Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 13, 2026

Administrator
HARMONY RIVER LIVING CENTER
1555 SHERWOOD STREET SOUTHEAST
HUTCHINSON, MN 55350

RE: CCN: 245114

Cycle Start Date: April 7, 2026

Dear Administrator:

On April 7, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F), 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)).

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 7, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 7, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 7, 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.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 7, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

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.

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

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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.

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

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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Administrator
HARMONY RIVER LIVING CENTER
1555 SHERWOOD STREET SOUTHEAST
HUTCHINSON, MN 55350

Re: State Nursing Home Licensing Orders
Event ID: 1F3575-H1

Dear Administrator:

The above facility survey was completed on April 7, 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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

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.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245114	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST , HUTCHINSON, Minnesota, 55350

(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 4/6/26 to 4/7/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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		04/13/2026
F0000	INITIAL COMMENTS On 4/6/26 to 4/7/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51141064C(iQIES #2800937). NO licensing orders were issued. The following complaints were reviewed: H51141065C (iQIES #1143196). NO licensing orders were issued. The following complaints were reviewed: H51149486C (iQIES #2684099), with a licensing order issued at F0689. 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	F0000		04/13/2026

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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F0000	Continued from page 1 has been attained.	F0000		04/13/2026
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, interview, and document review, the facility failed to provide care consistent with a resident's needs and care plan to eliminate/reduce the risk of an accident during cares in bed for 1 of 3 residents (R111). This resulted in actual harm to R111 when staff repositioned R111 on her side with one staff member instead of two staff members per care plan, causing R111 to roll out of the bed to the floor. As a result, R111 was admitted to the hospital on 12/4/25 for a fracture of the right femur and a closed fracture of the left hip. R111 had surgery on 12/6/25 on the right femur and surgery on 12/11/25 on the left hip femur. The facility had implemented actions to prevent recurrence prior to the survey on 4/6/26, therefore, the citation was issued at past non-compliance. R111's quarterly Minimal Set Data (MDS) dated 3/31/26, identified R111 as cognitively intact. R111 was dependent on staff for toileting, rolling to the left and right in bed, and lower body dressing and needed maximal assistance with upper body dressing. R111 had a diagnosis including fractures and diabetes. R111's care plan was revised on 8/28/24, identified R111 needed two staff for sling management and when moving up in bed. R111's care sheet, dated 11/26/25, identified R111 needed two staff for dressing, bathing, and transferring. R111's physical therapy discharge summary dated 9/30/25, identified R111 needed moderate to maximal assistance from two caregivers for rolling	F0689	"Past Noncompliance - no plan of correction required"	04/13/2026

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F0689 SS = G	Continued from page 2 to the left and right sides in bed. R111's incident report dated 12/1/25 at 7:40 p.m., identified R111 was assisted into bed with a full mechanical lift and the assistance from nursing assistant (NA)-A and NA-B. NA-B left the room to help another resident, and NA-A rolled R111 to change her brief. R111 rolled to the right side and fell from bed. R111 landed on the floor on her back, arms at her side, legs bent towards herself. Resident denied being hurt at the time of the fall. No medical attention required at the time of the fall. Medical provider notified on 12/1/25 at 8:25 p.m., sister notified 12/1/25 at 9:00 p.m., administrator notified, no time identified. The short term intervention was education for NA-A and NA-B to always use two staff for bed mobility. A note was made on the incident report that the resident and family did not want to go to the emergency department for evaluation. The medical doctor later gave orders to have R111 sent to the emergency room for evaluation. The evaluation at the emergency room showed a left femur fracture. State authority notified on 12/3/25 once facility received notification of the fracture diagnosis. On 12/3/25, electromagnetic waves (X-ray) revealed new displaced comminuted intertrochanteric/ periprosthetic fracture of the proximal left femur (fracture top of thigh bone). In addition, the x-ray revealed a displaced fracture of the right distal femoral diaphysis and metaphysis (fracture of the thighbone above the knee joint). On 12/6/25, surgical report revealed R111 had an insertion retrograde intramedullary nail placed in the right femur (treatment for fractures of the femoral shaft). On 12/11/25, surgical report identified removal intramedullary nail from left knee with replacement of an antegrade nail (used to stabilize fractures while maintaining alignment and length) to the left hip femur. R111's treatment medical record (TAR) identified staff to monitor R111's right hip, thigh, and knee surgical incision for any signs or symptoms of complications, from 12/16/25 until 1/7/26. Progress note dated 12/1/25 at 10:29 p.m., identified R111 fell in room at 7:40 p.m., R111 rolled out of bed. No injury noted. Fax sent to medical provider. Progress note dated 12/2/25 at 4:45 a.m., identified R111 complained of pain in her legs when being	F0689		04/13/2026

