



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 31, 2026

Administrator
JONES HARRISON RESIDENCE
3700 CEDAR LAKE AVENUE
MINNEAPOLIS, MN 55416

RE: CCN: 245460

Cycle Start Date: July 2, 2026

Dear Administrator:

On July 9, 2026, we notified you a remedy was imposed. On August 20, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 20, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 24, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 9, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 24, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 20, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 9, 2026

Administrator
Jones Harrison Residence
3700 CEDAR LAKE AVENUE
MINNEAPOLIS, MN 55416

RE: CCN: 245460
Cycle Start Date: July 2, 2026

Dear Administrator:

On July 2, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 24, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 24, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 24, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager

or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 24, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Jones Harrison Residence will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 24, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

**Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 2, 2027 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with the first name "Melissa" and last name "Poepping" clearly distinguishable.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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July 9, 2026

Administrator
Jones Harrison Residence
3700 CEDAR LAKE AVENUE
MINNEAPOLIS, MN 55416

Re: Event ID: 25C65F-H1

Dear Administrator:

The above facility survey was completed on July 2, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2026	
NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE , MINNEAPOLIS, Minnesota, 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) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/1/26- 7/2/26 , a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H54603130C / MN 3064040 & 3065149 with a deficiencies issued at F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			07/09/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure interventions to reduce the risk of			F0689	1. Corrective Action: R1 was immediately assessed following the fall and transferred for further medical evaluation and treatment. The interdisciplinary team reviewed the R1's care plan to ensure it accurately reflected the resident's current care needs and required interventions. The staff member involved was immediately removed from resident care pending investigation and is no longer employed by the facility. 2. Corrective Action as it Applies to Other Residents: A house-wide audit will be completed to observe staff providing care to residents requiring two-person assistance with transfers, bed mobility, and toileting to verify care plans were being followed. Residents requiring two-person assistance		07/20/2026

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 reverse for further 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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F0689 SS = G	Continued from page 1 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 3/9/26 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 6/9/26 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.			F0689	Continued from page 1 with transfers, bed mobility, and toileting were reviewed to ensure care plans accurately reflect current assistance needs. All licensed nurses and nursing assistants completed house-wide re-education on accessing the resident Kardex and verifying each resident's ADL assistance status prior to providing care. 3. Date of Compliance: 07/20/2026 4. Recurrence Will Be Prevented By: The facility will complete 6 audits weekly for four weeks, then 6 audits monthly for two months, of residents requiring two-person assistance with transfers, bed mobility, and toileting to verify care is being provided consistently with the resident's care plan. Audit findings will be reviewed through the facility's QAPI process. 5. Monitored By: Director of Nursing or Designee		07/20/2026

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F0689 SS = G	Continued from page 2 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 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			F0689			07/20/2026

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F0689 SS = G	Continued from page 3 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.			F0689			07/20/2026

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F0689 SS = G	Continued from page 4 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.			F0689			07/20/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/1/26 - 7/2/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during the survey. H54603130C / MN 3064040 & 3065149 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal			20000			07/09/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2026	
NAME OF PROVIDER OR SUPPLIER JONES HARRISON RESIDENCE				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CEDAR LAKE AVENUE , MINNEAPOLIS, Minnesota, 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) COMPLETION DATE
20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			07/09/2026