DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9IT7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00348

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245114**

2.STATE VENDOR OR MEDICAID NO.
(L2) **927400000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HARMONY RIVER LIVING CENTER**
(L4) **1555 SHERWOOD STREET SOUTHEAST**
(L5) **HUTCHINSON, MN** (L6) **55350**

4. TYPE OF ACTION: **7** (L8)

1. Initial — 2. Recertification
3. Termination — 4. CHOW
5. Validation — 6. Complaint
7. On-Site Visit — 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2008**

6. DATE OF SURVEY **09/29/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited — 1 TJC
2 AOA — 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)
13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Kathy Serie, Unit Supervisor — 09/292016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/19/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/15/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/31/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/28/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245114
October 19, 2016

Ms. Linda Krentz, Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

Dear Ms. Krentz:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 21, 2016 the above facility is certified for or recommended for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 19, 2016

Ms. Linda Krentz, Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

RE: Project Number S5114026

Dear Ms. Krentz:

On September 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 25, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 21, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 25, 2016, effective September 21, 2016 and therefore remedies outlined in our letter to you dated September 7, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245114	A. Building B. Wing	9/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 09/21/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 09/21/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 09/21/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 03048	DATE 09/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245114	A. Building 02 - NEW BLDG B. Wing	9/21/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 09/21/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 12424	DATE 09/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9IT7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00348

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245114**

2. STATE VENDOR OR MEDICAID NO. (L 2) **927400000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HARMONY RIVER LIVING CENTER**
(L4) **1555 SHERWOOD STREET SOUTHEAST**
(L5) **HUTCHINSON, MN** (L6) **55350**

4. TYPE OF ACTION: 2 (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2008**

6. DATE OF SURVEY **08/25/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Wendy Willson, HFE NE II 09/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/27/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **03/15/1967** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 7, 2016

Ms. Linda Krentz, Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

RE: Project Number S5114026

Dear Ms. Krentz:

On August 25, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 4, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 4, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 25, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	08/25/2016

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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a pressure-reducing heel boot was consistently applied to promote healing of a deep tissue injury as directed by the care plan for 1 of 1 resident (R75) reviewed for pressure ulcers. Findings include: R75's current diagnoses according to her face sheet, dated 8/25/16 included a right hip fracture, dementia and diabetes.	F 282	Harmony River Living Center will properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity and pressure injuries; to implement preventative measures; and to provide appropriate treatment modalities for pressure injuries according to standards of care. In an effort to continue this practice, Harmony River Living Center will do the following: R75 Care plan was reviewed for current modalities and remain appropriate. Resident Assistant Worksheets were	9/21/16

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

Electronically Signed | 09/16/2016

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 _____	08/25/2016

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

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F 282	Continued From page 1 R75's admission Minimum Data Set (MDS), dated 8/4/16 indicated severe cognitive impairment, risk for pressure ulcer development with no current pressure ulcers identified and indicated R75 required the extensive assistance of staff for bed mobility, transfers and dressing. R75's care plan, last revised 8/24/16 indicated R75 had a pressure ulcer to the right heel (unstageable suspected deep tissue injury) and was at risk for further impaired skin integrity related to cognitive impairment, diabetes, recent surgery/hospitalization, and immobility. Interventions included a pressure relieving air mattress on the bed, bed cradle on to lift blankets off feet, elevate heels off bed using pillows/heel elevation products while in bed and blue pressure reduction boot on at all times. R75's treatment sheets, dated 8/16 indicated daily skin monitoring for a reddened area on the right great toe and indicated the bandage was to be removed from R75's right heel and checked daily in the morning, bed cradle on each shift when in bed and create a tent for sheet when in bed, 3 inch thick towel or blanket under mattress pad at level of calf. No pressure to heels. During interview on 8/22/16, at 5:56 p.m. registered nurse (RN)-A indicated that R75 had an ulcer on the right heel, and the physician did not feel it required debridement. Staff were elevating the heels and had applied a tent on R75's bed to avoid pressure from the bed sheets. During observation on 8/23/16, at 7:21 a.m. R75 was resting in bed, with a towel rolled up underneath the right calf. A blue boot was in place on the foot, which had a cutout area over	F 282	updated to include pressure reducing heel boot application to be on at all times unless ambulating with therapy. Point of Care task assignment updated to reflect plan of care. ETar updated to include pressure reduction heel boot application monitor. Therapy was educated to have shoe on only with ambulation and ensure pressure reducing heel boot applied upon completion. All residents with pressure injury were reviewed to ensure that care plans, RA worksheets, POC, and ETar are up to date and being followed. Skin Risk policy reviewed and remains current. Nursing staff education on following care planned interventions reviewed on 9/14/16 and will be reviewed on 9/21/16. Orientation check list for all nursing staff reviewed and includes staff responsibilities. Random weekly audits with a minimum of 2 per week will be completed on the care plan, RA worksheets, POC task and Etar to ensure care plan is being followed on residents with pressure injuries with results reported to QA committee at its next scheduled meeting 10/28/16. QA committee will determine if the audits need to be continued or if other interventions should be instituted. DON responsible. Date Certain: 9/21/16	