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F0689 SS = G	Continued from page 3 moved. Progress note dated 12/2/25 at 10:02 a.m., identified R111 complained of pain all over, especially her right arm, right leg, and left hip. Bruise seen on the right inner knee and top of right foot just below the great toe. R111said the pain is not alleviated with oxycodone. Progress note dated 12/2/25 at 10:05 a.m., identified R111 wanted the x-ray done in the facility, did not want to be sent to the emergency department. Provider was updated on the request. Progress note dated 12/2/25 at 10:17 a.m., identified R111's sister was provided an update on the increased pain and R111's request to have x-ray completed in-house versus seeking emergency evaluation. Sister was in agreement. Progress note dated 12/2/25 at 9:42 p.m., identified fax was received from medical provider recommending R111 to be seen in the emergency department. R111 was given this information. R111 continued not to want to be seen in person. Brother was in the presence of this conversation with R111. This information was passed onto the medical provider. Progress note dated 12/3/25 at 9:56 a.m., identified R111 was sent to the emergency room due to pain in left hip and right foot and knee pain. Progress note dated 12/3/25 at 2:40 p.m., identified R11 would be transferring to Methodist Hospital. Progress note dated 12/13/25 at 2:16 p.m., identified R111 returned from the hospital. Bed assist device assessment completed 10/7/24 for grab bars. R111 was deemed appropriate for having grab bars attached to the upper portion of the bed. Bed assist device informed consent signed 12/18/25. Bed system device assessment completed 12/18/25, for grab bars, R111 was deemed appropriate for grab bars being attached to the upper portion of the bed. During an observation on 4/7/26 at 8:00 a.m., NA-C and NA-D went into R111’s room and informed R111 that they were going to get her ready for her bath. NA-C went to the left side of R111's bed, and NA-D went to the right side of the bed. NA-C instructed R111 to roll to the right side of the bed. NA-C and NA-D assisted R111 to lie on her right side and applied the lift sling for the mechanical lift under R111. NA-D and NA-C then assisted R111 to roll to	F0689		04/13/2026

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F0689 SS = G	Continued from page 4 her left side. Each time R111 rolled onto her side, she held onto the grab bars. NA-D positioned the lift straps between legs. R111 did not complain of pain or show any signs of anxiety during the rolling in the bed. Staff hooked the sling to the mechanical lift and lifted R111 out of bed and onto a shower chair. The lift sling was removed from under and behind the resident. NA-C brought the resident into the shower. At 8:23 a.m., NA-C and NA-D placed a mechanical sling under R111 and transferred R111 from the shower chair to the bed and lowered R111 onto the bed. NA-D went to the right side of the bed and NA-C was on the left side of the bed when rolling R111 in bed per care plan. During an interview on 4/6/26 at 1:21 p.m., R111 verified she fell out of bed and was injured. R111 indicated two staff were in her room, and one of the staff who was by the window left the room to help another resident. R111 rolled over to her right side, reached for the side table, and fell onto the floor. R111 indicated she used the mechanical lift before the fall. R111 indicated she feels safe having NA-A and NA-B provide care, as the fall was an accident. During an interview on 4/6/26 at 7:50 p.m., NA-B verified she was working the night R111 fell. NA-B indicated that she and NA-A laid R111 in bed using the mechanical lift. It came over the walkie that someone needed assistance. NA-B indicated she was not aware R111 was a two-assist for bed mobility and verified she did not read the nursing assistant care sheet at the start of the shift on 12/1/26. NA-B indicated she left the room to assist another resident. NA-B indicated R111 was recently changed to a two assist, as R111 had been a one assist with bed mobility. NA-B verified after the fall, she received education on R111 being a two-assist, and the need to read the nursing assistant care sheet before the start of the shift. NA-B indicated the facility took the grab bars away before the fall and was unsure why, but R111 now has the grab bars back on the bed. NA-B indicated R111 needed assistance with care and was a mechanical lift before the fall, and the fall has not changed her mobility. NA-B indicated R111 had two fractures from the fall. NA-B indicated R111 had more anxiety with rolling in bed right after returning from the hospital, but is back to her baseline. During an interview on 4/6/26 at 7:55 p.m., NA-A indicated on 12/1/25, NA-B assisted with transferring R111 into bed with the mechanical lift. When they were changing R111's brief, a call light went off, and it sounded on their pagers. NA-B left the room to answer the call light. NA-A went to roll	F0689		04/13/2026

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F0689 SS = G	Continued from page 5 R111 to the right, and R111 reached out for the nightstand because there were no grab bars on the bed and R111 fell on the floor. NA-A indicated R111's grab bars were taken away a few weeks before the fall and were put back on the bed after R111 returned from the hospital. R111 had some leg pain after the fall. NA-A indicated she was called to the office and had to complete refresher classes on nursing assistant responsibilities before returning to work. Education was also given on following the nursing assistant care sheet. During an interview on 4/7/26 at 10:37 a.m., TMA-A indicated R111 was a two assist for bed mobility, which started when the grab bars were removed a few weeks prior to the fall on 12/1/25. When R111 was changed to a two-assist, the nursing assistant care sheets were updated. When a change is made on the nursing care sheets, the changes are highlighted and placed on the communication clipboard and also hung up in the nurses station. TMA-A verified that she received education regarding the importance of following the nursing assistant care sheets when providing care, and that education was given to staff after R111's fall. During an interview on 4/7/26 at 10:50 a.m., NA-C indicated R111 required two staff to turn in bed prior to the fall on 12/1/25. NA-C indicated a mock survey was done at the facility a few weeks before the fall, and the mock survey results showed R111 grab bars should be removed. When the grab bars were removed, R111 was changed to a two assist when rolling in bed. NA-C indicated the nursing assistant care sheets were updated. NA-C indicated when the nursing assistant care sheets were updated, the changes would be highlighted and hung up on the wall in the nurse station, and written on the communication clipboard alerting staff to the changes. NA-C indicated R111 had anxiety and pain before the fall on 12/1/25. NA-C indicated R111 had increased anxiety right after the fall, but had returned to baseline. R111 required three staff to assist with bed mobility after returning from the hospital, as she had two fractures and her legs were kept straight. NA-C indicated R111 did not have rods put in, but had a procedure on both legs after the fall. NA-C indicated R111 grab bars were replaced after the fall, which R111 uses, and the grab bar helps R111 feel safe when rolling in bed. NA-C verified she received education regarding the importance of checking and following resident care sheets to ensure residents receiving the care they need. During an interview on 4/7/26 at 9:02 a.m.,	F0689		04/13/2026

