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	01/09/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure residents taking psychotropic medications had an appropriate clinical rationale for not attempting a gradual dose reduction of psychotropic medications, an appropriate diagnosis for use of antipsychotic medications, and non-pharmacological interventions were attempted and documented with as needed psychotropic use. The facility further failed to ensure behaviors were observed and documented to adequately justify psychotropic medication use. This had the ability to effect 3 of 5 residents (R63, R87 and R180) reviewed for unnecessary medications.Findings include:R63R63's quarterly Minimum Data Set (MDS), dated [DATE], indicated R63 was admitted to the care facility on 6/14/25 and had mild cognitive impairment. The MDS further indicated R63 received antipsychotic medication and antidepressant medication during the look-back period without a gradual dose reduction (GDR) attempted.R63's Order Summary Reported, dated 12/2/25, indicated R63 was on several medications including Aripiprazole (an antipsychotic medication) 10 milligrams (mg) two times a day for bipolar and Mirtazapine (an antidepressant) 7.5 mg at bedtime for insomnia.R63's Consultant Pharmacist's Medication Review, dated December 2025, indicated a pharmacist recommendation for a gradual dose reduction of R63's Aripiprazole and Mirtazapine, indicating per CMS [Centers for Medicare and Medicaid] guidelines, all psychotropic medications should be considered for a trial dose reduction at least twice within the first year of use. If a dose reduction is contraindicated, rigorous risk/benefit documentation should be provided. A review of recent provider progress notes did not yield a thorough risk/benefit assessment for this patient's [R63] psychotropic medications.The providers response on the R63's Consultant Pharmacist's Medication Review, dated December 2025, lacked a clinical rationale for not attempting a GDR, instead indicated R63 had been on Abilify [aripiprazole] since [approximately] 2014 for bipolar and mirtazapine since 2022.R63's electronic medical record (EMR) lacked any further documentation to address a clinical rationale for not attempting a GDR for R63's psychotropic (i.e. antipsychotic and antidepressant) medications.An interview on 1/9/26 at 10:50 a.m., with the director of nursing (DON) confirmed there was not a documented clinical rationale for not attempting a GDR for R63's psychotropic medications.R87R87's quarterly MDS, dated [DATE], indicated R87 was admitted to the care facility on 11/3/23 and had severe cognitive impairment. The MDS further indicated R87 had received antipsychotic medication during the look-back period.R87's EMR, indicated an order, dated 1/7/26, for quetiapine (an antipsychotic medication) 12.5 mg two times a day for anxiety, order by Favoured Hospice.R87's Consultant Pharmacist's Medication Review, dated July 2025, indicated per CMS guidelines, anxiety is not a sufficient diagnosis to warrant the use of antipsychotic medications.R87's EMR lacked behaviors notes or target behavior documentation to justify the need for a new antipsychotic medication.R87's December and January medication administration records lacked any evidence R87 had received as needed quetiapine or lorazepam (an antianxiety medication ordered for as needed use for 14 days, dated 11/24/25.)During an interview on 1/9/26 at 8:21 a.m., nurse manager and registered nurse (RN)-B stated she believed hospice was in contact with the family when the decision was made to schedule R87's quetiapine and stated R8 did get agitated at (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times and she believed R87 was receiving as needed quetiapine. RN-B further stated the facility had guidelines to follow for what diagnoses are appropriate, confirming anxiety was not an appropriate diagnosis for antipsychotic use, stating the medication was ordered by hospice. R108R108's quarterly MDS, dated [DATE], indicated R108 was admitted to the care facility on 12/6/24 and had severe cognitive impairment.R108's EMR contained an order, dated 1/6/26, for lorazepam (an antianxiety medication) 0.5 mg every 2 hours for anxiety, ordered by hospice. The EMR also contained an order for lorazepam 0.5mg every 2 hours as needed for 14 days, dated 12/28/25 and discontinued on 1/6/26.R108's medication administration records indicated R108 had received 6 doses of as needed lorazepam in December 2025 and 1 dose in January 2026 between 1/1/26 and 1/5/26.R108's EMR to include progress notes, medication and treatment administration records for December 2025 and January 2026 and behavior task documentation lacked documentation to