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	07/02/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure interventions to reduce the risk of falls were implemented for 1 of 3 residents (R1) reviewed for accidents. R1 fell from her bed when the nursing assistant (NA)-A repositioned her alone, R1's care planned interventions required two staff for repositioning. R1's fall resulted in a femur fracture with surgical intervention.Findings include: R1's care plan dated 12/15/26 indicated R1 required substantial assistance from two staff to assist and reposition every 2 hours. Substantial/maximum assistance of two staff for dressing assistance, bathing, and toilet use. R1 was able to determine when she has voided or had a bowel movement and would call for staff assistance when her incontinent brief required changing. R1's fall assessment dated [DATE] indicated R1 was a high fall risk. R1 was alert and oriented. R1 was chair bound and non-ambulatory. R1's quarterly minimum data set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating she was cognitively intact. She was dependent upon staff for toileting, dressing, hygiene, rolling from left to right in bed, and chair to bed transferring. R1's pertinent diagnoses were vascular myopathies (muscle disease caused by compromised blood flow or inflammatory changes in blood vessel supplying the muscles and chronic respiratory failure with hypoxia (the lungs cannot adequately transfer oxygen into the blood stream. R1's nursing progress note dated 6/29/26 at 3:01 p.m. indicated R1 was being changed in bed. R1 stated I was pushed too far on the edge of the bed. The fall description indicated at 11:18 a.m. the social worker notified the nurse, registered nurse (RN)-A that upon entering the room R1 was on the floor on her knees crying out in pain stating, I think my leg is broken. An injury was noted as a bruise to her left knee and swelling of her right knee below the knee cap. R1 was sent to the hospital for evaluation. R1's nursing progress note dated 6/29/26 at 5:06 p.m. indicated R1 had been admitted to the hospital with a right femur fracture. Upon on 7/1/26 at 4:43 p.m. R1's family member (FM)-A stated she was at the hospital and R1 was recovering from the surgery she had after the staff at the facility pushed her out of bed. She stated a new plate was put in R1's leg, the same leg R1 had prior surgery on years ago where a rod was placed. R1 would not be returning to the facility due to feeling unsafe following the fall incident. Upon interview on 7/2/26 at 10:25 a.m. social worker (SW)-A stated on 6/29/26 she was seated at her desk and heard (NA)-A yelling for help. She ran to R1's room and found R1 on the floor crying in pain. NA-A was the only staff member in the room. Almost immediately more staff entered the room with a mechanical lift to assist R1 off the floor. SW-A stated she attended training following the incident that involved ensuring staff were aware of how to obtain each resident Kardex (a quick-reference care summary of the residents) and follow the care plan for each resident. Upon interview on 7/2/26 at 10:45 a.m. RN-B stated she was in her office and heard yelling. She responded by getting the mechanical lift and rounded up other staff members for assistance. R1 required assistance of two staff as she was a heavy woman and unable to move herself. (NA)-A was repositioning R1 alone as she was changing bowel movement and pushed her too close to the edge of the bed and R1 fell to the floor fracturing her knee. The facilities investigation concluded that R1's care plan was not followed. Retraining of how to access the Kardex in the software system and to (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	make sure the Kardex was checked prior to administering care. R1 had required assistance from two staff since her admission date months prior. Upon interview on 7/2/26 at 12:46 p.m. (RN)-C stated she had assisted (NA)-A with R1 multiple times with morning cares and repositioning, so she was not certain why (NA)-A did not request assistance on the morning of her fall. Upon interview on 7/2/26 at 12:53 p.m. (RN)-D, nurse supervisor stated on 6/26/26 she was on the unit and heard commotion. By the time she got to R1's room staff were already assisting to get R1 back into bed. (RN)-D was part of the facilities investigation. She interviewed other residents who (NA)-A frequently worked with. She denied interviewing other residents on the unit to inquire whether other staff members followed the care plan or not. The education department was informed of the incident and the investigative findings. The education department wrote an education plan on how to access the Kardex and to remind staff to be sure to check the Kardex before providing care. She stated the facility would be completing audits; however, the management team had not yet come up with what the audits would look like. Upon interview on 7/2/26 at 1:10 p.m. the director of nursing, DON stated R1 was a bedbound resident who used a mechanical lift and required two staff members for transfers and reposition. (NA)-A did not follow the care plan, R1 fell out of bed and required surgery. (NA)-A was terminated from her position at the facility. Upon interview on 7/2/26 at 1:16 p.m. R1 stated she had a rod in her leg from another surgery about 14 years ago. On 7/1/26 she had surgery from the recent accident, and a plate was placed in her leg. The day of the incident (NA)-A had washed her face in bed and R1 needed her incontinence brief changed. NA-A did not turn on the call light or leave the room to request assistance. NA-A turned R1 on her side with hard hands and pushed R1 off the other side of the bed. R1 stated she hit her head on her oxygen tank, had instant knee pain, and later developed pain in her coccyx. R1 stated it was a common occurrence that NA-A did not have two staff for assistance, and it happened with other staff, but it was rare. Upon interview on 7/2/26 at 1:45 p.m. (NA)-A stated she was getting R1 ready for the day she had washed her hands and face and R1 had a bowel movement, so she was just changing and cleaning her. She did not believe two staff were needed to change her. She assisted R1 on her side and she rolled out of bed onto the floor. (NA)-A yelled for help immediately. She stated she was aware that R1 required two staff for repositioning, (NA)-A was aware of how to access the Kardex. Upon interview on 7/2/26 at 2:02 p.m. the Administrator stated she expected the staff to follow the care plan. She stated (NA)-A made a poor decision of not following R1's care plan. A facility policy titled Incident/Accident Reports dated 1/2024 indicated designated staff members will initiate an internal investigation as needed to determine the root cause of the incident. The staff member is designated by the Administrator and Director of Nursing. If there are allegations of abuse, neglect, or mistreatment follow internal and state abuse reporting procedures. Refer to and follow all policies on abuse and neglect. When the root cause analysis is completed, the investigator will document the findings in risk management discussed in an IDT meeting and discussed at Quality Assurance (QAPI) meetings to determine ongoing interventions and/or system changes. If reports to other agencies are made, indicate this in the documentation, along with the names or the agency representatives.