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F0689 SS = G	Continued from page 6 registered nurse care coordinator (RNCC)-A indicated R111 fell out of bed on 12/1/25 around 7:40 p.m., when NA-A rolled R111 on the right side towards the window and reached for the nightstand and fell out of bed. R111 had her nightstand between the bed and the window. After the fall, the nurse performed range of motion (ROM) without issues, and blood pressure was measured when lying and sitting. At the time of the fall, R111 did not report any pain. The doctor was updated on the fall with no injury by fax. During the night, R111 had pain. Family and R111 did not want R111 sent to the emergency room and wanted an X-ray done in-house. The doctor was updated by fax on the pain and the family's decision not to be sent out of the facility. The doctor did not want to have the X-ray done in-house and wanted R111 to be seen at the emergency room. After ongoing pain, the family and R111 agreed to be sent in for X-rays on 12/3/36. The X-ray showed R111 had two fractures. R111 had grab bars removed on 11/18/25, which R111 would sporadically use to assist in bed mobility. The facility had a mock survey, and since R111 did not initiate the grab bars, it was decided by staff to remove the grab bars. After the fall, an assessment was done, and it was determined R111 could hold onto the grab bars once staff turned her, and the grab bars were replaced after the assessment. During an interview on 4/7/26 at 9:22 a.m., administrator indicated R111 was a two assist for bed mobility when the grab bars were removed from the bed on 11/18/25. The nursing assistant care sheet was changed to reflect R111 was a two assist for turning in bed. Administrator verified that the nursing assistant care sheet was not being followed when resident fell out of bed. NA-A and NA-B transferred R111 into the bed, and NA-B went to help another resident. NA-A rolled resident on the right side. R111 reached for the nightstand and pulled on the nightstand, and fell. An investigation was completed. All care staff received education following the nursing assistant care sheets. Residents were interviewed about the care they received and if they had any concerns. Audits were completed on the nursing assistant care sheets to ensure they were accurate. Audits were completed ensuring care was done according to the nursing assistant care sheets. Administrator's expectation would be for staff to follow the nursing assistant care sheets to prevent accidents and ensure the safety of staff and residents. During an interview on 4/7/26 at 10:31 a.m., director of nursing (DON) indicated R111's fall occurred when R111 was transferred into bed by NA-A and	F0689		04/13/2026

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F0689 SS = G	Continued from page 7 NA-B. R111 was a two assist for turning in bed at the time of the fall. NA-B left the room, and R111 was rolled to her side. R111 reached for the side table and fell to the floor. DON was unable to determine if having a second staff member present would have prevented the fall. DON verified R111 received two new fractures from the fall. DON verified the nursing assistant care sheet indicated two staff for bed mobility and the nursing care sheet was not followed at the time of the fall. DON verified that the staff called administration after the fall, and the staff was interviewed regarding the fall. Education was given to NA-A and NA-B and was removed from the schedule. Residents were interviewed regarding their care to ensure residents felt they were receiving the care they needed. All care staff were provided with education on the importance of following the nursing assistant care sheet. NA-A was provided with education in-house and received extra classes before returning to work. Audits were carried out to ensure nursing care sheets and care plans are updated when changes are received. Audits were done to ensure staff were following the care sheets. During an interview on 4/7/26 at 1:02 p.m., physical therapist (PT) indicated R111 was discharged from physical therapy on 9/30/25, with instructions for two staff members for bed mobility. PT indicated R111 had grab bars prior to a mock survey that was completed by presbyterian homes. The mock survey indicated the grab bars to be removed and R111 to be an assist of two with transfers and bed mobility. PT indicated R111 had a fall on 12/1/26. When R111 returned from the hospital, R111 received physical therapy three times a week. Occupational therapy (OT) saw R111 twice a week when R111 returned from the hospital, PT requested that the grab bars be reinstated on 12/17/26. PT changed R111 to an assist of three when turning in bed, two staff to assist with turning, and one staff member to assist with leg positioning. The assistance of three was discontinued on 1/20/26. PT stated they would expect staff to follow PT recommendations to ensure the safety of staff and residents. During an interview on 4/7/26 at 3:40 p.m., medical provider (MP) indicated she was aware of the fall on 12/1/26. MP indicated she was under the understanding that R111 was being rolled in bed for cares when the fall occurred. The facility sent a fax after the fall occurred, indicating no injury. Later that day, MP received a fax that R111 was having pain and requested the portable X-ray machine, as the family and R111 did not want to be seen outside of the facility. MD responded to facility that R111	F0689		04/13/2026