justify the need for scheduled lorazepam every 2 hours. The EMR further lacked evidence that non-pharmacological interventions had been attempted prior to as needed lorazepam administration.During an interview on 1/8/26 at 10:25 a.m., nursing assistant (NA)-C stated she didn't know R108 to have much anxiety, stating maybe once and awhile. NA-C stated if R108 seemed anxious, she often wanted to see her daughter or be left alone.During an interview on 1/8/26 at 9:58 a.m., nurse manager and registered nurse (RN)-B stated it would be expected that R108's behaviors and non-pharmacological intervention attempts would be documented on the medication and treatment administration record, confirming there was no documentation of resident behaviors nor non-pharmacological interventions in the month of December or January.A facility policy titled Psychopharmacologic Drug Use, revised 5/2025, indicated:1. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: Without adequate monitoring; or without adequate indications for its use.2. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior, including antipsychotic medications and antianxiety medications. 3. If not clinically contraindicated, multiple non-pharmacological approaches have been attempted but did not relieve the medical symptoms which are presenting a danger or significant distress; and/or GDR was attempted, but clinical symptoms returned.4. Documentation in the resident's medical record will indicate the rationale for the use of psychotropic medication. The rationale must be based on sound risk/benefit analysis of the resident's symptoms and potential adverse effects of the drug.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to implement their written policy and procedure and ensure an allegation of sexual abuse was reported to the state agency for 1 of 2 residents (R81) reviewed for allegations of abuse.Findings include:R81's quarterly Minimum Data Set (MDS), dated [DATE], indicated R81 was admitted to the care facility on 7/22/23 and had severe cognitive impairment. The MDS further indicated R81 required partial to moderate assistance with most activities of daily living and required substantial assistance with toileting.R81's care plan, dated 7/16/25, indicated should resident report that she was sexually assaulted, staff should ensure resident is safe and report allegation to their supervisor immediately.R81's progress note, dated 12/14/25 at 11:25 a.m., indicated resident [R81] reported that she was sexually abused at night. Writer reported to daughter. Daughter ran the camera and reported two NAR [nursing assistants] changed resident and she went to sleep. Nothing wrong happened to resident as per the resident daughter. Daughter said, ?This is becoming a behavior issue.'During an interview on 1/8/26 at 11:33 a.m., registered nurse (RN)-C stated, every once and awhile she would get report that R81 told staff, Someone raped her or hurt her. RN-C stated it was expected that those allegations be reported to their supervisor because there were timeframes they needed to follow for reporting and investigating.During an interview on 1/9/26 at 8:21 a.m., nurse manager and RN-B stated R81 had dementia and had made allegations of being raped in the past but nothing credible was found, and R81 later forgot about what she reported. RN-B stated R81's family had a camera in her room the family could review when allegations were made. RN-B stated she was off in December when R81 reported she felt sexually abused, however if it was reported to her today, she would discuss it with the director of nursing (DON), and they would typically file a VA [vulnerable adult] report. She expected it to have been reported to the supervisor who was covering for her while she was off (RN-D).During an interview on 1/9/26 at 8:45 a.m., RN-D stated she recalled reading a progress note regarding R81 reporting an allegation of sexual abuse and that the camera in her room was reviewed by family. RN-D stated she would have expected that to be reported to the DON immediately to start investigating what happened.During an interview on 1/9/26 at 9:52 a.m., the director of social services (DSS)-A stated she was aware R81 had made allegations of sexual abuse, but she was just made aware of the allegation reported in December. DSS-A stated it would be expected that staff investigate to gather as much information as possible and if staff can't prove it didn't happen it should be reported. DSS-A stated the allegation made in December should have been reported to the supervisor and the DON immediately.During an interview on 1/9/26 at 10:50 a.m., the DON confirmed the allegation of sexual abuse reported by R81 in December was not reported to her and she would