



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 29, 2026

Administrator
HARMONY GARDENS
1438 COUNTY ROAD C EAST
MAPLEWOOD, MN 55109

RE: CCN: 245381

Cycle Start Date: March 26, 2026

Dear Administrator:

On April 28, 2026, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

The Minnesota Department of Health completed a revisit on April 29, 2026. Additionally, the Minnesota Department of Public Safety completed a revisit and a Federal Monitoring visit on June 25, 2026 to confirm that your facility had attained and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 26, 2026 did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

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



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June 29, 2026

Administrator
HARMONY GARDENS
1438 COUNTY ROAD C EAST
MAPLEWOOD, MN 55109

Re: Reinspection Results
Event ID: 1E3EC2-H2

Dear Administrator:

On April 29, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 26, 2026. At this time these correction orders were found corrected.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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April 6, 2026

Administrator
HARMONY GARDENS
1438 COUNTY ROAD C EAST
MAPLEWOOD, MN 55109

RE: CCN:245381

Cycle Start Date: March 26, 2026

Dear Administrator:

On March 26, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, 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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 approved 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 26, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 26, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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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April 6, 2026

Administrator

HARMONY GARDENS

1438 COUNTY ROAD C EAST

MAPLEWOOD, MN 55109

Re: State Nursing Home Licensing Orders

Event ID: 1E3EC2-H1

Dear Administrator:

The above facility survey was completed on March 26, 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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.

Please feel free to call me with any questions.



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: 245381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER HARMONY GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 1438 COUNTY ROAD C EAST , MAPLEWOOD, Minnesota, 55109	
(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
E0000	Initial Comments On 3/23/26-3/26/26, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/27/2026
F0000	INITIAL COMMENTS On 3/23/26-3/26/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with no deficiencies cited: H53818840C (2608137). 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 substantial compliance with the regulations has been attained.	F0000		04/27/2026
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity.	F0604	F0604 This Plan of Correction Constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not	04/27/2026

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026
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F0604 SS = D	<p>Continued from page 1</p> <p>The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 resident (R44) reviewed for restraints.</p> <p>Findings include:</p> <p>R44's quarterly Minimum Data Set (MDS) dated 12/23/25, indicated R44 had severe cognitive impairment, required substantial/maximal assistance for bed mobility, and was dependent for transfers. R44's MDS further indicated R44 did not experience any falls since admission, was receiving hospice care and did not use any restraints. R44's diagnoses included generalized muscle weakness, adjustment disorder with mixed anxiety and depressed mood, and chronic obstructive pulmonary disease (COPD, chronic lung disease).</p>	F0604	<p>Continued from page 1</p> <p>an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.</p> <p>It is the policy of Cassia-Harmony Gardens to comply with F0604-Right to be Free from Physical Restraints.</p> <p>To assure continued compliance, the following plan has been put into place:</p> <p>Regarding cited resident:</p> <p>The pillows were removed from underneath the sheets of R44 and placed appropriately on 3/24/26. R44 fall interventions have been reviewed and remain appropriate.</p> <p>Actions taken to identify other potential residents having similar occurrences:</p> <p>We determined that all other residents that may utilize a device or equipment that could be placed in a manner that would be considered restraint are at risk. An audit was conducted of those individuals to ensure that they were placed appropriately.</p> <p>Measures put in place to ensure deficient practice does not reoccur:</p> <p>Education provided to nursing department, therapy, and ancillary staff regarding the definition of restraint, and practices that could be considered restraining. Education provided about Cassia policy and CMS regulation regarding use of restraints-including resident right to be free from any physical restraints imposed for purposes of convenience.</p> <p>Effective implementation of actions will be monitored by:</p> <p>DON or designee to audit weekly x 4 weeks, then monthly x 2 months, for appropriate use of devices that could be considered restraints. Results of these audits will be reviewed by the facility QA&A committee to make the decision if further monitoring or audits are recommended.</p> <p>Those responsible for maintaining compliance will be:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026
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F0604 SS = D	<p>Continued from page 2</p> <p>R44's care plan dated 3/10/26, indicated R44 was at risk for falls and used body pillows to define the edge of the bed.</p> <p>R44's nursing care sheet printed 3/9/26, indicated R44 required two-person assistance using a mechanical lift for transfers and one person assist every 2-3 hours for repositioning. R44 used a body pillow for positioning.</p> <p>During observation on 3/23/26 at 2:19 p.m., R44 was lying in bed and had one body pillow on each side of him. The pillows were on the bed and tucked under the fitted sheet.</p> <p>During observation on 3/24/26 at 1:07 p.m., R44 was in bed sleeping and had a body pillow on each side of him tucked under the fitted sheet.</p> <p>During observation and interview on 3/24/26 at 1:21 p.m., registered nurse (RN)-A went into R44's room and removed the pillows from under the fitted sheet and placed alongside R44 in bed. RN-A stated she was just checking to ensure R44's care sheet was being followed and that the body pillows were on top of the sheet as care planned. RN-A confirmed she found the pillows tucked under the fitted sheet and stated they should not have been that way. RN-A stated when pillows were tucked under fitted sheets they could act as a restraint. RN-A stated R44 could not remove the tucked in pillows.</p> <p>During interview on 3/24/26 at 3:08 p.m., nursing assistant (NA)-A stated R44 should have pillows on either side of him for positioning and to prevent him from rolling out of bed. NA-A further stated the pillows should never be tucked under the fitted sheet since that would act as a restraint, which was not allowed.</p> <p>During interview on 3/24/26 at 3:16 p.m., licensed practical nurse (LPN)-A stated R44 had pillows on his bed on each side of him to prevent him from rolling out of bed. LPN-A further stated the pillows were supposed to be tucked under the fitted sheet to ensure they remained in place.</p> <p>During interview on 3/24/26 at 3:23 p.m., LPN-B stated R44 had pillows on his bed to help define the edges of the bed as a falls intervention. LPN-B further stated the pillows should never be tucked under the fitted sheet which would restrict R44's movement and be considered a restraint.</p>	F0604	<p>Continued from page 2</p> <p>The DON or designee is responsible for maintaining compliance.</p> <p>Completion date for certification purposes only is: 4/27/2026</p>	

