STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jones Harrison Residence	3700 Cedar Lake Avenue Minneapolis, MN 55416

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44648 Based on observation, interview and document review, the facility failed to develop a comprehensive baseline care plan within 48 hours after admission to the facility for 1 of 5 residents (R1) whose person-centered care plan instructions were not identified until nine days after admission when she fell and sustained a hip fracture. Findings include: R1's nursing progress note dated 6/27/24 at 9:41 p.m., indicated she arrived at the facility on a stretcher from the hospital. Upon arrival she had behaviors such as hitting staff and trying to stand up. The nurse put her in a wheelchair by the nursing station for close observation to prevent her from falling. She was up most of the night and required the assistance of two staff to toilet her. R1's nursing progress note dated 6/28/24 at 5:48 a.m., indicated she was very confused and resisted care from the staff. R1's admission Minimum Data Set (MDS) dated [DATE], indicated she was admitted to the facility on [DATE]. She had disorganized thoughts during the assessment, and they were unable to determine her cognitive level. Her behaviors included kicking and hitting others. She was incontinent of urine and bowel and required assistance from one staff member to toilet. She was able to walk independently. Medical history included a brain disorder, breast cancer, weakness, heart disease, impaired communication, diabetes, and abnormal mobility. R1's Admission/Readmission note dated 7/11/24, indicated her preferences, mobility level, medication used, activities of daily living (walking, dressing, toileting, eating, hygiene, etc.) risk for falling, cognition, communication, and a head-to-toe assessment. Based on the assessment additional fields popped up to require a care plan entry along with a list of applicable care plan interventions. R1's care plan created on 7/6/24, indicated the creation date was nine days after her admission to the facility. In addition, it was the same day she fell in her bathroom resulted in a hospitalization to treat a fractured hip. The only assessments completed prior to the 48-hour deadline was a risk for skin injury and a fall assessment. The fall assessment completed had a risk score of six and would not automatically update the findings on her care plan. Only the admission/readmission document would update a care plan. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/30/24 at 11:02 a.m., registered nurse (RN)-A stated the admission/readmission assessment should be completed on the shift they arrived on. If unable to complete the assessment he would report it to the next shifts nursing staff who would finish it. He stated the evening shift did most of the admission assessments because most residents arrive from the hospital later in the day. When a deficit was identified the document would open care plan interventions to choose from. Once the document was done the care plan would be automatically updated with the findings. During interview on 7/30/24 at 11:11 a.m., RN-B stated the evening nursing shift did most of the resident admissions to the facility. The facility required the admission/readmission assessment completed within the first 24 hours. During interview on 7/30/24 at 11:14 a.m., the director of nursing (DON) stated a new resident's baseline assessment should be completed within the first 24 hours. The facility does the baseline and comprehensive assessment at the same time. She stated R1 arrived at the facility four hours after the time given by the hospital. She added, when R1 arrived her confusion, and striking out at staff hampered the assessment process. Facility policy MDS/CARE PLAN PROCESS dated 2/1/24, indicated a nurse would complete the baseline assessment for all admissions and readmissions to the facility. The baseline care plan provided resident problems and interventions to meet their initial needs. The baseline care plan was a temporary care plan until the staff had time to do a full comprehensive assessment.