have expected it to be.A facility policy, titled Vulnerable Adult - Abuse Prohibition Plan, revised 10/2024, indicated:Mandated reporters in skilled nursing facilities ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported, and a report made immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do notresult in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. The report will be made to the Minnesota Department of Health (MDH)/OHFC. During the shift that the alleged abuse/neglect, unexplained injury or suspected crime is first observed, a mandated reporter/covered individual will immediately make an initial report to their supervisor, after securing the resident's safety. Steps must be taken to ensure that no resident in the facility remains in danger of maltreatment, including medical intervention if needed.If potential maltreatment is suspected or unknown, the Supervisor will immediately report to the Administrator (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or designee Director of Nursing.Immediate steps are taken to protect the vulnerable adult from harm while the situation is being investigated.External Reporting Procedure1. The Administrator and/or Director of Nursing or their designee will complete the MDH/OHFC on-line report.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure an allegation of sexual abuse was thoroughly investigated for 1 of 2 residents (R81) reviewed for allegations of abuse. Findings include:R81's quarterly Minimum Data Set (MDS), dated [DATE], indicated R81 was admitted to the care facility on 7/22/23 and had severe cognitive impairment. The MDS further indicated R81 required partial to moderate assistance with most activities of daily living and required substantial assistance with toileting.R81's care plan, dated 7/16/25, indicated should resident report that she was sexually assaulted, staff should ensure resident is safe and report allegation to their supervisor immediately.R81's progress note, dated 12/14/25, indicated resident [R81] reported that she was sexually abused at night. Writer reported to daughter. Daughter ran the camera and reported two NAR [nursing assistants] changed resident and she went to sleep. Nothing wrong happened to resident as per the resident daughter. Daughter said, ?This is becoming a behavior issue.'During an interview on 1/8/26 at 11:33 a.m., registered nurse (RN)-C stated, every once and awhile she would get report that R81 told staff, Someone raped her or hurt her. RN-C stated it was expected that those allegations be reported to their supervisor because they were timeframes they needed to follow for reporting and investigating.During an interview on 1/9/26 at 8:21 a.m., nurse manager and RN-B stated R81 had dementia and had made allegations of being raped in the past but nothing credible was found, and R81 later forgot about what she reported. RN-B stated R81's family had a camera in her room the family could review when allegations were made. RN-B stated she was off in December when R81 reported she felt sexually abused, however if it was reported to her today, she would discuss it with the director of nursing (DON) so that it could be properly investigated. During an interview on 1/9/26 at 8:45 a.m., RN-D stated she recalled reading a progress note regarding R81 reporting an allegation of sexual abuse and that the camera in her room was reviewed by family. RN-D stated she would have expected that to be reported to the DON immediately to start investigating what happened.During an interview on 1/9/26 at 9:52 a.m., the director of social services (DSS)-A stated she was aware R81 had made allegations of sexual abuse, but she was just made aware of the allegation reported in December. DSS-A stated it would be expected that staff investigate to gather as much information as possible and if staff can't prove it didn't happen it should be reported. DSS-A stated the allegation made in December should have immediately been reported to the supervisor and the DON for investigation. During an interview on 1/9/26 at 10:50 a.m., the DON confirmed the allegation of sexual abuse reported by R81 in December was not reported to her and she would have expected it to be so that it could have been thoroughly investigated. A facility policy, titled Vulnerable Adult - Abuse Prohibition Plan, revised 10/2024, indicated:During the shift that the alleged abuse/neglect, unexplained injury or suspected crime is first observed, a mandated reporter/covered individual will immediately make an initial report to their supervisor, after securing the resident's safety. Steps must be taken to ensure that no resident in the facility remains in danger of maltreatment, including medical intervention if needed.If