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F0604 SS = D	Continued from page 3 During interview on 3/25/26 at 1:45 p.m., regional director of clinical services (RDCS) stated it was not the facility's expectation to use pillows under the fitted sheet. During interview on 3/26/26 at 12:12 p.m., director of nursing (DON) stated would not expect pillows to be placed under the fitted sheets and only used for positioning or to define the edge of the bed and placed only on top of the bed sheets. DON further stated if placed under the sheet, residents could not easily remove them. Facility policy Restraints: physical last reviewed 2/18/26, indicated a physical restraint was any "material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement."	F0604		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F0640	F0640 This Plan of Correction Constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia-Harmony Gardens to comply with F0640-Encoding and transmitting Resident assessments. To assure continued compliance, the following plan has been put into place: Regarding cited resident: Resident R30 d/c MDS was completed on 4/9/26 per CMS requirements. Actions taken to identify other potential residents having similar occurrences: We have determined that there is a risk for non-completion of discharge MDS's for every resident that discharges. Audit completed of all discharged residents in the last 30 days to ensure MDS assessments were completed as required by CMS. Measures put in place to ensure deficient practice does	04/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026
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F0640 SS = D	<p>Continued from page 4</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. <p>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure a subset (i.e., discharge) Minimum Data Set (MDS) was completed and transmitted to the Centers for Medicare and Medicaid (CMS) database in a timely manner for 1 of 1 resident (R30) reviewed for MDS accuracy.</p> <p>Findings include:</p> <p>The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI manual), dated 10/2025, identified all applicable MDS along with their completion and transmission dates were required. This included, "Discharge Assessment - return not anticipated," listed with a transmission date of, "MDS Completion Date + 14 calendar days."</p> <p>R30's Census List, printed 3/26/26, identified R30's most recent admission to the facility as 11/4/25. R30 remained in the facility in the same room until</p>	F0640	<p>Continued from page 4</p> <p>not reoccur:</p> <p>Re-education provided to MDS nurses regarding processes expected to ensure timely completion of discharge MDS's as required by CMS.</p> <p>Effective implementation of actions will be monitored by:</p> <p>DON or designee to audit discharge MDS completion weekly x 4 weeks, then monthly x 2 months to ensure MDS completion per CMS regulation. Results of these audits will be reviewed by the facility QA &A committee to make the decision if further monitoring or audits are recommended.</p> <p>Those responsible for maintaining compliance will be:</p> <p>The DON or designee is responsible for maintaining compliance.</p> <p>Completion date for certification purposes only is:</p> <p>4/27/2026</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER HARMONY GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1438 COUNTY ROAD C EAST , MAPLEWOOD, Minnesota, 55109		
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F0640 SS = D	<p>Continued from page 5 12/5/25. The census identified R30's status on 12/5/25 as "Discharge-Return Not Anticipated."</p> <p>R30's progress note dated 12/5/25 at 1:22 p.m., indicated R30 discharged from community at 1:23 p.m.</p> <p>Review of R30's MDS 3.0 resident assessments list printed on 3/25/26, indicated an admission and 5-day assessment had been completed, and a discharge assessment status of "Late." The discharge assessment had an ARD (assessment reference date) due date of 12/5/25, and a completion due date of 12/19/25.</p> <p>Review of R30's medical record on 3/26/26, lacked evidence a discharge MDS had been started, completed or transmitted to CMS despite R30 discharging several months prior.</p> <p>During interview via telephone on 3/26/26 at 10:59 a.m., MDS registered nurse (MDS-RN) stated discharge assessments should be completed per the RAI manual but were usually completed and transmitted within 30 days of discharge. MDS-RN reviewed R30's medical record and confirmed a discharge assessment was not completed and should have been. MDS-RN could not explain why R30's discharge assessment was not completed as required.</p> <p>During interview on 3/26/26 at 12:12 p.m., director of nursing (DON) stated expectation for the MDS assessments to be completed per the RAI manual and facility policy.</p> <p>Facility policy MDS-RAI Process dated 3/17/26, indicated, "The MDS Coordinator/RAI Lead is responsible to assure that MDS assessments are completed and locked in the software in compliance with the regulatory schedule requirements."</p>	F0640		
F0690 SS = D	<p>Bowel/Bladder Incontinence, Catheter, UTI</p> <p>CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence.</p> <p>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p>	F0690	<p>F0690</p> <p>This Plan of Correction Constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.</p> <p>It is the policy of Cassia-Harmony Gardens to comply with F0690-Bowel and Bladder Incontinence, Catheter, UTI.</p> <p>To assure continued compliance, the following plan has been put into place:</p>	04/27/2026

