Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 21, 2026

Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

RE: CCN:245528
Cycle Start Date: May 6, 2026

Dear Administrator:

On May 6, 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 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

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 August 6, 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 November 6, 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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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May 21, 2026

Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

Re: Event ID: 230882-H1

Dear Administrator:

The above facility survey was completed on May 6, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING **01 - MAIN BUILD...** B. WING	**05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH , HARMONY, Minnesota, 55939**

(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/05/2026. At the time of this survey, GUNDERSEN HARMONY CARE 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	K0000		06/12/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245528	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR 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. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. GUNDERSEN HARMONY CARE CENTER is a 1 story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1967 an addition was constructed and was determined to be of Type II(111) construction. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for	K0000		06/12/2026

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K0000 Bldg. 01	Continued from page 2 automatic fire department notification. There are two occupancies in the building. The nursing home (I-2) and an outpatient clinic (B) with proper fire separation. The facility has a capacity of 43 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/12/2026
K0345 SS = F Bldg. 01	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 maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 10.18.3, 14.3.1, Table 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that no documentation was presented to confirm that semi-annual visual inspection of the fire alarm system is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345	K 0345 Fire Alarm System – Testing and Maintenance. No documentation presented to confirm semi-annual visual inspection of the fire alarm system is occurring. Solution: Corrective Action: Perform first of this year’s two semi-annual visual inspection of the fire alarm system. Measures so deficiency does not reoccur: Add task to master calendar and confirm all tasks done monthly. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Will be completed June 12, 2026.	06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245528	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**

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K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that the documentation present for review exhibited a lack of randomness in the conducting of 2nd shift fire drills. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	K0712 Fire Drills. Documentation present for review indicated a lack of randomness in the conducting of the second shift fire drills. Solution: Corrective Action: A calendar was created starting with Jan 1, 2026, where every fire drill is predetermined so quarterly each shift (AM, PM, NOC) a fire drill will be held at various times and at least 90 minutes apart. This calendar is private so staff will not know when the drills are to be held. Measures so deficiency does not reoccur: Add task to master calendar and confirm all tasks done monthly. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Was completed May 29, 2026.	05/29/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM	K0914	K0914 Electrical Systems – Maintenance and Testing. Review of available documentation indicated that failures indicated in the 12/13/2025 annual electrical outlet testing had not been addressed or corrected. Solution: Corrective Action: The electrical outlets were evaluated with needed repairs identified Dec 13, 2025. Vendor will be contacted to make these known repairs immediately. Measures so deficiency does not reoccur: Add master calendar and confirm all tasks done monthly.	06/12/2026

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K0914 SS = F Bldg. 01	Continued from page 4 test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by a review of available documentation that findings / failures noted in the annual electrical outlet testing documentation, completed 12/13/2025, had not been addressed / corrected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0914	Continued from page 4 Vendor will be given 15 – 30 days to complete a repair with immediate follow-up made with vendor if work not done on time. Anticipated completion date will be noted in the calendar to watch for delays. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Will be completed June 12, 2026.	06/12/2026
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K0923	K0923 Gas Equipment – Cylinder and Container Storage. 1) room adjacent to south nurse’s station was found unsecured and had mixed storage of cylinders. 2) room in west wing of facility had no identified location for cylinders, exhibited combustible storage in the room and non-compliant room construction. Solution: Corrective Action: Replace doorknob and lock on Oxygen Storage Room adjacent to South Nurses Station so it is locked in its normal state. Consolidate Oxygen tanks, both full and empty, in the Oxygen Storage Room adjacent to South Nurses Station. Clear signage will indicate Full Oxygen Tank storage area and Empty Oxygen Tank storage area within that room. No Oxygen tanks will be stored in the room in the West wing where some tanks had been stored.	06/12/2026

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K0923 SS = F Bldg. 01	Continued from page 5 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 at 11:45 AM, it was revealed by observation that in the Med Gas (O2), adjacent to the South Nurses Station was found unsecured, and having mixed storage of cylinders. On 05/05/2026 at 11:55 AM, it was revealed by observation that in the Med Gas (O2), in the West wing of the facility had no identified location(s) for cylinders, exhibited combustible storage in the room, and non-compliant room construction. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0923	Continued from page 5 Measures so deficiency does not recur: Monitor Oxygen Storage room monthly to confirm tanks are being stored properly and that room lock is functioning properly. Monitor so solutions sustained: Monitor monthly to confirm proper storage. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Will be completed June 12, 2026.	06/12/2026

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K0353 SS = C Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain documentation of the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, 9.7.7., 9.7.8, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.2. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that no documentation was presented for review associated with the most recent (2025) 5-yr inspection. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	K0353 Sprinkler System – Maintenance and Testing. No documentation presented to confirm most recent (2025) five-year inspection. Solution: Corrective Action: Paperwork and report from five-year inspection by Olympic Fire Protection Corp. performed Oct 14, 2025, was located. Measures so deficiency does not reoccur: Add task to master calendar and confirm all tasks done monthly. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Was completed May 29, 2026.	05/29/2026