potential maltreatment is suspected or unknown, the Supervisor will immediately report to the Administrator and/or designee Director of Nursing.Immediate steps are taken to protect the vulnerable adult from harm while the situation is being investigated.The Building Charge, Nurse Manager, Director of Nursing, or Administrator will immediately institute an internal investigation of the reported allegation or incident. The investigation may include but not limited to:a. Interviews of staff and written statements from staffb. Resident interviewsc. Resident Representative interviewsd. Witness interviews and written statements of incidente. Care observationsf. Environmental review g. Resident health status/Medical record review

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and document review, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for 1 of 1 residents (R18) reviewed for hospice.Findings include: During an observation on 1/5/26 at 1:41 p.m., R18 was observed lying in bed with her eyes closed. During a follow up interview and observation on 01/7/26 at 8:50 a.m., R18 was observed in the dining room. R18 smiled but did not answer questions. R18's quarterly MDS assessment, dated 11/1/25, identified R18 had severely impaired cognition. Diagnoses included dementia (significant loss of memory, thinking and reasoning skills), atrial fibrillation (an irregular and often rapid heart rhythm), dysphagia (difficulty swallowing), chronic pain and hemiplegia (paralysis affecting one side of the body). The MDS contained section O which contained a section hospice care which was marked no indicating R18 did not receive hospice services. R18's orders, printed 1/9/26, included the following order:-ok for hospice to evaluate, treat and accept with a start date of 8/1/24-call hospice in case of an emergency [number listed] with a start date of 10/29/25 R18's electronic medical record (EMR) contained a section titled special instructions which was listed R18's name, allergies and code status which indicated [name of hospice] hospice. R18's care plan, printed 1/6/26, indicated R18 was enrolled in hospice with a potential for knowledge deficit of hospice philosophy/program and an expected physical and cognitive decline which was last revised on 11/5/24. The care plan did contain additional information regarding R18 and hospice and interventions. During an interview on 1/7/26 at 9:20 a.m., licensed practical nurse (LPN)-A verified R18 was on hospice. During an interview on 1/8/26 at 10:57 a.m., director of MDS (MDS)-A verified R18 was on hospice. MDS-A indicated the last MDS was coded incorrectly and should have indicated R18 was on hospice. MDS-A stated a modification for R18's quarterly MDS assessment on 11/1/25 had been submitted after review. During an interview on 1/9/26 at 11:10 a.m., director of nursing (DON) stated the accuracy of MDS was important and it helps ensure staffing levels are appropriate and appropriate cares are provided to all residents. A facility policy titled MDS/Care Plan Process/Resident Assessment, revised 10/21/25. Under the section Accuracy of Assessments, the document indicated the assessment must represent an accurate picture of the resident's status during the observation period of the MDS.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a resident's nails were kept clean and trim for 1 of 3 residents (R90) reviewed for activities of daily living. Findings include: R90's quarterly Minimum Data Set (MDS), dated [DATE], indicated R90 was cognitively intact, had upper and lower extremity impairments on one side and required substantial to maximum assistance with activities of daily living. R90's care plan, dated 7/10/24, indicated R90 had limited physical mobility and self-care performance deficit related to hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness or reduced strength on one side of the body) following a cerebral infarction (stroke) affecting his right side, required assist of two staff with bathing/showering, and directed staff to provide nail care as needed. During observation and interview on 1/5/26 at 4:25 p.m., R90 had fingernails approximately 1/4 inch long with dark matter underneath them. R90 looked down at his nails and stated, they do need to be trimmed and cleaned. During a second observation on 1/8/25 at 10:34 a.m., R90's nails continued to extend past his fingertips with dark matter still underneath all of his nails. During an interview on 1/8/26 at 10:25 a.m., nursing assistant (NA)-C stated it was the expectation that residents receive nail care whenever it is needed but also on bath days. NA-C also stated every morning facility staff should be assisting residents with washing their hands and ensuring their nails