee on May 6, 2021. R3 was admitted to the licensee on September 17, 2018. R4 was admitted to the licensee on May 4, 2021. R1, R2, R3 and R4's records lacked evidence the licensee provided the resident, or residents' designated representative, with the required policies and procedures for the ALFDC license. On April 26, 2023, assisted living director (ALD)-D stated they did not have, nor were aware, they were required to have documented proof the dementia policies had been provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care,	02310			

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02310	Continued From page 49 medical or nursing standards for two of two residents (R3, R4) who utilized consumer bed rails. This resulted in issuance of an immediate correction order on April 24, 2023, at approximately 5:15 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3 had a diagnosis of cervicalgia, mild cognitive impairment, and chemotherapy. R3's Service Plan signed on August 16, 2021, indicated they received services for linen changes, safety checks, and showers. R3's 90-day nursing assessments were reviewed and had not included bed rail assessments. On April 24, 2023, at 12:46 p.m., the surveyor observed a black rectangle shaped consumer bed rail affixed to the right side of R3's bed, R3 was in the bed at the time lying immediately next to the bed rail. The bed rail positioned to the middle to upper portion of the bed. A strap was used around the box spring to secure it to the bed. The bed rail was installed loosely and could easily be pushed and pulled away from the bed creating a gap of approximately six inches. On April 24, 2023, at 12:46 p.m., R3 stated they	02310		

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02310	Continued From page 50 had used the bed rail in the facility for some time. R3 stated the facility did not have anything to do with the bed rail and did not assess it. R3 stated the bed rail was loose and probably needed to be checked. R4 R4 had a diagnosis of sepsis, abdominal pain, and hyperlipidemia. R4's Service Plan signed February 19, 2023, indicated they received services for bathing, activities of daily living (ADLs), and medication management. R4's 90-day nursing assessments were reviewed and had not included bed rail assessments. On April 24, 2023, at 1:55 p.m., the surveyor observed black U-shaped consumer bed rail affixed on the right side of R4's head-of-bed attached to the bed frame with a black nylon strap. R4's bed also had a rectangle shaped consumer bed rail observed affixed to the right side of R4's foot-of-bed which had a white towel hung over it with clear packaging tape wrapped around it to hold the towel in place and to close the gap between the horizontal bars. On April 24, 2023, at 1:55 p.m., R4 stated his family put the bed rails on the bed. R4 stated it was installed when he was admitted to the facility. R4 stated someone looked at it recently but was not sure who it was. R4 stated on multiple occasions his foot became, "trapped," in the bed rail at the end of the bed. R4 stated, "my foot got stuck and couldn't get it out," and required him to summon assistance from staff. R4 stated the facility taped the towel to the bed rail and closed the gap using the tape to prevent R4's foot from getting stuck again.	02310			

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02310	Continued From page 51 On April 24, 2023, at 2:20 p.m., director of nursing (DON)-A stated there were only two residents with bed rails. DON-A stated the bed rail assessments were their own separate assessment completed outside of the comprehensive 90-day assessments. DON-A stated to their knowledge R3 and R4 had not had bed rail assessments at all. Surveyor pointed out and showed a bed rail assessment was completed by DON-A on March 10, 2023. DON-A then stated the bed rail assessment was not completed by themselves, it was completed by the previous DON, [DON-E], and stated the assessment was signed off using DON-A's name. DON-A stated they did not have manufacturer information for any of the bed rails, and had not checked for consumer recall. DON-A stated they were unsure if they had a risk vs benefit form for bed rails. DON-A stated they were unsure if the bed rails were installed properly or if they were appropriate or safe for the resident. On April 24, 2023, at 3:48 p.m., assisted living director (ALD)-A stated they were aware there were issues with bed rails. ALD-A stated the previous DON, DON-E, was working on bed rails as one of her projects but did not get it completed before leaving the licensee. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep	02310			