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F 282	Continued From page 2	F 282		

the right heel to relieve pressure. R75 had an air mattress with a foot cradle in place.

During observation on 8/23/16, at 9:20 a.m. R75 was seated in the hallway on the Agate Trail Unit, with a shoe on the right foot. The right foot was resting directly on the footrests.

During observation on 8/23/16, at 11:16 a.m., R75 was noted leaving the therapy department with therapy staff. Her right foot still had the shoe on it, and was directly resting upon the footrest.

During interview on 8/23/16, at 11:19 a.m. physical therapist (PT)-A stated R75 wore shoes in therapy for walking, and the shoes she had on now were new and brought in by family due to a wound on the right heel. PT-A placed R75 at the dining room table and walked back to the therapy department, leaving the shoe on R75's foot.

During observation and interview on 8/23/16, at 2:08 p.m. the occupational therapy assistant (COTA)-A indicated R75 wore shoes in therapy. R75 had a blue boot on at this time and was assisted out of bed by COTA-A, who removed the boot and applied her shoes. COTA-A indicated the boot was usually worn in bed and seemed to be off when she was up.

During observation and interview on 8/24/16, at 7:36 a.m. R75's heel wound was visualized with licensed practical nurse (LPN)-B. The area had rolled skin about the edges and a purple center. R75's blue boot was noted to be lying to the right of her bed, on the other side of her nightstand at the head of the bed. A small purple intact area was noted as well to the medial aspect of the right great toe. LPN-A indicated she had thought

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F 282	Continued From page 3 R75 wore the boot when up in the wheelchair, but not in bed. RN-A came into the room and also visualized the heel area, and stated R75 should have been wearing the blue pressure reduction boot while in bed and was to wear it at all times in the chair, but could use the shoes for therapy. RN-A stated R75 may have "thrown it off." During interview on 8/24/16, at 9:42 a.m. RN-B indicated R75's right heel boot should be on at all times, except when walking with therapy. RN-B indicated she had written R75's care plan and pulled up R75's nursing assistant care guide, which lacked instruction with regard to the right heel boot. RN-B stated she would add this to the care guide now. During interview on 8/25/16, at 10:29 a.m. nursing assistant (NA)-A indicated R75 was usually pretty cooperative with cares, and did not usually remove or throw off her heel boot. During interview on 8/25/16, at 1:34 p.m. the director of nursing (DON) indicated she would have expected the boot to be left on R75 at all times when she was not walking, and for therapy and nursing to communicate with each other when R75 completed her treatments so that the boot could be put back on. The facility policy entitled Pressure Ulcer/Injury Policy and Procedure, last revised 5/16 indicated to avoid positioning the resident on a pressure ulcer/injury. Use protective pressure reducing devices in bed and wheelchair sitting surface as ordered.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		9/21/16

