Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 29, 2024

Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

RE: CCN: 245114
Cycle Start Date: January 9, 2024

Dear Administrator:

On February 22, 2024, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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February 29, 2024

Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

Re: Reinspection Results
Event ID: 6XE712

Dear Administrator:

On February 22, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 9, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2024

Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

RE: CCN: 245114
Cycle Start Date: January 9, 2024

Dear Administrator:

On January 9, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

To be acceptable, a provider's ePOC must include the following:

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

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

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

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

DEPARTMENT CONTACT

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

Nikki Sassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 April 9, 2024 (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 July 9, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
January 24, 2024

Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

Re: State Nursing Home Licensing Orders
Event ID: 6XE711

Dear Administrator:

The above facility was surveyed on January 7, 2024 through January 9, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Nikki Sassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245114	A. BUILDING _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 1/7/24 through 1/9/24, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. 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.	E 000		
F 000	INITIAL COMMENTS On 1/7/24 through 1/9/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed, found in Complainace: MN96616 with H number: H51148608C MN99801 with H number: H51148749C MN99802 with H number: H51148763C The following complaints was reviewed found not in Compliance with NO deficiencies cited: MN95309 with H number: H51148606C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 02/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		2/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 2 by: Based on observation, interview and document review, the facility failed to ensure medication carts were properly secured for 4 of 8 medication carts observed. Findings Include: On 1/8/24, at 8:50 a.m. during medication observation trained medication aide (TMA)-A stepped away from medication cart, entered nursing office out of view of medication (med) cart with lock button observed to be in extended position. TMA-A returned to cart, continued with medication administration When interviewed on 1/8/24, at 9:03 a.m. TMA-A stated when lock button in extended position the medication cart was unlocked. TMA-A demonstrated entering code into touchpad on top surface of cart locked med cart by pulling lock button into cart. TMA-A then re-entered code demonstarting lock button extended out from cart then opening drawer demonstrating med cart was unlocked. On 1/8/24, at 9:04 a.m. observed TMA-A step away from med cart with lock button extended out. TMA-A went into nurse office dropped blood pressure machine into office, then assisted a resident around the corder from the ned cart, TMA-A was out of view of med cart On 1/8/24, at 9:07 a.m. TMA-A returned to med cart, TMA-A stated when walking away from med cart they should try to remeber to lock med cart so nobody could open the cart and remove items. TMA-A further stated the med cart would self lock, first beeping several times, but was unsure	F 761	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F761. However, 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. F761 On 1/9/2024 upon learning of concern, immediate staff education was initiated which consisted of facility-wide messaging on expectation of proper medication securement. 1:1 education began to all TMA's, LPN's, and RN's on medication cart securement. On 1/10/2024, the auto-lock timing feature of the medication carts was reduced from factory setting to the minimum time allotment at one-minute. Ongoing staff 1:1 education with auditing of understanding continued. All new employees will be educated on the medication securement expectation through the orientation process. Audits will be completed on medication cart securements twice weekly x2 weeks in random neighborhoods and random shifts to ensure compliance. The cadence will continue weekly x4 weeks, then monthly with audit results analyzed for trends and reported to QAA committee in April 2024 for further recommendations.	

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F 761	Continued From page 3 how long cart remaind unlocked prior to self locking. On 1/9/24, at 2:50 p.m. TMA-B was observed to walk away from med cart, lock button in outward position. When interviewed TMA-B stated the medication cart self locked, stated about 30 seconds but was not sure how long until med cart self-locked. On 1/9/24, 2:56 p.m. observed med cart outside of nurse office, no staff around. Med cart beeped loudly several times then self locked. On 1/9/24, at 2:58 p.m. licensed practical nurse (LPN)-A was observed to walk away from med cart with lock button in outward position. When interviewed LPN-A stated when she walked away the med cart should have been locked to keep people from opening the cart. LPN-A stated unsure how long med cart remained unlocked before it would self lock, the med cart was newer and they had not timed how long the cart remaind unlocked. On 1/9/24, at 3:27 p.m. LPN-B was observed to walk down the hallway with med cart unlocked. When interviewed LPN-B stated the cart locked itself but was unsure of how long the cart remained unlocked before locking itself. LPN-B stated the cart should be locked, don't want anobody to get into the cart. When interviewed on 1/9/24, at 3:46 p.m. director of nursing stated the med carts stay unlocked for 5 minutes and 13 seconds. The time the cart is unlocked is a factory preset, staff were trained to lock immediately.	F 761	If any outliers are identified immediate securement of medication cart and re-education to occur. The Clinical Administrator/Designee will be responsible for compliance. Date certain: 2/1/2024. Responsible Party: Clinical Administrator	