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02310	Continued From page 52 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/26/2023
NAME OF PROVIDER OR SUPPLIER JONES HARRISON ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE MINNEAPOLIS, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 53 measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rails/Assist Bars policy dated October 2022, indicated, "All residents of [Licensee] will be assessed for appropriateness of side rail use, family will be informed of the risk and benefits associated with side rail risk." Further, "Upon admission and annually or the implementation of a new device, the resident will be assessed for physical devices. The assessment will be reviewed quarterly." PLAN OF CORRECTION (POC) POST IMMEDIATE CORRECTION ORDER NOTIFICATION On April 24, 2023, at 7:47 p.m., the licensee's immediate order POC was received via email and identified four additional residents (R6, R7, R8, R9) with bed rails who received services under the assisted living facility with dementia care (ALFDC) license. On April 25, 2023, at 9:30 a.m., DON-A provided bed rail assessments dated April 24, 2023, along with signed Side/Assist Rails Consent forms (risk versus benefits) dated April 24 and 25, 2023, for R3, R4, R6, R7, R8 and R9. On April 25, 2023, at 9:50 a.m., the surveyor observed bed rails for R3 and R4 and both were unchanged from when they were observed on April 24, 2023. R3's bed rail was still loose and easily pulled approximately six inches from the side of the bed. R4's bed rails were still in place, the bed rail on the right side of R4's foot-of-bed still had a white towel hung over it with clear packaging tape wrapped around it to hold the	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2023
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02310	Continued From page 54 towel in place and to close the gap between the horizontal bars. On April 25, 2023, at 10:05 a.m., the surveyor observed R9's hospital bed with bed rails which were installed firmly. R9 stated DON-A came to the room and looked at the bed rails but did not touch them or take measurements. On April 25, 2023, at 10:14 a.m., the surveyor observed R7's hospital bed with bed rails which were installed firmly. On April 25, 2023, at 10:24 a.m., DON-A stated measurements were not performed on the hospital beds for R7, R8 and R9 and the consumer bed rails manufacturer information was not reviewed for R3, R4, and R6 as they did not have the information. A message was left for R3's family to see if they could get the manufacturer information or they would need to remove the bed rail. DON-A acknowledged changes were not made to R3 or R4's consumer bed rails since the licensee was notified of the immediate order, and the Side/Assist Rails Consent forms for all six residents were signed without proper verification of safe installation with measurements or manufacturer information. On April 25, 2023, at 10:45 a.m., the surveor observed DON-A performing measurements for entrapment zones on the hospital bed rails for R7, R8 and R9. R6 would not allow surveyor to access to their room for bed rail observation. On April 25, 2023, at 11:20 a.m., DON-A stated they just completed examination of R3, R4 and R6 consumer bedrails but could not find any manufacturer identifying information. DON-A wanted to look online to see if they could find a	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2023
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02310	Continued From page 55 consumer bed rail which looked similar to R3, R4 and R6's and use that manufacturer information for installation. Surveyor stated they could not use another manufacturer's information for installation. On April 26, 2023, at 11:15 a.m., the surveyor observed R4's bed rail, the towel and tape remained on it. On April 26, 2023, at 11:20 a.m., the surveyor observed R3's bed rail without R3 in the bed. Without R3's body weight in the bed, the bed rail easily pulled completely out from under the mattress without resistance. Surveyor lifted the mattress and a nylon installation strap for the bed rail was wrapped around the box spring but provided no tension to prevent the bed rail from moving. On April 26, 2023, at 11:25 a.m., ALD-D stated they wanted to know how they were supposed to get immediacy removed for the immediate order. Surveyor stated immediacy had not been removed as the three residents with consumer bed rails were still unsafe until it was known the bedrails were installed properly. On April 26, 2023, at 1:00 p.m., DON-A stated they were aware R3's bed rail pulled completely out without R3 in the bed, no action had been taken as they were waiting to hear back from R3's family with manufacturer information. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/26/2023
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03000	Continued From page 56	03000			
03000 SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30734	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2023
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03000	Continued From page 57 determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of five residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R7's diagnoses included hypothyroidism, major depressive disorder, urinary tract infection, and unspecified pain. R7's service plan dated February 1, 2023, indicated R7 received services for bathing, dressing, grooming, transfers, mobility, toileting, medication administration, and housekeeping.	03000			

Minnesota Department of Health

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03000	Continued From page 58 R7's progress note dated April 11, 2023, at 9:48 a.m., indicated a late entry was made for R7's suspected fall the previous night. The note indicated the fall was unwitnessed and R7 was transferred to the hospital that morning due to severe pain. R7's progress note dated April 17, 2023, at 3:57 p.m., indicated R7 had returned to community from hospital and was enrolled with hospice. On April 26, 2023, at 9:21 a.m., the surveyor requested to review an incident report or MAARC report related to R7's fall. Director of nursing (DON)-A located one progress note dated April 11, 2023, which indicated R7 had a suspected fall that was not witnessed. No incident report, fall follow up report, or MAARC report was located or provided to the surveyor, and DON-A stated, "I thought the MAARC report is for abuse, not a fall, and we didn't get the info from the hospital that there was a hip fracture until the next day, so we never reported that. We never report a basic fall with injury." The licensee's Abuse, Neglect, Mistreatment, Misappropriation of Resident Property policy dated, June 5, 2019, read, "Any staff person whom [sic] witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to the administrator/DON and that person will complete an incident report. a. if the incident appears to be suspected abuse, neglect or financial exploitation, The Director of Nursing (DON) or designee will immediately make a report no more than 2 hours after receiving notification. a. "Immediately" means as soon as possible from the time the Director of Nursing/Designee	03000			