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F 314	Continued From page 4 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a pressure-reducing heel boot was consistently applied to promote healing of a deep tissue injury for 1 of 1 resident (R75) reviewed for pressure ulcers. Findings include: R75's current diagnoses according to her face sheet, dated 8/25/16 included a right hip fracture, dementia and diabetes. R75's admission Minimum Data Set (MDS), dated 8/4/16 indicated severe cognitive impairment, risk for pressure ulcer development with no current pressure ulcers identified and indicated R75 required the extensive assistance of staff for bed mobility, transfers and dressing. R75's Care Area Assessment (CAA) for pressure ulcers, dated 8/11/16 indicated R75 was at risk for pressure ulcer development due to a recent hip fracture, complicating diagnoses including dementia and diabetes and severe cognitive	F 314	Harmony River Living Center will properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity and pressure injury per Skin Risk Policy. R75 skin is monitored with cares for any changes in condition and reported to licensed staff. Weekly body audits are completed by licensed staff per skin risk policy. Weekly wound assessments are completed by Registered Nurse and physicians are updated with changes. On 9/6/16 Skin Risk and Braden was completed with notes showing wound improving. R75 Care plan was reviewed for current modalities and remains appropriate. Resident Assistant Worksheet was updated to include pressure reducing heel boot application to be on at all times unless ambulating with therapy. Point of Care task assignment updated to reflect plan of care. ETar updated to include pressure reduction heel boot application monitor. Therapy was educated to have shoe on only with	

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F 314	Continued From page 5 impairment. R75's care plan, last revised 8/24/16 indicated R75 had a pressure ulcer to the right heel (unstageable suspected deep tissue injury) and was at risk for further impaired skin integrity related to cognitive impairment, diabetes, recent surgery/hospitalization, and immobility. Interventions included a pressure relieving air mattress on the bed, bed cradle on to lift blankets off feet, elevate heels off bed using pillows/heel elevation products while in bed and blue pressure reduction boot on at all times. R75's treatment sheets, dated 8/16 indicated daily skin monitoring for a reddened area on the right great toe and indicated the bandage was to be removed from R75's right heel and checked daily in the morning, measured on Tuesday evenings each week (last completed on 8/23/16), bed cradle on each shift when in bed and create a tent for sheet when in bed and a 3 inch thick towel or blanket under mattress pad at level of calf. No pressure to heels. R75's Skin Risk and Braden assessment, dated 7/30/16 indicated R75 had a moderate risk of pressure ulcer development, and was off loaded with staff assistance and with transfers. Predisposing factors for pressure ulcers included cardiovascular disease and diabetes, and a recent fracture. Friction and shearing was noted to be a problem, as well as occasionally moist skin. R75's Skin Risk and Braden assessment, dated 8/16/16 indicated R75 had a current pressure ulcer and was not able to off load so was repositioned by staff when in the chair. R75 had	F 314	ambulation and ensure pressure reducing heel boot applied upon completion. All residents with pressure injury were reviewed to ensure that care plan, RA worksheets, POC, and ETar are up to date and being followed. Skin Risk policy reviewed and remains current. Staff Education on following care planned interventions reviewed on 9/14/16 and will be reviewed on 9/21/16. Orientation check list for all nursing staff reviewed and includes staff responsibilities. Random weekly audits with a minimum of 2 per week will be completed on the care plan, RA worksheets, POC task and ETar to ensure care plan being followed for residents with pressure injuries. Results will be reported to the QA committee on 10/28/16. The QA committee will determine if the audits need to be continued or if other interventions should be instituted. DON Responsible. Date Certain 9/21/16	

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an air mattress in place and a wheelchair cushion, interventions included using a blue boot on the right heel, a foot cradle in bed, a wheelchair cushion, air mattress and pillows as needed. Continue to monitor the right foot on a daily basis.