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F0689 SS = G	Continued from page 8 needed to be seen, as without an assessment, MP-A would not know which joints or limbs would need to be x-rayed without an evaluation. The following day, MP-A was sent a third fax from the facility indicating R111 was refusing the in person evaluation. MP indicated she requested the facility to inform R111's sister that R111 needed to be evaluated in person for a trauma evaluation and the importance of having this evaluation. After the facility talked with the resident and sister, the facility then sent R111 to the emergency room. R111 had a new displaced fracture of the left femur and a right knee distal diaphysis and metaphysis. From the emergency room, R111 was sent to Regions Hospital in St. Paul. R111 was admitted later that night, around midnight on 1/4/26, and discharged on 1/13/26. The consultant orthopedic surgeon recommended what we call a palliative surgical repair to help R111 with pain and symptoms. On 12/6/26, a nail was placed into the right femur. On 12/11/26, a nail was placed into the left hip femur. MP-A was not aware that the staff was not following the care plan when R111 fell. MP-A indicated that two staff should have been providing care, but it would be speculative to say that having two staff would have prevented the fall. MP-A indicated R111 had anxiety and pain before the fall, which did increase after the fall, but R111's pain and anxiety have since returned to baseline. Verification of corrective action was confirmed by interview with facility staff and review of training documentation. The nursing assistant involved verified she was promptly re-educated on the importance of following the nursing assistant care sheets. Documentation showed the facility had developed, implemented, and completed a plan to ensure that any staff responsible for providing cares were trained. This was confirmed by review of training records and staff interview. Observation of care in bed observed and verified that staff were following the nursing assistant care sheets. Interviews were conducted with other residents in the neighborhood about the NA-A and NA-B performance, which indicated residents had no concerns with cares. Facility was able to demonstrate monitoring of the corrective action and sustained compliance. Review of policy titled Fall Prevention and Management Program Policy dated 1/26, identified, that upon admission, quarterly, annually and with significant change all residents will be assessed for their risk for falls. The Clinical Administrator is responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment in collaboration	F0689		04/13/2026

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F0689 SS = G	Continued from page 9 with facility equipment experts to aid in fall prevention. Clinical Coordinator or designee is responsible for implementation and oversight of individualized residents fall prevention care as follows: Assessing fall risk upon admission, quarterly, with significant change in condition. Determining risk for fall and establishing appropriate interventions in the care plan related to fall risk in the plan of care. Implementing the interventions specific to fall risk data collection. Supervising personnel in delivering safe and personalized care. Evaluating the effectiveness of interventions in relation to the resident specific plan of care. Collaborating with the interdisciplinary team in the prevention of falls. Appropriately managing residents who experience a fall by implementing interventions to prevent further falls. The facility will complete fall tracking with review every month. The information will be brought to the QAPI committee quarterly for review. A site and/or household root cause analysis will be completed by an interdisciplinary team. Action plans will be created as needed. The past noncompliance that began on 12/1/25. The deficient practice was corrected by 12/9/25, after the facility implemented a systemic plan that induced the following actions: immediate education on facility policy for all NA's and nurses to review the nursing assistant care sheet prior to the start of the shift. Interviews with staff on 4/6/26 and 4/7/26, confirmed understanding of reviewing the nursing assistant care sheet before the start of the shift for changes. Observation of transfers on 4/7/26 demonstrated compliance with transfers and bed mobility.	F0689		04/13/2026

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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 4/6/26 to 4/7/26, a standard 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H51141064C(iQIES #2800937). NO licensing	20000		04/13/2026

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

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20000	Continued from page 1 orders were issued. The following complaints were reviewed: H51141065C (iQIES #1143196). NO licensing orders were issued. The following complaints were reviewed: H51149486C (iQIES #2684099), with a licensing order issued at F0689. 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 surveyor’s 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. 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. 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.	20000		04/13/2026

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20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide care consistent with a resident's needs and care plan to eliminate/reduce the risk of an accident during cares in bed for 1 of 3 residents (R111). This resulted in actual harm to R111 when staff repositioned R111 on her side with one staff member instead of two staff members per care plan, causing R111 to roll out of the bed to the floor. As a result, R111 was admitted to the hospital on 12/4/25 for a fracture of the right femur and a closed fracture of the left hip. R111 had surgery on 12/6/25 on the right femur and surgery on 12/11/25 on the left hip femur. The facility had implemented actions to prevent recurrence prior to the survey on 4/6/26, therefore, the citation was issued at past non-compliance. R111's quarterly Minimal Set Data (MDS) dated 3/31/26, identified R111 as cognitively intact. R111 was dependent on staff for toileting, rolling to the left and right in bed, and lower body dressing and needed maximal assistance with upper body dressing. R111 had a diagnosis including fractures and diabetes. R111's care plan was revised on 8/28/24, identified R111 needed two staff for sling management and when moving up in bed. R111's care sheet, dated 11/26/25, identified R111 needed two staff for dressing, bathing, and transferring. R111's physical therapy discharge summary dated 9/30/25, identified R111 needed moderate to maximal assistance from two caregivers for rolling to the left and right sides in bed. R111's incident report dated 12/1/25 at 7:40 p.m.,	20830	Corrected. The deficient practice was corrected by 12/9/2025 after the facility implemented a systemic plan of education and audits.	04/13/2026