are clean. During an interview on 1/9/26 at 8:21 a.m., nurse manager and registered nurse (RN)-B stated it would be expected that staff keep resident's nails clean and provide nail care on bath days. RN-B confirmed there were no notes in the electronic medical record regarding R90's nail care being completed. A facility policy on Activities of Daily Living was not received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a medication order, written in error and without documented justification was appropriately questions and doubled checked before implementing and administering the medication multiple times for 1 of 1 resident (R108) reviewed for unnecessary medications. Findings include:R108's quarterly MDS, dated [DATE], indicated R108 was admitted to the care facility on [DATE] and has severe cognitive impairment.R108's EMR contained an order, dated [DATE], for lorazepam (an antianxiety medication) 0.5 mg every 2 hours for anxiety, ordered by hospice. The EMR also contained an order for lorazepam 0.5mg every 2 hours as needed for 14 days, dated [DATE] - [DATE] and a second as needed order dated [DATE] and discontinued on [DATE].R108's medication administration records indicated R108 had received 6 doses of as needed lorazepam in [DATE] and 1 dose in [DATE] between [DATE] and [DATE]. Between [DATE] and [DATE], R108 received a total of 11 doses of scheduled lorazepam.R108's [DATE] treatment administration record directed staff to monitor for side effects of the psychotropic medication Seroquel but not lorazepam.R108's EMR to include progress notes, medication and treatment administration records for [DATE] and [DATE] and behavior task documentation, lacked documentation to justify the need to scheduled lorazepam every 2 hours. During an interview on [DATE] at 12:19 p.m., R108's emergency contact and family member (FM)-A stated the facility had called her recently regarding R108's lorazepam order asking her if she was okay with them discontinuing the order. FM-A asked the staff to keep it available to her if she needed it, but not to be scheduled around the clock every 2 hours. During the interview R108 was sitting unassisted on the side of her bed, eating her lunch independently. FM-A stated she had wondered why R108 had seemed more confused today and wondered if it was the extra doses of lorazepam she had received.During an interview on [DATE] at 12:26 p.m., registered nurse (RN)-C confirmed R108 was receiving 0.5 mg of lorazepam every 2 hours scheduled but was not working when the order changed from as needed to scheduled, so was not sure why the medication was scheduled. During the interview, nurse manager and RN-B stated she would investigate where the order came from.During a follow up interview on [DATE] at 1:00 p.m., nurse manager and RN-B stated the order for lorazepam 0.5mg every 2 hours scheduled was given by the hospice registered nurse case manager (RNCM).During an interview on [DATE] at 2:17 p.m., the hospice RNCM stated the order for lorazepam 0.5mg every 2 hours as needed had expired so he wrote a new order for it yesterday ([DATE]). The hospice RNCM stated his intention was for the medication to be as needed and stated, I don't think she [R108] needs that much [0.5mg scheduled every 2 hours]. The hospice RNCM then stated he actually meant to schedule the lorazepam 0.5mg every 12 hours, not every 2 hours as every 2 hours scheduled would be a sharp increase.During a third follow up interview on [DATE] at 2:44 p.m., nurse manager and RN-B stated she would investigate where the miscommunication came from, stating FM-A should be aware R108 was receiving lorazepam every 2 hours.During an interview on [DATE] at 3:03 p.m., consulting pharmacist (CP)-A stated if R108's system was not use to that much lorazepam it would be important to monitor her for increased lethargy or confusion. CP-A further stated 0.5mg of lorazepam every 2 hours was probably not harm level dose but he would want to ensure R108 was monitored and not showing signs of sedation.During a fourth follow up interview on [DATE] at 9:58 a.m., nurse manager and RN-B stated she would expect to see behaviors and non-pharmacological intervention attempts documented on the medication and treatment administration records for R108 justifying the need for lorazepam every 2 hours, confirming the records lacked such documentation. RN-B stated she spoke with the hospice RNCM who confirmed the order for lorazepam every 2 hours was written in error, and it should have been scheduled every 12 hours, not every 2 hours.During an interview on [DATE] at 10:25 a.m., nursing assistant (NA)-C stated she didn't know R108 to have much anxiety, stating maybe once and awhile. NA-C stated if R108 seemed anxious, she