R75's nursing progress notes included the following entries related to the right heel ulcer and reddened toe:

-8/23/16 - Right heel area now dry scabbed area, no drainage. Residual area from prior blister reddened and measures 2 x 2 cm. Blackened area 1.2 cm x 0.4 cm. The surrounding skin was blanchable and pink in color, treatment was listed as a blue boot and pillow to keep the pressure off the heel and sides of the foot. A secondary note, also dated 8/23/16 indicated R75's foot had been seen by the physician and indicated R75 had a red spot on the distal aspect of the upper right great toe, which the physician felt was pressure from the bed sheets. A foot cradle was applied to R75's bed.

-8/18/16 - Physician examined R75's foot, noted pressure sores on the great toe and heel and area was not debrided, no need for a bandage and open to area. Orders were indicated to create a tent for the sheets and place a three inch thick towel or blanket under the mattress pad at the level of the calf, allow no pressure to heels. Return to clinic if does not improve.

-8/17/16 - Faxed order received regarding the heel ulcer indicated the physician agreed with off loading and to cushion R75's heel with a boot and frequent repositioning, continue to monitor, if wound increases in size or redness extends

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should be evaluated by provider. A secondary progress note, dated 8/17/16 indicated R75's responsible party was notified of the ulcerations and that R75 would be seeing a physician to evaluate the areas. The ulcers were noted to be on R75's recently affected side with the hip fracture, a blue pressure relief boot was in place, bed cradle for blankets, and family brought in larger size shoes for R75. An appointment was to be scheduled with a podiatrist due to R75's diabetic diagnosis and new foot concerns.

-8/16/16 - R75 had a pressure ulcer on right heel. The whole reddened/black area/blister area measures 4.2 cm x 7 cm. Blister area measures 2.2 cm x 2.4 cm. Center of heel blackened area measures 1 cm x 0.6 cm. Resident has a non blanch-able and firm area on the right great toe that measures 0.8 x 0.6 cm. The wound bed was closed, surrounding skin intact and blanch-able. Tegaderm foam dressing applied and a foot cradle on bed, morning shift to contact family.

A dietary note dated 8/15/16, indicated R75 had a heel ulcer that nursing was monitoring, relieving pressure and treating per orders and was on a high nutrient dense supplement up to 12 ounces per day.

During interview on 8/22/16, at 5:56 p.m. registered nurse (RN)-A indicated that R75 had an ulcer on the right heel, and the physician did not feel it needed debridement. Staff were elevating the heels and had applied a tent on R75's bed to avoid pressure from the bed sheets.

During observation on 8/23/16, at 7:21 a.m., R75 was resting in bed, with a towel rolled up underneath the right calf. A blue boot was in

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F 314	Continued From page 8	F 314		

place on the foot, which had a cutout area over the right heel to relieve pressure. R75 had an air mattress with a foot cradle in place.

During observation on 8/23/16, at 9:20 a.m. R75 was seated in the hallway on the Agate Trail Unit, with a shoe on the right foot. The right foot was resting directly on the footrests. No boot was evident.

During observation on 8/23/16, at 11:16 a.m., R75 was noted leaving the therapy department with therapy staff. Her right foot still had the shoe on it, and was directly resting on the footrest.

During interview on 8/23/16, at 11:19 a.m. physical therapist (PT)-A stated R75 wore shoes in therapy for walking, and that the shoes she had on now were new and brought in by family due to a wound on the right heel. PT-A placed R75 at the dining room table and walked back to the therapy department, leaving the shoe on R75's foot.

During observation and interview on 8/23/16, at 2:08 p.m. the occupational therapy assistant (COTA)-A indicated R75 wore shoes in therapy. R75 had a blue boot on at this time and was assisted out of bed by COTA-A, who removed the boot and applied her shoes. COTA-A indicated the boot was usually worn in bed and seemed to be off when she was up.