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F 761	Continued From page 4 Undated Medication Ordering and Receiving Policy identified medications and biologicals are stored safely, securely and properly, following manufacturers recommendations or those of the supplier.	F 761		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		2/9/24

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F 883	Continued From page 5 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of the 5 residents (R16, R63, R89) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the	F 883	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F883. However, 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. F883 On 1/10/2024 all residents and responsible parties received education material and evaluated for opportunity of Prevnar20 vaccination. A letter was sent	

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F 883	Continued From page 6 complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R16's face sheet, dated 1/9/2024, indicated she was 93 years old. The immunization record, dated 1/5/2024, indicated she received a PPSV23 on 9/25/2018 and a PCV13 on 8/26/2015. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R16 was offered or received PCV20. R63's face sheet, dated 1/8/2024, indicated he was 86 years old. The immunization record, dated 1/8/2024, indicated he received a PPSV23 on 1/1/1998, a PPSV23 on 12/18/2013 and a PCV13 on 11/25//2015. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R63 was offered or received PCV20. R89's face sheet, dated 1/9/2024, indicated he was 82 years old. The immunization record, dated 1/8/2024, indicated he received a PPSV23 on 7/11/1997, a PPSV23 on 3/18/2009 and a PCV13 on 1/15/2016. The record indicated R89 was provided education and consented to receiving a PCV20 on 12/6/23 but had not yet received it.	F 883	via email and standard mail. On 1/12/2024, QAA committee, which includes Infection Control Nurse, Medical Director, and Administration, reviewed area of concern and in agreement for plan of education and offering to all eligible residents. On 1/15/2024, Resident Council received further education on Prevnar20 vaccination. On 1/17/2024, Family Council received further in-person education on Prevnar20 vaccination. The three of five residents identified were immediately educated and offered the Prevnar20 vaccination. R16 declined immunization, R63 accepted and will receive administration on or before 02/09/2024, R89 accepted and will receive administration on or before 02/09/2024. A house-wide audit was completed to identify potential eligible residents to receive the vaccination. Of those eligible, shared decision making was initiated, and vaccinations to occur as indicated. All new residents continue to receive education on Prevnar20 vaccine upon admission by Admissions Staff and receive administration as indicated by Infection Control Nurse and physician based upon medical stability.	

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	245114	A. BUILDING _____ B. WING _____	C 01/09/2024

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F 883	Continued From page 7 During an interview with infection preventionist (IP), on 1/9/2024 at 10:27 a.m., IP indicated immunizations are verified upon admission through MIIC (Minnesota Immunization Information Connection). IP stated vaccine education is done with residents and families at council meetings. IP stated IP would ask residents and/or their families if immunizations were desired and consents were obtained if immunizations were needed. IP stated if a resident consents to a vaccine an order would then be obtained from the provider, and it could be administered in the facility. IP verified R16's, R63's, and R89's pneumococcal immunizations as listed above. IP stated the facility policies were followed to determine resident eligibility for all vaccines. IP verified R16 and R63 had not been offered or provided education on PCV20. IP verified R89 had been offered, provided education, and consented to the PCV20 on 12/6/23, but had not yet received it. IP verified there had been no shared clinical decision making with the resident providers regarding pneumococcal immunizations for R16, R63 and R89. The plan to educate and obtain consents for the PCV20 had recently been implemented six to eight weeks ago for new admits only and a process to determine eligibility, educate and obtain consents for all other residents had not yet been started. IP indicated residents and families were recently informed through a facility Winter 2024 newsletter that a process for reviewing current guidance and eligibility for pneumococcal vaccinations was coming and residents and families would be contacted. A facility policy titled Pneumococcal Vaccination dated July 2023 identified, residents should be vaccinated in accordance with the CDC's	F 883	Report of compliance, rate of vaccine acceptance, and administration audit results will be reported at next QAA Committee meeting in April 2024 for review and further recommendations. The Infection Control Nurse/Clinical Administrator will be responsible for compliance. Date certain: 2/9/2024. Responsible Party: Infection Control Nurse	

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F 883	Continued From page 8 pneumococcal vaccine recommendations.	F 883		