often wanted to see her daughter or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left alone.During a follow up interview on [DATE] at 10:46 a.m., FM-A again confirmed she did not believe that R108 needed antianxiety medication every 2 hours or even scheduled every 12 hours and she only wanted it available to R108 as needed, stating she [R108] has seemed very doped up lately.During an interview on [DATE] at 10:50 a.m., the director of nursing (DON) stated she would have expected that either the floor nurses or the nurse manager question the lorazepam order and why, without justification and without as needed dose use to support, the order went from lorazepam 0.5mg every 2 hours as needed to scheduled every 2 hours.A facility policy titled Medication Administration-General Guidelines, dated [DATE], indicated, If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the MD/NP [doctor/nurse practitioner] for clarification. This interaction with the pharmacy and/or MD/NP and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and document review, the facility failed to assess and develop non-pharmacological interventions to promote comfort for 1 of 2 residents (R4) reviewed for pain management.Findings include: R4's admission Minimum Data Set (MDS) assessment, dated 12/1/25, indicated R4 had intact cognition. Diagnoses included the following: rheumatoid arthritis (chronic autoimmune disease where the immune system attacks joint linings, causing pain, swelling, stiffness, fatigues and damage to joints), Sjogren's syndrome (chronic autoimmune disease which can cause symptoms including fatigue and joint pain), arthrodesisis status (indicated that patient has undergone surgical joint fusion), muscle weakness, and chronic pain. Further the assessment identified R4 received PRN (as needed) pain medications and received non-medication interventions for pain. Furthermore, R4 identified she frequently had pain which occasionally effects sleep, interferes with day-to day activities and rated pain at a 10 out of 10 on a pain scale with 10 as the worst pain. During an interview on 1/5/26 at 3:06 p.m., R4 stated that she has chronic pain which was over the top. R4 stated I think there is more that they could do. R4 stated they do not offer any alternatives to medication such as massage, heat, ice or essential oils. R4 stated I do think it would be helpful. R4's care plan reviewed 1/6/26, identified resident was on pain medication therapy related to rheumatoid arthritis. The care plan indicated to review pain medication efficacy, assess whether pain intensity was acceptable to resident and monitor for side effects. The care plan lacked evidence of offering non-pharmacological interventions prior to administering as needed (PRN) medications, what non-pharmacological interventions have been tried, what has been effective and not effective and what non-pharmacological interventions should be used.R4's January medication administration record (MAR/TAR), printed 1/6/26, included the following orders: - acetaminophen (pain medication) 325 milligram (mg) tablet: give two tablets by mouth every 6 hours as needed for pain with a start date of 12/17/25. The medication had been administered a total of 12 times in January. A pain scale was used on administration of acetaminophen which showed pain scale rating of 3-10 and effectiveness of medication was documented. - oxycodone (opioid pain medication) 5 mg: give 5 mg by mouth every 6 hours as needed for pain with a start date of 12/19/25. The medication had been administered a total of 17 times in January. A pain scale was used on administration of oxycodone which showed pain scale rating of 0-10 and effectiveness of medication. R4's MAR/TAR lacked evidence of non-pharmacological interventions being offered prior to administration of as-needed pain medication. R4's progress notes, dated 1/1/26 to 1/6/26 were reviewed and lacked evidence of non-pharmacological interventions being offered to R4 for pain. During an interview on 1/7/26 at 8:31 a.m., nursing assistant (NA)-A stated when a resident reported they had pain, a nursing assistant asked what kind pain they were having and reported that immediately to the nurse. NA-A stated nursing assistants were not to offer any interventions as they were to report everything to the nurse. NA-A stated R4 did have pain. NA-A stated they had not offered any non-pharmacological interventions such as heat or ice to R4 to help with pain. During an interview on 1/7/26 at 9:32 a.m., licensed practical nurse (LPN)-B stated when it was reported that a resident had pain the nurse needed to assess the resident to find out where the pain was coming from, have them rate the pain, and check to see if they could get