During observation and interview on 8/24/16, at 7:36 a.m. R75's heel wound was visualized with licensed practical nurse (LPN)-B. The area had rolled skin about the edges and a purple center. A paper wound measurement strip was noted to by lying in the bed next to R75's foot. LPN-B

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stated "maybe they forgot it last night," as R75's wound had been measured then. R75's blue boot was noted to be lying to the right of her bed, on the other side of her nightstand at the head of the bed. A small purple intact area was noted as well to the medial aspect of the right great toe. LPN-A indicated she had thought R75 wore the boot when up in the wheelchair, but not in bed. RN-A came into the room and also visualized the heel area, and stated R75 should have been wearing the blue pressure reduction boot in bed and was to wear it at all times in the chair, but could use the shoes for therapy. RN-A stated R75 may have "thrown it off."

During interview on 8/24/16, at 9:42 a.m. RN-B indicated R75's right heel boot should be on at all times, except when walking with therapy. RN-B indicated she had written R75's care plan and pulled up R75's nursing assistant care guide, which lacked instruction with regard to the right heel boot. RN-B stated she would add this to the care guide now.

During interview on 8/25/16, at 10:29 a.m. nursing assistant (NA)-A indicated R75 was usually pretty cooperative with cares, and did not usually remove or throw off her heel boot.

During interview on 8/25/16, at 1:34 p.m. the director of nursing (DON) indicated she would have expected the boot to be left on R75 at all times when she was not walking, and for therapy and nursing to communicate with each other when R75 completed her treatments so that the boot could be put back on.

The facility policy entitled Pressure Ulcer/Injury Policy and Procedure, last revised 5/16 indicated

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F 314	Continued From page 10 to avoid positioning the resident on a pressure ulcer/injury. Use protective pressure reducing devices in bed and wheelchair sitting surface as ordered.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a clear indication for the ongoing use of Remeron (antidepressant used for	F 329	Harmony River Living Center recognizes and ensures that a resident has a clear indication for the ongoing use of an	9/21/16

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F 329	Continued From page 11 sleep) and it's effectiveness was assessed for 1 of 5 residents (R59) reviewed for unnecessary medications. Findings include: Review of R59's annual Minimum Data Set (MDS) assessment dated 5/19/16, identified R59 received a antidepressant 7 days per week. The MDS also identified R59 was free of mood or behavior indicators. Documentation in the physician orders, dated 8/24/16, identified R59 with the following diagnoses: unspecified dementia without behavioral disturbance, Major depressive disorder-recurrent, insomnia-unspecified, sleep apnea, stupor and chronic pain. R59's physician orders, dated 8/24/16, included Remeron 15 milligrams (mg) by mouth at bedtime to promote sleep and Zoloft (antidepressant) 25 mg by mouth in the afternoon related to depressive disorder. During review of R59's care plan, dated 5/24/16, the care plan identified R59 had diagnoses of depression, insomnia and sleep apnea and also identified R59's PHQ-9 (depression scale) indicated minimal signs of depression. The care plan identified interventions to include: 1. Monitor/document for side effects and effectiveness per policy. 2. Monitor medications for sleep and side effects. 3. Address pain concerns. 4. Encourage daytime activities to promote sleep at night. 5. Observe and report to physician signs and symptoms of depression, including:	F 329	antidepressant and its effectiveness. In and effort to continue this practice, Harmony River Living Center will do the following: Resident R59 physician orders for antidepressant Remeron 15mg qhs were reviewed. On 8/25/16 order was obtained to reduce Remeron to 7.5mg qhs. Resident care plan reviewed and updated to reflect sleep hygiene interventions and outcome of reduction. On 9/14/15 Resident Psychoactive Drug Assessment was completed. Psychoactive Medication and Unnecessary Medication Use Policy was reviewed and found to be current. Pharmacy Consultant will review antidepressants on a monthly basis and request physician documented support for the unnecessary medications and clear indication for use. Per Psychoactive Drug Use Policy, reduction attempts will be requested within the 1st year of use on two separate quarters with one month between attempts unless clinically contraindicated. After the first year of use a gradual dose reduction will be attempted annually unless clinically contraindicated. All residents on antidepressants were reviewed to ensure that they have a clear indication for use. Care plans reviewed and reflect appropriate interventions. Physician rounding on all residents will continue to address those residents who are on antidepressant and qualify per policy. Will have physician address possible reduction or why reduction attempt is contraindicated. Psychotropic Medication Reduction Spreadsheet will be	