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20830	Continued from page 3 identified R111 was assisted into bed with a full mechanical lift and the assistance from nursing assistant (NA)-A and NA-B. NA-B left the room to help another resident, and NA-A rolled R111 to change her brief. R111 rolled to the right side and fell from bed. R111 landed on the floor on her back, arms at her side, legs bent towards herself. Resident denied being hurt at the time of the fall. No medical attention required at the time of the fall. Medical provider notified on 12/1/25 at 8:25 p.m., sister notified 12/1/25 at 9:00 p.m., administrator notified, no time identified. The short term intervention was education for NA-A and NA-B to always use two staff for bed mobility. A note was made on the incident report that the resident and family did not want to go to the emergency department for evaluation. The medical doctor later gave orders to have R111 sent to the emergency room for evaluation. The evaluation at the emergency room showed a left femur fracture. State authority notified on 12/3/25 once facility received notification of the fracture diagnosis. On 12/3/25, electromagnetic waves (X-ray) revealed new displaced comminuted intertrochanteric/ periprosthetic fracture of the proximal left femur (fracture top of thigh bone). In addition, the x-ray revealed a displaced fracture of the right distal femoral diaphysis and metaphysis (fracture of the thighbone above the knee joint). On 12/6/25, surgical report revealed R111 had an insertion retrograde intramedullary nail placed in the right femur (treatment for fractures of the femoral shaft). On 12/11/25, surgical report identified removal intramedullary nail from left knee with replacement of an antegrade nail (used to stabilize fractures while maintaining alignment and length) to the left hip femur. R111's treatment medical record (TAR) identified staff to monitor R111's right hip, thigh, and knee surgical incision for any signs or symptoms of complications, from 12/16/25 until 1/7/26. Progress note dated 12/1/25 at 10:29 p.m., identified R111 fell in room at 7:40 p.m., R111 rolled out of bed. No injury noted. Fax sent to medical provider. Progress note dated 12/2/25 at 4:45 a.m., identified R111 complained of pain in her legs when being moved. Progress note dated 12/2/25 at 10:02 a.m., identified	20830		04/13/2026

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20830	Continued from page 4 R111 complained of pain all over, especially her right arm, right leg, and left hip. Bruise seen on the right inner knee and top of right foot just below the great toe. R111said the pain is not alleviated with oxycodone. Progress note dated 12/2/25 at 10:05 a.m., identified R111 wanted the x-ray done in the facility, did not want to be sent to the emergency department. Provider was updated on the request. Progress note dated 12/2/25 at 10:17 a.m., identified R111's sister was provided an update on the increased pain and R111's request to have x-ray completed in-house versus seeking emergency evaluation. Sister was in agreement. Progress note dated 12/2/25 at 9:42 p.m., identified fax was received from medical provider recommending R111 to be seen in the emergency department. R111 was given this information. R111 continued not to want to be seen in person. Brother was in the presence of this conversation with R111. This information was passed onto the medical provider. Progress note dated 12/3/25 at 9:56 a.m., identified R111 was sent to the emergency room due to pain in left hip and right foot and knee pain. Progress note dated 12/3/25 at 2:40 p.m., identified R11 would be transferring to Methodist Hospital. Progress note dated 12/13/25 at 2:16 p.m., identified R111 returned from the hospital. Bed assist device assessment completed 10/7/24 for grab bars. R111 was deemed appropriate for having grab bars attached to the upper portion of the bed. Bed assist device informed consent signed 12/18/25. Bed system device assessment completed 12/18/25, for grab bars, R111 was deemed appropriate for grab bars being attached to the upper portion of the bed. During an observation on 4/7/26 at 8:00 a.m., NA-C and NA-D went into R111’s room and informed R111 that they were going to get her ready for her bath. NA-C went to the left side of R111's bed, and NA-D went to the right side of the bed. NA-C instructed R111 to roll to the right side of the bed. NA-C and NA-D assisted R111 to lie on her right side and applied the lift sling for the mechanical lift under R111. NA-D and NA-C then assisted R111 to roll to her left side. Each time R111 rolled onto her side, she held onto the grab bars. NA-D positioned the lift straps between legs. R111 did not complain of pain	20830		04/13/2026