medication for the pain. LPN-B stated the nurse also needed to look to see if the resident just had medication. LPN-B stated the nurse would follow up with the provider if the pain was something new or out of the ordinary. LPN-B stated a non-pharmacological intervention might be offered depending on the resident and the situation. LPN-B stated if a non-pharmacological intervention was offered, it would be documented in the progress note. During an interview on 1/7/26 at 12:52 p.m., assistant nurse manager (LPN)-C and registered nurse manager (RN)-A stated the expectation would be non-pharmacological interventions were offered and documented prior to administering PRN pain medications. LPN-C stated the nonpharmacological interventions should be listed on the care plan. RN-A stated the nonpharmacological intervention should also be listed on the (continued on next page)

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	01/09/2026

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MAR and documented prior to administration. During a follow up interview on 1/8/26 at 8:13 a.m., RN-A verified there were no non-pharmacological interventions offered to R4 prior to administration of as needed pain medication. RN-A verified the care plan had been updated after interview on 1/7/26.During an interview on 1/9/26 at 11:11 a.m., director of nursing (DON) stated the expectation would be that non-pharmacological interventions would be offered and documented prior to the use of PRN pain medications. A facility policy titled Pain Medication, reviewed 8/8/25, indicated that all residents have the right for appropriate pain evaluation and pain medication. The policy indicated non-pharmacological interventions research supports physical activity and exercise as a part of most treatment programs for chronic pain.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and document review the facility failed to develop a comprehensive person-centered care plan with goals and interventions utilizing a trauma-informed approach including monitoring of PTSD (post-traumatic stress disorder) for 1 of 1 (R2) residents reviewed for trauma-informed care.Findings include: R2's quarterly Minimum Data Set (MDS) assessment, dated 11/26/25, indicated R4 had severely impaired cognition. Diagnoses included: PTSD, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, depression, dementia (significant loss of memory, thinking and reasoning skills), and seizure disorder (condition where the brain has abnormal electrical activity suddenly that temporarily disrupts normal function). R2's Psychosocial History Assessment, dated 11/19/25, identified through a question with a radio-button answered yes that R2 experienced any significant life events that continued to affect R2's life. The assessment form disclosed R2 stated long ago and did not specify further regarding traumatic events. R2 identified smoking cigarettes once in a while helped get through difficult times. R2 did not specify any particular triggers. Furthermore, the assessment identified R2 was seen by a provider for mental health. R2's care plan, printed 1/8/26, identified R2 was resistive to care and had a history of becoming aggressive with staff during cares and accusing staff of attempting to hurt her. Interventions included: followed by psych, provide reassurance, provide consistency in care to promote comfort with ADLs and maintain consistency in timing of ADLs, caregivers and routines as much as possible. The care plan lacked evidence mention of R2 suffering from PTSD, discussing possible triggers, interventions to determine triggers, measurable objectives, interventions, and timeframes for how staff are expected to meet R2's desired goals and outcomes concerning her PTSD. During an interview on 1/5/26 at 1:56 p.m., R2 was observed lying in bed. R2 was nonsensical and repeated self. During an interview on 1/8/26 at 12:15 p.m., R2 was observed lying in bed. R2 asked what was for lunch and then said goodbye as she waiting for her lunch and declined to talk any further. During an interview on 1/8/26 at 12:20 p.m., nursing assistant (NA)-B stated if a resident had PTSD and had triggers it would be on their care plan. NA-B stated they do not believe that R2 has PTSD. NA-B stated there are no known triggers for R2. During an interview on 1/8/26 at 12:30 p.m., licensed practical nurse (LPN)-B stated if a resident had a diagnosis of PTSD, that would be listed on the care plan along with any triggers. LPN-B reviewed R2's diagnoses and verified R2 had a diagnosis of PTSD and stated this information along with any triggers should be on the care plan. During an interview on 1/8/26 at 12:36 p.m., director of social services (DSS)-A stated it's important to