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F0690 SS = D	<p>Continued from page 6</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed to assess residents' ability to independently empty and report urine output for 1 of 1 resident (R50) reviewed who had a urinary catheter.</p> <p>Findings include:</p> <p>R50's quarterly Minimum Data Set (MDS) dated 12/2/25, indicated intact cognition and diagnoses of Parkinson's disease, urine retention, and overactive bladder. It further indicated R50 had an indwelling catheter and was independent with toileting. R50's physician's order dated 2/19/21, indicated catheter care: catheter output three times a day. R50's care plan reviewed/revised 2/26/26, indicated R50 had a chronic supra pubic catheter (long term use urinary catheter via abdominal incision) changed monthly by urologist due to inability to manage with straight catheter, urinary retention enlarged, prostrate and history of urinary tract infections (UTI). Interventions included catheter cares, monitor for UTI, monitor and report any concerns, monitor urine output every shift and notify provider of concerns, assist with elimination as needed. Furthermore, R50 requested change from night urine bag to leg bag during the day per resident preference despite education of increased risk of infection. R50's care sheet dated 1/8/26, indicated R50 had a suprapubic catheter and was continent of bowel.</p>	F0690	<p>Continued from page 6</p> <p>Regarding cited resident:</p> <p>Immediate assessment completed on resident R50 to ensure ability to complete catheter cares by self. Education provided to resident. Successful Return demonstration observed.</p> <p>Actions taken to identify other potential residents having similar occurrences:</p> <p>All residents with foley catheters that express the wish to complete cares independently have been assessed for ability/appropriateness, physicians order obtained, and care planned accordingly.</p> <p>Measures put in place to ensure deficient practice does not reoccur:</p> <p>Education provided to licensed staff regarding completion of appropriate documentation and assessments regarding foley catheter self-care.</p> <p>Effective implementation of actions will be monitored by:</p> <p>DON or designee to audit individuals with catheters for appropriate assessment/documentation weekly x 4 weeks, then monthly x 2 months to ensure appropriate measures are put into place per CMS regulation. Results of these audits will be reviewed by the facility QA &A committee to make the decision if further monitoring or audits are recommended.</p> <p>Those responsible for maintaining compliance will be:</p> <p>DON or designee is responsible for maintaining compliance.</p> <p>Completion date for certification purposes only is:</p> <p>4/27/26</p>	