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20830	Continued from page 5 or show any signs of anxiety during the rolling in the bed. Staff hooked the sling to the mechanical lift and lifted R111 out of bed and onto a shower chair. The lift sling was removed from under and behind the resident. NA-C brought the resident into the shower. At 8:23 a.m., NA-C and NA-D placed a mechanical sling under R111 and transferred R111 from the shower chair to the bed and lowered R111 onto the bed. NA-D went to the right side of the bed and NA-C was on the left side of the bed when rolling R111 in bed per care plan. During an interview on 4/6/26 at 1:21 p.m., R111 verified she fell out of bed and was injured. R111 indicated two staff were in her room, and one of the staff who was by the window left the room to help another resident. R111 rolled over to her right side, reached for the side table, and fell onto the floor. R111 indicated she used the mechanical lift before the fall. R111 indicated she feels safe having NA-A and NA-B provide care, as the fall was an accident. During an interview on 4/6/26 at 7:50 p.m., NA-B verified she was working the night R111 fell. NA-B indicated that she and NA-A laid R111 in bed using the mechanical lift. It came over the walkie that someone needed assistance. NA-B indicated she was not aware R111 was a two-assist for bed mobility and verified she did not read the nursing assistant care sheet at the start of the shift on 12/1/26. NA-B indicated she left the room to assist another resident. NA-B indicated R111 was recently changed to a two assist, as R111 had been a one assist with bed mobility. NA-B verified after the fall, she received education on R111 being a two-assist, and the need to read the nursing assistant care sheet before the start of the shift. NA-B indicated the facility took the grab bars away before the fall and was unsure why, but R111 now has the grab bars back on the bed. NA-B indicated R111 needed assistance with care and was a mechanical lift before the fall, and the fall has not changed her mobility. NA-B indicated R111 had two fractures from the fall. NA-B indicated R111 had more anxiety with rolling in bed right after returning from the hospital, but is back to her baseline. During an interview on 4/6/26 at 7:55 p.m., NA-A indicated on 12/1/25, NA-B assisted with transferring R111 into bed with the mechanical lift. When they were changing R111's brief, a call light went off, and it sounded on their pagers. NA-B left the room to answer the call light. NA-A went to roll R111 to the right, and R111 reached out for the nightstand because there were no grab bars on the bed and R111 fell on the floor. NA-A indicated	20830		04/13/2026

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20830	Continued from page 6 R111's grab bars were taken away a few weeks before the fall and were put back on the bed after R111 returned from the hospital. R111 had some leg pain after the fall. NA-A indicated she was called to the office and had to complete refresher classes on nursing assistant responsibilities before returning to work. Education was also given on following the nursing assistant care sheet. During an interview on 4/7/26 at 10:37 a.m., TMA-A indicated R111 was a two assist for bed mobility, which started when the grab bars were removed a few weeks prior to the fall on 12/1/25. When R111 was changed to a two-assist, the nursing assistant care sheets were updated. When a change is made on the nursing care sheets, the changes are highlighted and placed on the communication clipboard and also hung up in the nurses station. TMA-A verified that she received education regarding the importance of following the nursing assistant care sheets when providing care, and that education was given to staff after R111's fall. During an interview on 4/7/26 at 10:50 a.m., NA-C indicated R111 required two staff to turn in bed prior to the fall on 12/1/25. NA-C indicated a mock survey was done at the facility a few weeks before the fall, and the mock survey results showed R111 grab bars should be removed. When the grab bars were removed, R111 was changed to a two assist when rolling in bed. NA-C indicated the nursing assistant care sheets were updated. NA-C indicated when the nursing assistant care sheets were updated, the changes would be highlighted and hung up on the wall in the nurse station, and written on the communication clipboard alerting staff to the changes. NA-C indicated R111 had anxiety and pain before the fall on 12/1/25. NA-C indicated R111 had increased anxiety right after the fall, but had returned to baseline. R111 required three staff to assist with bed mobility after returning from the hospital, as she had two fractures and her legs were kept straight. NA-C indicated R111 did not have rods put in, but had a procedure on both legs after the fall. NA-C indicated R111 grab bars were replaced after the fall, which R111 uses, and the grab bar helps R111 feel safe when rolling in bed. NA-C verified she received education regarding the importance of checking and following resident care sheets to ensure residents receiving the care they need. During an interview on 4/7/26 at 9:02 a.m., registered nurse care coordinator (RNCC)-A indicated R111 fell out of bed on 12/1/25 around 7:40 p.m., when NA-A rolled R111 on the right side	20830		04/13/2026

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20830	Continued from page 7 towards the window and reached for the nightstand and fell out of bed. R111 had her nightstand between the bed and the window. After the fall, the nurse performed range of motion (ROM) without issues, and blood pressure was measured when lying and sitting. At the time of the fall, R111 did not report any pain. The doctor was updated on the fall with no injury by fax. During the night, R111 had pain. Family and R111 did not want R111 sent to the emergency room and wanted an X-ray done in-house. The doctor was updated by fax on the pain and the family's decision not to be sent out of the facility. The doctor did not want to have the X-ray done in-house and wanted R111 to be seen at the emergency room. After ongoing pain, the family and R111 agreed to be sent in for X-rays on 12/3/36. The X-ray showed R111 had two fractures. R111 had grab bars removed on 11/18/25, which R111 would sporadically use to assist in bed mobility. The facility had a mock survey, and since R111 did not initiate the grab bars, it was decided by staff to remove the grab bars. After the fall, an assessment was done, and it was determined R111 could hold onto the grab bars once staff turned her, and the grab bars were replaced after the assessment. During an interview on 4/7/26 at 9:22 a.m., administrator indicated R111 was a two assist for bed mobility when the grab bars were removed from the bed on 11/18/25. The nursing assistant care sheet was changed to reflect R111 was a two assist for turning in bed. Administrator verified that the nursing assistant care sheet was not being followed when resident fell out of bed. NA-A and NA-B transferred R111 into the bed, and NA-B went to help another resident. NA-A rolled resident on the right side. R111 reached for the nightstand and pulled on the nightstand, and fell. An investigation was completed. All care staff received education following the nursing assistant care sheets. Residents were interviewed about the care they received and if they had any concerns. Audits were completed on the nursing assistant care sheets to ensure they were accurate. Audits were completed ensuring care was done according to the nursing assistant care sheets. Administrator's expectation would be for staff to follow the nursing assistant care sheets to prevent accidents and ensure the safety of staff and residents. During an interview on 4/7/26 at 10:31 a.m., director of nursing (DON) indicated R111's fall occurred when R111 was transferred into bed by NA-A and NA-B. R111 was a two assist for turning in bed at the time of the fall. NA-B left the room, and R111 was rolled to her side. R111 reached for the side	20830		04/13/2026