gather all the information possible either form the resident, medical records, family, other providers to help not retraumatize a resident when they have a history of trauma or PTSD. DSS-A stated it is important to try to identify triggers and communicate this information to all the staff. During a follow up interview on 1/9/26 at 10:25 a.m., SSD-A verified she was able to review R2's medical record. SSD-A verified there was not a trauma care plan prior to interview yesterday and should have been. SSD-A reviewed the initial assessment completed that did not identify triggers, reviewed therapist notes that did identify trauma history and how that could be related to current behaviors. SSD-A stated she updated R2's care plan to reflect a trauma history. SSD-A stated it is important to gather all this information from all sources to do their best to not retrigger a resident, even if they can't identify a trigger, and avoid further trauma. During an interview on 1/9/26 at 11:09 a.m., director of nursing (DON) stated a residents trauma history needs to be assessed and care planned so staff are aware of the trauma, so they don't retraumatize residents. A facility policy titled Trauma Informed Care, reviewed 1/22/25, identified the goal of trauma informed care is to ensure an environment that is safe and sensitive and to ensure the available of trained professionals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to ensure laundry was laundered according to standard infection control practices, with the potential to affect all 116 residents residing in the facility. Findings include:The Centers for Disease Control and Prevention's (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities: Laundry and Bedding resource dated 1/8/24, indicated that damp laundry should not be left in machines overnight. During an observation and interview on 1/8/25 at 12:45 p.m., multiple (greater than ten) cloth mop heads were observed in the laundry machine. Laundry aide (LA)-A stated that the mop heads, cleaning rags, microfiber cloths, and clothing protectors would be brought down to the laundry room throughout the day. The non-laundry staff would then start the laundry machine in the evening. The non-laundry staff would not assist in moving the clothing to the drying machine. The laundry aide confirmed that the usual practice was for the laundry listed above to be cleaned, left wet in the washing machine overnight, and then she would put it in the dryer the following day. During an interview on 1/8/25 at 2:29 p.m., the infection preventionist (IP) stated she was unaware that damp laundry was being left in the washing machine overnight after being washed. The IP stated she thought this practice could be improved and not something she would do at home but was unsure what the infection control risk was. The facility's Linen Handling to Prevent and Control Infection Transmission policy, dated 11/11/24, was reviewed and did not include direction on whether laundry could be left in the machine overnight.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information based on payroll during 1 of 1 quarter (Fiscal Year Quarter 4 2025 - July 1 - September 30) reviewed, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 116 residents at the facility.Findings include: The CMS PBJ Staffing Data Report for Fiscal Year Quarter 4 2025 dated 1/2/26, indicated the facility had no registered nurse (RN) hours, and lacked licensed nursing coverage for 24 hours per day on the following 25 dates: 8/1, 8/3-8/8, 8/11-8/15, 8/18-8,22, 8/24-8/31. Review of the staff schedules and time sheets indicated the facility had the appropriate licensed 24-hour nursing coverage and RN hours as required. During interview on 1/6/26 at 1:59 p.m., administrator stated she was responsible for submitting the staffing data and was not surprised the report triggered for the missing RN and licensed nursing hours. She stated she attempted to submit the August data and stayed late to complete the submission; however, she encountered technical issues and it didn't go through. During an interview on 1/9/26 at 11:04 a.m., the director of nursing (DON) stated the administrator was in charge of submitting the PBJ report and she didn't have anything to do with submitting it. The DON stated she knew the administrator was having troubles submitting the report for August. The DON stated the facility as a registered nurse in the building at all times so knows that the report wasn't accurate. The facility Payroll Based Journal - Error Report and XML Files policy revised 1/25, indicated administrators or designees will log onto the CMS website and enter data, check validation report, and verify the submitted report is accurate and complete.