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F0690 SS = D	Continued from page 7 Assist with catheter cares as needed. R50 was Independent per preference for urine output each shift. R50's medical record lacked assessment or education on how to empty the leg drainage bag, measure output, or report to the nurse independently. During observation and interview on 3/23/26 at 1:27 p.m., R70 was sitting in his electric wheelchair in his room. R50 stated he did things on his own. This included transferring, emptying his catheter bag, and changing catheter urine bags. R50 further stated the only thing staff did with the catheter was change it. During observation on 3/24/2026 at 1:35 p.m., R50 was headed down the hallway towards his room in his electric wheelchair. He went into his bathroom and stated his stomach hurt and he thinks it's because the leg bag of his catheter was full. R50 took a graduated cylinder out of the cabinet in his room and leaned over and emptied his bag of urine into the graduated cylinder. R50 was not wearing any gloves. At 1:42 p.m. he came out of his room with a small piece of paper and waited by the medication cart. Licensed practical nurse (LPN-C) came out of the charting room next to the medication cart and R50 handed her the piece of paper stating, "that is my output for the day." LPN-C took the piece of paper and then entered the amount into the computer. During interview on 3/24/26 at 2:06 p.m., nursing assistant (NA)-C stated the nursing assistants were required to use care sheets to know how to care for each resident. NA-C further stated they do minimal cares for R50 such as bring him food and clean his bottom. They don't assist him with his catheter (emptying the bag, measuring the output, changing the bag), stating "He does all that." During interview on 3/24/26 at 2:58 p.m., NA-D stated the nursing assistants used care sheets to know how to care for each resident. NA-D further stated they did not do many cares for R50 except wash his back, bottom, and get him a new gown. When asked specifically about R70's catheter, NA-D stated, "He does that himself." During interview on 3/25/26 at 9:00 a.m., licensed practical nurse (LPN)-C verified R50 does his own catheter cares (in regard to emptying the bag and measuring his output) and stated if residents are complete their own cares, there should be some type of assessment, and it should be documented in be in their care plan. Documentation could also be put in a modified self-medication assessment or attached a progress note. LPN-C was unable to find an assessment or a progress note and verified it wasn't in R70's care plan and should have been. During interview on 3/26/26 at approximately 2:45 p.m., the director of nursing (DON) stated in general if a resident was completing their own catheter cares, an assessment should be performed to ensure they were doing it correctly. R50 had been performing his own catheter	F0690		

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F0690 SS = D	Continued from page 8 cares since he was admitted here, and it was always something he had just done for himself. The DON further stated the nurses check on him periodically to make sure he's doing the catheter cares correctly but was unable to find any documentation. A facility policy regarding assessing residents when they are providing their own cares was asked for but not received.	F0690		
F0812 SS = F	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators were labeled, dated, and not expired. This had the potential to affect all 61 residents who received food from the facility kitchen.</p> <p>Findings include:</p> <p>On 3/25/26 at 10:40 a.m., director of food and nutrition (DFN) provided a tour of the facility kitchen. In the walk-in refrigerator there was a container of beets labeled with an opened date of 2/23. Multiple white patches of a substance were observed on</p>	F0812	<p>F0812</p> <p>This Plan of Correction Constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.</p> <p>It is the policy of Cassia-Harmony Gardens to comply with F0812 - Storage of perishable food.</p> <p>To assure continued compliance, the following plan has been put into place:</p> <p>Regarding cited issue-immediate action:</p> <p>The expired items were disposed of on 3-25-26. All expired food items have been removed from the kitchen and discarded.</p> <p>Actions taken to identify other potential similar occurrences:</p> <p>The improper storage of foods that are expired, or unlabeled, has the potential to affect all residents. All items identified in corrective action will be completed to ensure the safety of all residents. Cooks will be trained on proper food storage and expiration dates.</p> <p>Measures put in place to ensure deficient practice does not reoccur:</p> <p>Culinary Director, or designee, will complete an expired food items audit to determine that all foods are properly stored and disposed of according to policy.</p> <p>Effective implementation of actions will be monitored by:</p>	04/27/2026