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	245114	A. BUILDING _____ B. WING _____	08/25/2016

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F 329	Continued From page 12 hopelessness, anxiety, sadness, insomnia, anorexia, negative statements and tearfulness. R59's care plan further identified there was a trial reduction of Zoloft on 9/11/15 but identified no reduction attempt of the Remeron which was being used for sleep disturbance. The care plan also failed to identify the Remeron being utilized as a sleep aide. On 4/6/16, the pharmacy consultant documented on the Review of Consultant Pharmacist Communication to Physician form that there was no concern of depression noted for R59 since the Zoloft was decreased in 9/2015 to 25 mg daily. The pharmacist also identified R59 continued on Remeron 15 mg at bedtime. The pharmacy consultant documented that an attempt to reduce the Zoloft would be possible now and asked if the physician would consider a reduction. The pharmacist identified if a reduction was not appropriate the physician should document ongoing need for both Remeron and Zoloft. On 7/7/16, the pharmacy consultant documented the same irregularity as identified on the 4/6/16, pharmacy consult note as there was no evidence the physician had responded. On 8/10/16 the physician identified on the pharmacy consultant form "Keep same" with no indication of why the reduction should not be attempted. R59's Psychoactive Drug Assessment, completed 5/15/16, identified R59 was taking Remeron 15 mg every night and Zoloft 25 mg every day. The Zoloft was reduced from 50 mg to 25 mg on 9/11/2015 per R59's request. The assessment further identified within the first year of psychopharmacological medication use an attempted gradual dose reduction must be attempted annually and two separate quarters	F 329	utilized to track on-going reviews and reductions per policy. Audits of medication indication, care planned interventions and reduction will be competed on a random basis with a minimum of 10% per week. Results of the audits will be forwarded to the QA committee on 10/28/16. The QA committee will determine if the audits need to be continued or if other interventions should be instituted. Education will be completed by 9/21/16 for all RN/LPN staff. Plan of correction will be reviewed with QA committee on 10/28/16. DON Responsible. Date Certain: 9/21/16	

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F 329	Continued From page 13	F 329		

with one month between attempts unless clinically contraindicated. After the first year of use a gradual dose reduction must be attempted annually unless clinically contraindicated. The assessment also identified Hypnotics/sedatives used routinely beyond manufacturer recommendations should be tapered quarterly after consideration of sleep study and sleep routines.

During interview with registered nurse (RN)-C on 8/24/16, at 9:56 a.m. RN-C stated that R59 sleep pattern was not a problem so staff did not assess her response to the use of the Remeron for sleep purposes.

On 8/24/16, at 10:20 a.m. the director of nursing (DON) was interviewed and verified there was no sleep assessment for the use of the remeron and that a gradual dose reduction had been attempted since R59 was admitted 8/2014. The DON verified the Remeron was being utilized for the diagnosis of sleep problem and verified there was not a good assessment of R59's sleep pattern as it was not really noted as a concern.

The facility policy for psychoactive medications titled, "Psychoactive Medication and Unnecessary Medication Use Policy" dated 5/2016 identified the following:
1. Each resident's drug regimen must be free form unnecessary drugs. Unnecessary drugs are any drugs when used:
* In excessive duration.
* Without adequate Monitoring.
* Without adequate indications for its use
* In the presence of adverse consequences, which indicate the dose should be reduced or discontinued.