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2 000	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 1/7/24 through 1/9/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey and NO licensing orders were issued: MN96616 with H number: H51148608C MN99801 with H number: H51148749C MN99802 with H number: H51148763C MN95309 with H number: H51148606C Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 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.	2 000		

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21610	Continued From page 2	21610		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: F761: Labelling and storage MOELLER, LYNN Based on observation, interview and document review, the facility failed to ensure medication carts were properly secured for 4 of 8 medication carts observed. Findings Include: On 1/8/24, at 8:50 a.m. during medication observation trained medication aide (TMA)-A stepped away from medication cart, entered nursing office out of view of medication (med) cart with lock button observed to be in extended position. TMA-A returned to cart, continued with medication administration When interviewed on 1/8/24, at 9:03 a.m. TMA-A stated when lock button in extended position the medication cart was unlocked. TMA-A demonstrated entering code into touchpad on top surface of cart locked med cart by pulling lock button into cart. TMA-A then re-entered code demonstarting lock button extended out from cart then opening drawer demonstrating med cart was unlocked.	21610	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F761. However, 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. F761 On 1/9/2024 upon learning of concern, immediate staff education was initiated which consisted of facility-wide messaging on expectation of proper medication securement. 1:1 education began to all TMA's, LPN's, and RN's on medication cart securement. On 1/10/2024, the auto-lock timing feature of the medication carts was reduced from factory setting to the minimum time allotment at one-minute. Ongoing staff 1:1 education with auditing of understanding continued. All new employees will be educated on the medication securement expectation	2/1/24

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21610	Continued From page 3 On 1/8/24, at 9:04 a.m. observed TMA-A step away from med cart with lock button extended out. TMA-A went into nurse office dropped blood pressure machine into office, then assisted a resident around the corder from the ned cart, TMA-A was out of view of med cart On 1/8/24, at 9:07 a.m. TMA-A returned to med cart, TMA-A stated when walking away from med cart they should try to remeber to lock med cart so nobody could open the cart and remove items. TMA-A further stated the med cart would self lock, first beeping several times, but was unsure how long cart remaind unlocked prior to self locking. On 1/9/24, at 2:50 p.m. TMA-B was observed to walk away from med cart, lock button in outward position. When interviewed TMA-B stated the medication cart self locked, stated about 30 seconds but was not sure how long until med cart self-locked. On 1/9/24, 2:56 p.m. observed med cart outside of nurse office, no staff around. Med cart beeped loudly several times then self locked. On 1/9/24, at 2:58 p.m. licensed practical nurse (LPN)-A was observed to walk away from med cart with lock button in outward position. When interviewed LPN-A stated when she walked away the med cart should have been locked to keep people from opening the cart. LPN-A stated unsure how long med cart remained unlocked before it would self lock, the med cart was newer and they had not timed how long the cart remaind unlocked. On 1/9/24, at 3:27 p.m. LPN-B was observed to walk down the hallway with med cart unlocked.	21610	through the orientation process. Audits will be completed on medication cart securements twice weekly x2 weeks in random neighborhoods and random shifts to ensure compliance. The cadence will continue weekly x4 weeks, then monthly with audit results analyzed for trends and reported to QAA committee in April 2024 for further recommendations. If any outliers are identified immediate securement of medication cart and re-education to occur. The Clinical Administrator/Designee will be responsible for compliance. Date certain: 2/1/2024. Responsible Party: Clinical Administrator	

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21610	Continued From page 4 When interviewed LPN-B stated the cart locked itself but was unsure of how long the cart remained unlocked before locking itself. LPN-B stated the cart should be locked, don't want anobody to get into the cart. When interviewed on 1/9/24, at 3:46 p.m. director of nursing stated the med carts stay unlocked for 5 minutes and 13 seconds. The time the cart is unlocked is a factory preset, staff were trained to lock immediately. Undated Medication Ordering and Receiving Policy identified medications and biologicals are stored safely, securely and properly, following manufacturers recommendations or those of the supplier. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/08/2024. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/02/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 120 beds and had a census of 113 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation,	K 324	This Plan of Correction constitutes our	2/2/24