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F0812 SS = F	<p>Continued from page 9 the top surface of the beets. DFN confirmed and stated the substance was mold. DNF further stated the beets had been opened longer than seven days and should have been discarded. In addition, a container of potato salad was observed in the same refrigerator, labeled with an opened date of 3/10. DNF confirmed and stated the potato salad was expired and should have been discarded. In a standalone refrigerator, an individual sized prepared salad, a half-full container of fresh strawberries and a quarter-full container of fresh blueberries were observed with no label or date. DFN stated these food items should have a label to indicate when they were opened. DFN stated all food should be labeled and dated to indicate when the container was opened. Food was only good for seven days after opening and should be discarded after that date.</p> <p>During interview on 3/26/26 at 10:32 a.m., regional director of food and nutrition (RDFN) stated she would expect food to be removed after 7 days in refrigerator, and all food should be labeled with the date it was opened.</p> <p>During interview on 3/26/26 at 12:45 p.m., administrator stated would expect all food stored in the refrigerators to be labeled, dated and discard appropriately.</p> <p>Facility policy Refrigerator and Freezer Storage dated 1/9/26, indicated that all food should be stored appropriately to maintain food safety. All food should be clearly labeled and must be discarded after seven days.</p>	F0812	<p>Continued from page 9</p> <p>Auditing of the main kitchen areas (refrigerators & dry storage) to ensure there no expired food items, and all items are labeled. Audits will be completed weekly x 4 weeks and then monthly x 2 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.</p> <p>Those responsible for maintaining compliance will be:</p> <p>The Culinary Director, or designee, is responsible for maintaining compliance.</p> <p>Completion date for certification purposes only is: 4/27/2026</p>	

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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 3/23/26-3/26/26, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following licensing orders are issued at (0510) and (1100). Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	20000		04/27/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	Continued from page 1 The following complaint was reviewed during the survey: H53818840C (2608137). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors, findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
20510	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 2 Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 resident (R44) reviewed for restraints. Findings include:	20510	Corrected	04/27/2026

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20510	<p>Continued from page 2</p> <p>R44's quarterly Minimum Data Set (MDS) dated 12/23/25, indicated R44 had severe cognitive impairment, required substantial/maximal assistance for bed mobility, and was dependent for transfers. R44's MDS further indicated R44 did not experience any falls since admission, was receiving hospice care and did not use any restraints. R44's diagnoses included generalized muscle weakness, adjustment disorder with mixed anxiety and depressed mood, and chronic obstructive pulmonary disease (COPD, chronic lung disease).</p> <p>R44's care plan dated 3/10/26, indicated R44 was at risk for falls and used body pillows to define the edge of the bed.</p> <p>R44's nursing care sheet printed 3/9/26, indicated R44 required two-person assistance using a mechanical lift for transfers and one person assist every 2-3 hours for repositioning. R44 used a body pillow for positioning.</p> <p>During observation on 3/23/26 at 2:19 p.m., R44 was lying in bed and had one body pillow on each side of him. The pillows were on the bed and tucked under the fitted sheet.</p> <p>During observation on 3/24/26 at 1:07 p.m., R44 was in bed sleeping and had a body pillow on each side of him tucked under the fitted sheet.</p> <p>During observation and interview on 3/24/26 at 1:21 p.m., registered nurse (RN)-A went into R44's room and removed the pillows from under the fitted sheet and placed alongside R44 in bed. RN-A stated she was just checking to ensure R44's care sheet was being followed and that the body pillows were on top of the sheet as care planned. RN-A confirmed she found the pillows tucked under the fitted sheet and stated they should not have been that way. RN-A stated when pillows were tucked under fitted sheets they could act as a restraint. RN-A stated R44 could not remove the tucked in pillows.</p> <p>During interview on 3/24/26 at 3:08 p.m., nursing assistant (NA)-A stated R44 should have pillows on either side of him for positioning and to prevent him from rolling out of bed. NA-A further stated the</p>	20510		