Minnesota Department of Health

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03000	Continued From page 59 received initial knowledge that the incident occurred. b. If it is unclear based whether maltreatment has occurred, an investigation into the incident will begin immediately. c. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to the CEP. d. If it appears that a crime may have been committed, the Director of Nursing/ Designee will immediately contact the police if the witness has not already done so." Additionally, the licensee's Abuse, Neglect, Mistreatment, Misappropriation of Resident Property policy dated, June 5, 2019, read, "The Nursing Home Administrator/Director of Nursing or designee will report abuse to the state agency per State and Federal requirements as stated in the final paragraphs of this policy. Other definitions of abuse: 12. Injuries of unknown origin: -The source of the injury was not observed by any person or the source of the injury could not be explained by the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000			

Type: Full
Date: 04/25/23
Time: 13:35:00
Report: 1023231097

Food and Beverage Establishment Inspection Report

Page 1

Location:

Jones Harrison Assisted Living
3700 Cedar Lake Avenue
Minneapolis, MN55416
Hennepin County, 27

Establishment Info:

ID #: 0038722
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129202030
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils**4-703.11B ** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

HIGH TEMP DISH MACHINE NOT HOT ENOUGH. INSTRUCTED OPERATOR TO SERVICE EQUIPMENT AND VERIFY EFFECTIVE SANITIZING TEMPERATURES TO ELIMINATE PATHOGENS.

Comply By: 04/25/23

4-300 Equipment Numbers and Capacities**4-302.13B ** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HIGH TEMP DISH MACHINE IN USE BUT OPERATOR STATED NO METHOD OF VERIFYING UTENSIL SURFACE TEMPERATURE. INSTRUCTED OPERATOR TO ACQUIRE AND USE THIS DEVICE TO VERIFY EFFECTIVE SANITIZING TEMPERATURES TO ELIMINATE PATHOGENS.

Comply By: 04/25/23

2-400 Hygienic Practices**2-401.11B**

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

OBSERVED OPEN BEVERAGE CAN IN FOOD PREP AREA. STORE FOOD/BEVERAGES IN DESIGNATED AREA AWAY FROM FOOD OR USE CONTAINER THAT CAN BE FULLY CLOSED.

Comply By: 04/25/23

Type: Full
Date: 04/25/23
Time: 13:35:00
Report: 1023231097
Jones Harrison Assisted Living

Food and Beverage Establishment
Inspection Report

4-600 Cleaning Equipment and Utensils
4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.
OBSERVED DRIED FOOD DEBRIS IN MICROWAVE.
Comply By: 04/25/23

Surface and Equipment Sanitizers

S&S: = 400PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

S&S: = 400PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Hot Water: = at 151 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER #1
Violation Issued: No

Process/Item: Cold Hold/RICE
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER #2
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 154 Degrees Fahrenheit - Location: HOT BOX
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	1	2

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

THIS FACILITY CONSISTS OF A FULL SERVICE KITCHEN AREA WITH TYPE I HOOD/ANSUL AND PREP SINK. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE

Type: Full
Date: 04/25/23
Time: 13:35:00
Report: 1023231097
Jones Harrison Assisted Living

Food and Beverage Establishment Inspection Report

Page 3

- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023231097 of 04/25/23.

Certified Food Protection Manager PAUL METTY

Certification Number: 79818 Expires: 11/07/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

PAUL METTY
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us

Type: Follow-Up
Date: 04/26/23
Time: 09:50:25
Report: 1023231098

Food and Beverage Establishment Inspection Report

Page 1

Location:

Jones Harrison Assisted Living
3700 Cedar Lake Avenue
Minneapolis, MN55416
Hennepin County, 27

Establishment Info:

ID #: 0038722
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129202030
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders previously issued on 04/25/23 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HIGH TEMP DISH MACHINE IN USE BUT OPERATOR STATED NO METHOD OF VERIFYING UTENSIL SURFACE TEMPERATURE. INSTRUCTED OPERATOR TO ACQUIRE AND USE THIS DEVICE TO VERIFY EFFECTIVE SANITIZING TEMPERATURES TO ELIMINATE PATHOGENS.

Issued on: 04/25/23

Comply By: 04/25/23

2-400 Hygienic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

OBSERVED OPEN BEVERAGE CAN IN FOOD PREP AREA. STORE FOOD/BEVERAGES IN DESIGNATED AREA AWAY FROM FOOD OR USE CONTAINER THAT CAN BE FULLY CLOSED.

Issued on: 04/25/23

Comply By: 04/25/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED DRIED FOOD DEBRIS IN MICROWAVE.

Issued on: 04/25/23

Comply By: 04/25/23

Type: Follow-Up
Date: 04/26/23
Time: 09:50:25
Report: 1023231098
Jones Harrison Assisted Living

Food and Beverage Establishment
Inspection Report

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	1	2

INSPECTOR VERIFIED DISH MACHINE REACHED CORRECT TEMPERATURES TO ENSURE SAFE FOOD OPERATIONS.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023231098 of 04/26/23.

Certified Food Protection ManagerPAUL METTY

Certification Number: 79818 Expires: 11/07/24

Inspection report reviewed with person in charge and emailed.

Signed:PAUL METTY
PERSON IN CHARGE

Signed:Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us