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20830	Continued from page 8 table and fell to the floor. DON was unable to determine if having a second staff member present would have prevented the fall. DON verified R111 received two new fractures from the fall. DON verified the nursing assistant care sheet indicated two staff for bed mobility and the nursing care sheet was not followed at the time of the fall. DON verified that the staff called administration after the fall, and the staff was interviewed regarding the fall. Education was given to NA-A and NA-B and was removed from the schedule. Residents were interviewed regarding their care to ensure residents felt they were receiving the care they needed. All care staff were provided with education on the importance of following the nursing assistant care sheet. NA-A was provided with education in-house and received extra classes before returning to work. Audits were carried out to ensure nursing care sheets and care plans are updated when changes are received. Audits were done to ensure staff were following the care sheets. During an interview on 4/7/26 at 1:02 p.m., physical therapist (PT) indicated R111 was discharged from physical therapy on 9/30/25, with instructions for two staff members for bed mobility. PT indicated R111 had grab bars prior to a mock survey that was completed by presbyterian homes. The mock survey indicated the grab bars to be removed and R111 to be an assist of two with transfers and bed mobility. PT indicated R111 had a fall on 12/1/26. When R111 returned from the hospital, R111 received physical therapy three times a week. Occupational therapy (OT) saw R111 twice a week when R111 returned from the hospital, PT requested that the grab bars be reinstated on 12/17/26. PT changed R111 to an assist of three when turning in bed, two staff to assist with turning, and one staff member to assist with leg positioning. The assistance of three was discontinued on 1/20/26. PT stated they would expect staff to follow PT recommendations to ensure the safety of staff and residents. During an interview on 4/7/26 at 3:40 p.m., medical provider (MP) indicated she was aware of the fall on 12/1/26. MP indicated she was under the understanding that R111 was being rolled in bed for cares when the fall occurred. The facility sent a fax after the fall occurred, indicating no injury. Later that day, MP received a fax that R111 was having pain and requested the portable X-ray machine, as the family and R111 did not want to be seen outside of the facility. MD responded to facility that R111 needed to be seen, as without an assessment, MP-A would not know which joints or limbs would need to be x-rayed without an evaluation. The following day,	20830		04/13/2026

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20830	Continued from page 9 MP-A was sent a third fax from the facility indicating R111 was refusing the in person evaluation. MP indicated she requested the facility to inform R111's sister that R111 needed to be evaluated in person for a trauma evaluation and the importance of having this evaluation. After the facility talked with the resident and sister, the facility then sent R111 to the emergency room. R111 had a new displaced fracture of the left femur and a right knee distal diaphysis and metaphysis. From the emergency room, R111 was sent to Regions Hospital in St. Paul. R111 was admitted later that night, around midnight on 1/4/26, and discharged on 1/13/26. The consultant orthopedic surgeon recommended what we call a palliative surgical repair to help R111 with pain and symptoms. On 12/6/26, a nail was placed into the right femur. On 12/11/26, a nail was placed into the left hip femur. MP-A was not aware that the staff was not following the care plan when R111 fell. MP-A indicated that two staff should have been providing care, but it would be speculative to say that having two staff would have prevented the fall. MP-A indicated R111 had anxiety and pain before the fall, which did increase after the fall, but R111's pain and anxiety have since returned to baseline. Verification of corrective action was confirmed by interview with facility staff and review of training documentation. The nursing assistant involved verified she was promptly re-educated on the importance of following the nursing assistant care sheets. Documentation showed the facility had developed, implemented, and completed a plan to ensure that any staff responsible for providing cares were trained. This was confirmed by review of training records and staff interview. Observation of care in bed observed and verified that staff were following the nursing assistant care sheets. Interviews were conducted with other residents in the neighborhood about the NA-A and NA-B performance, which indicated residents had no concerns with cares. Facility was able to demonstrate monitoring of the corrective action and sustained compliance. Review of policy titled Fall Prevention and Management Program Policy dated 1/26, identified, that upon admission, quarterly, annually and with significant change all residents will be assessed for their risk for falls. The Clinical Administrator is responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment in collaboration with facility equipment experts to aid in fall prevention. Clinical Coordinator or designee is responsible for implementation and oversight of	20830		04/13/2026