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20510	<p>Continued from page 3 pillows should never be tucked under the fitted sheet since that would act as a restraint, which was not allowed.</p> <p>During interview on 3/24/26 at 3:16 p.m., licensed practical nurse (LPN)-A stated R44 had pillows on his bed on each side of him to prevent him from rolling out of bed. LPN-A further stated the pillows were supposed to be tucked under the fitted sheet to ensure they remained in place.</p> <p>During interview on 3/24/26 at 3:23 p.m., LPN-B stated R44 had pillows on his bed to help define the edges of the bed as a falls intervention. LPN-B further stated the pillows should never be tucked under the fitted sheet which would restrict R44's movement and be considered a restraint.</p> <p>During interview on 3/25/26 at 1:45 p.m., regional director of clinical services (RDSCS) stated it was not the facility's expectation to use pillows under the fitted sheet.</p> <p>During interview on 3/26/26 at 12:12 p.m., director of nursing (DON) stated would not expect pillows to be placed under the fitted sheets and only used for positioning or to define the edge of the bed and placed only on top of the bed sheets. DON further stated if placed under the sheet, residents could not easily remove them.</p> <p>Facility policy Restraints: physical last reviewed 2/18/26, indicated a physical restraint was any "material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement."</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit staff and resident interaction and ensure residents are not being restrained inappropriately. The DON or designee could educate staff on what is a potential restraint and what is required to use a restraint in a nursing home. Those residents utilizing potential restraints could be comprehensively assessed and the information brought to the interdisciplinary team to ensure it is the least restrictive alternative for each individual and orders obtained. The facility could conduct audits to ensure residents are not being restrained without appropriate</p>	20510		

Minnesota State 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 03/26/2026
NAME OF PROVIDER OR SUPPLIER HARMONY GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 1438 COUNTY ROAD C EAST , MAPLEWOOD, Minnesota, 55109	
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20510	Continued from page 4 assessments and orders in place. TIME PERIOD for CORRECTION: Twenty-one (21) days.	20510		
21100	<p>Food Supplies; Storage of Perishable food</p> <p>CFR(s): MN Rule 4658.0650 Subp. 5</p> <p>Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators were labeled, dated, and not expired. This had the potential to affect all 61 residents who received food from the facility kitchen.</p> <p>Findings include:</p> <p>On 3/25/26 at 10:40 a.m., director of food and nutrition (DFN) provided a tour of the facility kitchen. In the walk-in refrigerator there was a container of beets labeled with an opened date of 2/23. Multiple white patches of a substance were observed on the top surface of the beets. DFN confirmed and stated the substance was mold. DNF further stated the beets had been opened longer than seven days and should have been discarded. In addition, a container of potato salad was observed in the same refrigerator, labeled with an opened date of 3/10. DNF confirmed and stated the potato salad was expired and should have been discarded. In a standalone refrigerator, an individual sized prepared salad, a half-full container of fresh strawberries and a quarter-full container of fresh blueberries were observed with no label or date. DFN stated these food items should have a label to indicate when they were opened. DFN stated all food should be labeled and dated to indicate when the container was opened. Food was only good for seven days after opening and should be discarded after that date.</p> <p>During interview on 3/26/26 at 10:32 a.m., regional director of food and nutrition (RDFN) stated she would expect food to be removed after 7 days in refrigerator, and all food should be labeled with the date it was opened.</p>	21100	Corrected	04/27/2026

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21100	<p>Continued from page 5</p> <p>During interview on 3/26/26 at 12:45 p.m., administrator stated would expect all food stored in the refrigerators to be labeled, dated and discard appropriately.</p> <p>Facility policy Refrigerator and Freezer Storage dated 1/9/26, indicated that all food should be stored appropriately to maintain food safety. All food should be clearly labeled and must be discarded after seven days. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026
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K0000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted on 03/25/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Harmony Gardens was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</p> <p>By email to:</p>	K0000		04/27/2026

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026
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K0000	Continued from page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Harmony Gardens is a 1 story building with a partial basement constructed in 2022 and is type V (111)construction. The building is protected by a full fire sprinkler system and has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0321 SS = E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K0321	K0321 This Plan of Correction Constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was	04/27/2026