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K 324	Continued From page 3 observation, and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1, 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.3, and the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/08/2024 between 09:00 AM and 1:30 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 kitchen hood suppression system had conducted the 12-year hydrostatic test on the Ansul cylinder. Documentation for the kitchen hood suppression system showed that the last hydrostatic test on the cylinder occurred in 2011. 2. On 01/08/2024 between 9:00 AM and 1:30 PM, it was revealed by observation that the lockout switches installed on the residential stoves located in all neighborhood kitchens and in the Rehab Area were not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 324	written allegation of compliance for deficiency cited on K324. However, 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 Ansul System 12-year hydrostatic test was completed on 1/26/2024. The system was found to be in working order with replacement of cylinder completed by Dynamic Fire Protection. To ensure ongoing compliance, a Regulatory Compliance Task has been scheduled in the facility work order system with a frequency of every 12 years. Environmental Services Director will ensure ongoing compliance. The installation of timers to all nine identified areas of the building will occur as soon as supplier and contractor availability allows. On 2/1/2024, iGuard Stove Automatic Stove Shut Off System timers were ordered from supplier. Until the timers can be installed, all household stoves have been placed out of order with instructions that are not able to be used. Signage placed 2/1/2024. Environmental Services Director will ensure compliance with installation process.	
K 363 SS=F	Corridor - Doors	K 363		2/2/24

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K 363	Continued From page 4 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,	K 363		

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	245114	A. BUILDING **02 - NEW BLDG** B. WING _____	**01/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 5 etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/08/2024 between 9:00 AM and 1:30 PM, it was revealed by observation that the doors to the clean linen rooms had a magnetic hold-open device for the door that was not connected to the fire alarm system. This violation occurred in the following wings: Pleasant Stream, Wooded Glen, Valley Creek, Hillside Bend, Meadowood, and Agate Trail. 2. On 01/08/2024 between 9:00 AM and 1:30 PM, it was revealed by observation that the doors to the Refuse and Recycling rooms on the first floor by Fern Pathway and on the 2nd floor by Stonebrook had a magnetic hold-open device for the door that was not connected to the fire alarm system. 3. On 01/08/2024 between 9:00 AM and 1:30 PM, it was revealed by observation the door to room 215 was propped open. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 363	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on K363. However, 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 1/10/2024, a facility-wide audit was completed to identify rooms that had magnetic hold-open devices not connected to the fire alarm system. Facility work-orders were placed to have all identified door magnets removed. By 1/19/2024 all door magnets not tied to the fire alarm system were removed by Facility Services staff members. A secondary audit was conducted by Environmental Services Director to ensure all were removed and compliance was in place. Environmental Services Director will ensure ongoing compliance. Room 215 was identified as having an item in front of door, propping open the door. Item immediately removed upon discovery by Environmental Services Director. Education was completed to all staff on inability to have items propping open doors. Audits will be completed to ensure no items are used to keep doors ajar. On going compliance audits will be performed by Facility Services staff during monthly rounds. Environmental Services	

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K 363	Continued From page 6	K 363	Director will ensure ongoing compliance.	
K 372 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 REQUIREMENT 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: 1. On 01/08/2024 between 9:00 AM and 1:30 PM, it was revealed by observation that there were penetrations in the smoke barrier above the smoke barrier doors leading into Wooded Glen without fire caulking. 2. On 01/08/2024 between 9:00 AM and 1:30 PM, it was revealed by observation that there were penetrations in the smoke barrier above the	K 372	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on K372. However, 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 1/9/2024 a facility-wide audit was completed to identify any penetration in smoke barriers that were not fire caulked. On 1/17/2024, fire caulking occurred to all identified areas as discovered during survey and subsequent audit. A Regulatory Compliance Task has been placed in the facility work order system on	1/17/24

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K 372	Continued From page 7 smoke barrier doors leading into Meadowood where red wires were running through the barrier without fire caulking. An interview with the Director of Environmental Services Director verified these deficient findings at the time of discovery.	K 372	an annual frequency. Environmental Services Director will ensure ongoing compliance.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical	K 920	This Plan of Correction constitutes our written allegation of compliance for	1/17/24

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K 920	Continued From page 8 adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, section 400.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/08/2024 between 9:00 AM and 1:30 PM, it was revealed observation there was an extension cord in room 248 being used to power a Christmas tree and holiday lights. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 920	deficiency cited on K920. However, 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. Upon discovery of extension cord within resident room, cord was immediately removed. On 1/9/2024 a facility-wide audit was completed with no further extension cords identified. On 1/10/2024 residents and families received education on compliance. On 1/15/2024, Resident Council received further education on compliance and on 1/17/2024, Family Council also received further in-person education on compliance. To prevent future recurrence, educational material placed in admission packet for all new admissions. On going compliance audits will be performed by Facility Services staff during monthly rounds. Environmental Services Director will ensure ongoing compliance.	