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GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH , HARMONY, Minnesota, 55939**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/05/2026. At the time of this survey, GUNDERSEN HARMONY CARE 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	K0000		06/12/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245528	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH , HARMONY, Minnesota, 55939**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR 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. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. GUNDERSEN HARMONY CARE CENTER is a 1 story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1967 an addition was constructed and was determined to be of Type II(111) construction. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for	K0000		06/12/2026

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K0000 Bldg. 01	Continued from page 2 automatic fire department notification. There are two occupancies in the building. The nursing home (I-2) and an outpatient clinic (B) with proper fire separation. The facility has a capacity of 43 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/12/2026
K0345 SS = F Bldg. 01	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 maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 10.18.3, 14.3.1, Table 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that no documentation was presented to confirm that semi-annual visual inspection of the fire alarm system is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345	K 0345 Fire Alarm System – Testing and Maintenance. No documentation presented to confirm semi-annual visual inspection of the fire alarm system is occurring. Solution: Corrective Action: Perform first of this year’s two semi-annual visual inspection of the fire alarm system. Measures so deficiency does not reoccur: Add task to master calendar and confirm all tasks done monthly. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Will be completed June 12, 2026.	06/12/2026

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K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that the documentation present for review exhibited a lack of randomness in the conducting of 2nd shift fire drills. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	K0712 Fire Drills. Documentation present for review indicated a lack of randomness in the conducting of the second shift fire drills. Solution: Corrective Action: A calendar was created starting with Jan 1, 2026, where every fire drill is predetermined so quarterly each shift (AM, PM, NOC) a fire drill will be held at various times and at least 90 minutes apart. This calendar is private so staff will not know when the drills are to be held. Measures so deficiency does not reoccur: Add task to master calendar and confirm all tasks done monthly. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Was completed May 29, 2026.	05/29/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM	K0914	K0914 Electrical Systems – Maintenance and Testing. Review of available documentation indicated that failures indicated in the 12/13/2025 annual electrical outlet testing had not been addressed or corrected. Solution: Corrective Action: The electrical outlets were evaluated with needed repairs identified Dec 13, 2025. Vendor will be contacted to make these known repairs immediately. Measures so deficiency does not reoccur: Add master calendar and confirm all tasks done monthly.	06/12/2026

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K0914 SS = F Bldg. 01	Continued from page 4 test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by a review of available documentation that findings / failures noted in the annual electrical outlet testing documentation, completed 12/13/2025, had not been addressed / corrected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0914	Continued from page 4 Vendor will be given 15 – 30 days to complete a repair with immediate follow-up made with vendor if work not done on time. Anticipated completion date will be noted in the calendar to watch for delays. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Will be completed June 12, 2026.	06/12/2026
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K0923	K0923 Gas Equipment – Cylinder and Container Storage. 1) room adjacent to south nurse’s station was found unsecured and had mixed storage of cylinders. 2) room in west wing of facility had no identified location for cylinders, exhibited combustible storage in the room and non-compliant room construction. Solution: Corrective Action: Replace doorknob and lock on Oxygen Storage Room adjacent to South Nurses Station so it is locked in its normal state. Consolidate Oxygen tanks, both full and empty, in the Oxygen Storage Room adjacent to South Nurses Station. Clear signage will indicate Full Oxygen Tank storage area and Empty Oxygen Tank storage area within that room. No Oxygen tanks will be stored in the room in the West wing where some tanks had been stored.	06/12/2026

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K0923 SS = F Bldg. 01	Continued from page 5 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/05/2026 at 11:45 AM, it was revealed by observation that in the Med Gas (O2), adjacent to the South Nurses Station was found unsecured, and having mixed storage of cylinders. On 05/05/2026 at 11:55 AM, it was revealed by observation that in the Med Gas (O2), in the West wing of the facility had no identified location(s) for cylinders, exhibited combustible storage in the room, and non-compliant room construction. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0923	Continued from page 5 Measures so deficiency does not recur: Monitor Oxygen Storage room monthly to confirm tanks are being stored properly and that room lock is functioning properly. Monitor so solutions sustained: Monitor monthly to confirm proper storage. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Will be completed June 12, 2026.	06/12/2026

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K0353 SS = C Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain documentation of the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, 9.7.7., 9.7.8, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.2. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 05/05/2026 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that no documentation was presented for review associated with the most recent (2025) 5-yr inspection. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	K0353 Sprinkler System – Maintenance and Testing. No documentation presented to confirm most recent (2025) five-year inspection. Solution: Corrective Action: Paperwork and report from five-year inspection by Olympic Fire Protection Corp. performed Oct 14, 2025, was located. Measures so deficiency does not reoccur: Add task to master calendar and confirm all tasks done monthly. Monitor so solutions sustained: Monitor monthly to confirm task was completed. Who corrective actions / who monitor compliance: Rod Johnson, Maintenance Director will perform the task. Chuck Ness, Administrator, will monitor that task was successfully completed. Proposed date of completion: Was completed May 29, 2026.	05/29/2026