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K0321 SS = E	<p>Continued from page 2 2012 New</p> <p>Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> <p>18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms</p> <p>b. Laundries (larger than 100 square feet)</p> <p>c. Repair, Maintenance, and Paint Shops</p> <p>d. Soiled Linen Rooms (exceeding 64 gallons)</p> <p>e. Trash Collection Rooms (exceeding 64 gallons)</p> <p>f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet)</p> <p>g. Combustible Storage Rooms/Spaces (over 100 square feet)</p> <p>h. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, and 8.3.3.1. These deficient findings could have a patterned impact on the residents within the facility.</p> <p>1. On 03/25/2026 at 11:13 AM, it was revealed by observation that the door to the soiled utility in</p>	K0321	<p>Continued from page 2 cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.</p> <p>It is the policy of Cassia-Harmony Gardens to comply with K0321 - Hazardous Areas - Enclosure</p> <p>To assure continued compliance, the following plan has been put into place:</p> <p>Regarding cited deficiency- Action taken or planned to correct deficiency:</p> <p>Vendor was called to schedule a repair. Doors stops were removed on 3/25/2026. One of two doors was repaired on 4/7/2026. Second door was repaired on 4/10/2026.</p> <p>Measures put in place to ensure deficient practice does not reoccur:</p> <p>These deficient findings could have a patterned impact on the residents within the facility. Door audits to be completed monthly for three months to ensure compliance with proper latching and no further use of door wedges. Staff education will be provided regarding NFPA 101 and Life Safety Code policies.</p> <p>Effective implementation of actions will be monitored by:</p> <p>The Administrator is responsible for ensuring compliance and auditing measures.</p> <p>Those responsible for maintained compliance will be:</p> <p>The Administrator is responsible for ensuring compliance with this plan of correction. Results of these audits will be reviewed by the facility QA&A committee to make the decision if further monitoring or audits are recommended.</p> <p>Completion date for certification purposes only is: 4/27/2026</p>	

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K0321 SS = E	Continued from page 3 Geranium would not latch properly. 2. On 03/25/2026 at 11:22 AM, it was revealed by observation that the door to the soiled utility in Lily would not latch properly and was missing the internal hardware for the door. 3. On 03/25/2026 at 11:35 AM, it was revealed by observation that the doors that led to the corridor in the laundry room were being held up by door wedges. Door wedges were removed and thrown away at the time of the survey An interview with the Campus Administrator verified these deficient finding at the time of discovery.	K0321		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.4.1, 9.6.1.3, and 9.6.1.5, NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.2.2, 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3. This deficient finding could have a widespread impact on the residents within the facility. On 03/26/2026 at 10:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of smoke detector sensitivity testing. An interview with the Campus Administrator verified this deficient finding at the time of discovery.	K0345	K0345 This Plan of Correction Constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia-Harmony Gardens to comply with K0345 - Fire Alarm System - Testing and Maintenance To assure continued compliance, the following plan has been put into place: Regarding cited deficiency- Action taken or planned to correct deficiency: Vendor was called on 3/25/2026, 4/10/26, and 4/14/2026 to schedule prompt service for sensitivity testing. A recurring testing contract will be reviewed and established with vendor and administrator. Measures put in place to ensure deficient practice does not reoccur: This deficient finding could have a widespread impact on the residents within the facility. Staff education will be provided on the importance of timely vendor fire suppression testing and maintenance, and the procedures for contacting vendors.	04/27/2026

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K0345 SS = F		K0345	Continued from page 4 Effective implementation of actions will be monitored by: The Administrator is responsible for ensuring compliance with this plan of correction and implementation. Results of these corrective measures will be reviewed by the facility QA&A committee to make the decision if further monitoring is recommended. Those responsible for maintained compliance will be: The Administrator is responsible for ensuring compliance. Completion date for certification purposes only is: 4/27/2026	
K0521 SS = F Bldg. 02	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2. This deficient finding could have a widespread impact on the residents within the facility. On 03/25/2026 at 10:31 AM, it was revealed by a review of available documentation that the facility was not completing inspections on the fire dampers. An interview with the Campus Administrator verified this deficient finding at the time of discovery.	K0521	K0521 This Plan of Correction Constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia-Harmony Gardens to comply with K0521 – HVAC To assure continued compliance, the following plan has been put into place: Regarding cited deficiency- Action taken or planned to correct deficiency: Vendor was called on 3/25/2026, 4/10/26, and 4/14/2026 to schedule prompt service for damper inspections. A recurring contract will be reviewed and established with vendor and administrator for ongoing inspection. Measures put in place to ensure deficient practice does not reoccur: This deficient finding could have a widespread impact on the residents within the facility. Facility will develop a life safety compliance calendar for ongoing fire protection testing. Staff education will be provided on the importance of timely inspections on the	04/27/2026

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K0521 SS = F Bldg. 02		K0521	Continued from page 5 fire dampers, and the procedures for contacting vendors. Effective implementation of actions will be monitored by: The Administrator is responsible for ensuring compliance with this plan of correction and implementation. Results of these corrective measures will be reviewed by the facility QA&A committee to make the decision if further monitoring is recommended. Those responsible for maintained compliance will be: The Administrator is responsible for ensuring compliance. Completion date for certification purposes only is: 4/27/2026	