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20830	Continued from page 10 individualized residents fall prevention care as follows: Assessing fall risk upon admission, quarterly, with significant change in condition. Determining risk for fall and establishing appropriate interventions in the care plan related to fall risk in the plan of care. Implementing the interventions specific to fall risk data collection. Supervising personnel in delivering safe and personalized care. Evaluating the effectiveness of interventions in relation to the resident specific plan of care. Collaborating with the interdisciplinary team in the prevention of falls. Appropriately managing residents who experience a fall by implementing interventions to prevent further falls. The facility will complete fall tracking with review every month. The information will be brought to the QAPI committee quarterly for review. A site and/or household root cause analysis will be completed by an interdisciplinary team. Action plans will be created as needed. The past noncompliance that began on 12/1/25. The deficient practice was corrected by 12/9/25, after the facility implemented a systemic plan that induced the following actions: immediate education on facility policy for all NA's and nurses to review the nursing assistant care sheet prior to the start of the shift. Interviews with staff on 4/6/26 and 4/7/26, confirmed understanding of reviewing the nursing assistant care sheet before the start of the shift for changes. Observation of transfers on 4/7/26 demonstrated compliance with transfers and bed mobility. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent falls. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		04/13/2026

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/07/2026. At the time of this survey, Harmony River Living Center 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 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		04/24/2026

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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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 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. Harmony River Living Center was constructed in 2012, is two-stories in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has an automatic fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Each Resident Room is equipped with hard-wired, single-station smoke detectors. The facility has a capacity of 120 beds and had a census of 111 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0321 SS = E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K0321	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on K321. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal	04/10/2026

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K0321 SS = E	Continued from page 2 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 04/07/2026 at 12:37 PM, it was revealed by observation that the door to the storage/trash room on the north side of the basement was being held open with a kickdown-style doorstop. This door is installed	K0321	Continued from page 2 law. On 4/10/2026, all kick down door stops identified during the inspection have been removed from the affected corridor doors. Each door was inspected to ensure it now closes and latches properly without obstruction. No residents were harmed by this deficiency. A facility wide audit of all resident room doors, smoke barrier doors, and corridor doors was completed. No additional kick down door stops, or other prohibited hold open devices were found. Any future findings will be corrected immediately. To prevent further recurrence, monthly door inspections for six months to ensure no kick down stops or other unapproved hold open devices are present. The Facility Services Director will be responsible for compliance. The Safety Committee will determine when monitoring can be reduced or discontinued based on sustained compliance.	

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K0321 SS = E	Continued from page 3 within a rated firewall assembly.On 04/07/2026 at 12:40 PM, it was revealed by observation that the door to the maintenance shop in the basement was being held open with a kickdown-style doorstop.On 04/07/2026 at 12:42 PM, it was revealed by observation that the door to the laundry room in the basement was being held open with a kickdown-style doorstop. An interview with the Facility Director verified these deficient findings at the time of discovery.	K0321		
K0351 SS = E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.15.10.1 and 8.15.10.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K0351	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on K351. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. The facility has contracted with a licensed fire protection company to install automatic fire sprinklers in the electrical equipment rooms/closets located on the first and second floors near Elevator 2. The installation is to be completed no later than May 31, 2026. Upon completion, the licensed contractor will provide a certification of installation that the new heads have been fully integrated into the existing system. The Facility Director will review the final installation report and contractor certification. These documents will be uploaded into the TELS system for permanent record-keeping. Maintenance staff have been educated on the requirement that all enclosed closets and equipment rooms must maintain unobstructed sprinkler coverage. The Facility Services Director will present the completion certificate and the results of the facility-wide audit to the Campus Administrator and Safety committee at the next quarterly meeting. The Regional Engineering Director will ensure any ongoing changes or modifications will include a sprinkler inspection on the Annual AFR (Annual Facility Review).	05/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST , HUTCHINSON, Minnesota, 55350

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K0351 SS = E	Continued from page 4 On 04/07/2026 at 12:10 PM, it was revealed by observation that the electrical equipment room/ closet on the second floor near elevator 2 did not have a fire sprinkler installed in it.On 04/07/2026 at 12:51 PM, it was revealed by observation that the electrical equipment room/ closet on the first floor near elevator 2 did not have a fire sprinkler installed in it. An interview with the Facility Director verified these deficient findings at the time of discovery.	K0351		
K0372 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include:On 04/07/2026 at 11:46 AM, it was revealed by observation that the smoke barrier above the smoke barrier doors outside of Agate Trail had two unsealed penetrations caused by electrical conduit.On 04/07/2026 at 11:51 AM, it was revealed by observation that the smoke barrier above the smoke barrier doors outside of Fern Pathway had unsealed penetrations caused by electrical conduit and air venting. An interview with the Facility Director verified these deficient findings at the time of discovery.	K0372	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on K372. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. On 4/10/2026, the identified unsealed penetrations in the smoke barriers were caulked shut. A facility-wide audit was completed to identify any further penetration to the smoke barriers. To prevent further recurrence, education to be provided to contractors completing services within the building to ensure any penetrations to the smoke barrier are sealed. Audits will be completed as needed after contracted services are finished for compliance of smoke barrier integrity. Facility Services Director will ensure compliance.	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BLDG B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

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K0372 K0761 SS = E SS = F Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/07/2026 between 10:00 AM and 01:00 PM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that the fire doors in the facility had been inspected within the last year. An interview with the Facility Director verified this deficient finding at the time of discovery.	K0372 K0761	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on K761. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. The facility has completed the fire door inspection with no concerns identified. To prevent further recurrence, an updated inspection log was implemented to the Electronic Preventative Maintenance record keeping system. The Facility Services Director will be responsible for ensuring documentation is obtained, filed, and monitored.	04/24/2026