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	07/09/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to identify a resident's highest level of wellbeing, develop individualized care plan interventions, involve the medical provider to review rejection of care, and develop new goals and treatment choices, for 2 out of 3 residents (R1 and R2) when both residents refused hygiene (washing face and hands, brushing hair and teeth), peri care (washing rectum and vaginal areas after incontinence), weekly bed baths, and reducing risk for developing pressure ulcers. In addition, R1 refused to let staff check her blood pressure (BP) required prior to giving medication, and monitoring R2's weight weekly as ordered. Findings include: R1's care plan dated 11/20/24, indicated she needed two staff to change her incontinent pad when soiled and transfer out of bed with a mechanical lift. Staff would do a sponge bath when unable to do a full bath or shower. She needed one staff member to turn from side to side in bed, dress, hygiene, and oral care. No indication she refused care. R1's care plan dated 11/22/25, indicated she would decline being weighed due to pain. The intervention was not updated since. R1's care plan dated 1/23/25, indicated only one reference to refusal of care associated with taking antidepressant medication and risk for refusal to eat. R1's nursing progress notes dated 3/7/25 through 7/9/25, indicated she refused: being weighed 28 times, incontinent care five times, blood pressure (BP) checked leading to missing Midodrine (medication to elevate BP) dose nine times, and weekly bed bath three times. R1's care plan dated 3/31/25, indicated she was bed bound and required the assistance of two staff members to bathe, incontinent care, turn in bed, dress, and transfer using a mechanical lift. She required the assistance from one staff member to perform daily hygiene and eating assistance. She had impaired hearing, and difficulty communicating her needs to staff. The care plan did not address any rejection of cares and there were no individualized interventions to minimize the refusals of care. R1's Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition, neuromuscular neuropathies (a disease effecting her nerves and muscles), inability to stand or walk, malnutrition, hearing loss, inability to urinate, difficulty swallowing and the history of alcohol abuse. Care Area Assessments (CAA) triggered inability to care for herself, move in bed, had a Foley catheter, impaired vision, inability to communicate, risk for falling, poor nutrition, risk for developing a pressure ulcer, use of anti-psychotropic medication to treat depression, anxiety, and Oxycodone (opioid) for chronic pain. R1's nursing assistants (NA) Kardex dated 7/8/25, indicated staff would identify risks related to refusing care, and re approach later. After 2 refusals they would notify the nurse. On 7/8/25 at 12:12 p.m., nurse manager registered nurse (RN)-A stated R1 had a history of refusing care. Staff would re-approach at a different time. If staff were unable to check her blood pressure before giving Midodrine, the dose would be held. She would expect the staff after a couple of refusals to update the medical provider for further guidance. On 7/8/25 at 1:00 p.m., director of nursing (DON) stated she expected her staff to notify the medical provider for any missed doses of medication, refusing weights, incontinent care, hygiene, medication, lab draws, and food, along with increased or decreased weights. Staff did not identify the root cause for rejection of care, including a risk benefit analysis. She also agreed R2's care plan did not identify refusal of care and lacked individualized care plan interventions. On 7/9/25 at 10:27 a.m., nurse practitioner (NP) stated staff updated her about R1 refusing BP checked prior to receiving Midodrine nine times on 7/8/25. She had been trying to adjust the Midodrine dose several times, because her blood pressure remained low. Had she known she could have educated R1 to gain compliance. She expected the staff would have contacted her in March when the behavior started not four months later. In addition, regarding activities of daily living (ADLS) refusals, she would have encouraged compliance by discussing the risk for developing pressure ulcers and infection. R2's medical record from 11/20/24 through 6/26/25, indicated in 38 weeks the facility weighed her eight times. R2's risk for altered nutrition care plan dated 11/22/25, indicated she would decline weights related to pain. No further interventions identified in the care plan to minimize the number of times she refused. R2's medical record dated 12-1-24 through 12-31-24, indicated staff would document her weight in two places. Weighing her was documented on the treatment administration record (TAR) and the actual weight under the results tab in point click care (PCC) electronic medical record. PCC documentation indicated staff weighed her, but there were no weights recorded under the result tab. R2's MD-A visit note dated 12/31/25, indicated her last weight was 203 lbs. R2's TAR dated 1-1-24 through 1-31-24, indicated staff weighed her every week, but only one weight was documented on 1/1/25. No indication the NP was notified. R2's TAR dated 2-1-24 through 2-28-24, indicated staff weighed