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F 329	Continued From page 14 2. If the drug is used outside the guidelines as identified. in paragraph 1 above, justification for the use of such drugs must include: a. Physician's note indicating why it is clinically appropriate and that the physician has carefully considered the risk/benefit to the resident. b. A medical/psychiatric evaluation to confirm the physician's judgment.	F 329		

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	245114	A. BUILDING **02 - NEW BLDG** B. WING _____	**08/23/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 23, 2016. At the time of this survey, Harmony River Living Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/16/2016

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 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Harmony River Living Center was constructed in 2012, is two-stories in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has an automatic fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Each Resident Room is equipped with hard-wired, single-station smoke detectors. The facility has a capacity of 120 beds and had a census of 116 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no	K 018		9/21/16

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K 018	Continued From page 2 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 3 corridor doors according to NFPA 101 LSC (00) section 18.3.6.3.1. This deficient practice could affect the safety of 116 of the 116 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 12:15 PM to 3:30 PM on 08/23/2016, observations and staff interview revealed that in each household there is a bi-fold door on a closet that is open to the corridor, these doors do not positively latch. This deficiency includes 8 doors within the facility. This deficient condition was verified by the Facility Engineer and Facility Administrator.	K 018	Harmony River Living Center has applied for an extension waiver with the State Fire Marshal Division in an effort to have an extended period of time up to 180 days to correct F018 NFPA 101 Life Safety Code Standard. This extension is necessary due to the need to modify the corridor walls. This modification may require architectural design and MN Department of Health review. Contractors will need to be contacted, materials ordered and construction completed. Confirmation from the State Fire Marshal completed to use 20 minute doors as these doors are not required to meet the hazardous space door requirements. Additional safe guards include: Each closet is fully sprinkled and all resident rooms are fully sprinkled. Each closet will be emptied for the duration until the new doors are completed. Weekly Audits will be completed by Engineering Services to ensure the closets are empty and out of use until new closet doors are installed. Findings will be reported to our QA committee for further suggestions. Administrator Responsible	

MDH
Minnesota
Department
of Health
Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
September 7, 2016

Ms. Linda Krentz, Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, MN 55350

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5114026

Dear Ms. Krentz:

The above facility was surveyed on August 22, 2016 through August 25, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 me.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00348	A. BUILDING: _____ B. WING _____	08/25/2016

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On 8/22/16-8/25/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a pressure-reducing heel boot was consistently applied to promote healing of a deep tissue injury as directed by the care plan for 1 of 1 resident (R75) reviewed for pressure ulcers. Findings include: R75's current diagnoses according to her face	2 565	"Corrected"	9/21/16

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2 565	Continued From page 2 sheet, dated 8/25/16 included a right hip fracture, dementia and diabetes. R75's admission Minimum Data Set (MDS), dated 8/4/16 indicated severe cognitive impairment, risk for pressure ulcer development with no current pressure ulcers identified and indicated R75 required the extensive assistance of staff for bed mobility, transfers and dressing. R75's care plan, last revised 8/24/16 indicated R75 had a pressure ulcer to the right heel (unstageable suspected deep tissue injury) and was at risk for further impaired skin integrity related to cognitive impairment, diabetes, recent surgery/hospitalization, and immobility. Interventions included a pressure relieving air mattress on the bed, bed cradle on to lift blankets off feet, elevate heels off bed using pillows/heel elevation products while in bed and blue pressure reduction boot on at all times. R75's treatment sheets, dated 8/16 indicated daily skin monitoring for a reddened area on the right great toe and indicated the bandage was to be removed from R75's right heel and checked daily in the morning, bed cradle on each shift when in bed and create a tent for sheet when in bed, 3 inch thick towel or blanket under mattress pad at level of calf. No pressure to heels. During interview on 8/22/16, at 5:56 p.m. registered nurse (RN)-A indicated that R75 had an ulcer on the right heel, and the physician did not feel it required debridement. Staff were elevating the heels and had applied a tent on R75's bed to avoid pressure from the bed sheets. During observation on 8/23/16, at 7:21 a.m. R75 was resting in bed, with a towel rolled up	2 565		

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2 565	Continued From page 3 underneath the right calf. A blue boot was in place on the foot, which had a cutout area over the right heel to relieve pressure. R75 had an air mattress with a foot cradle in place. During observation on 8/23/16, at 9:20 a.m. R75 was seated in the hallway on the Agate Trail Unit, with a shoe on the right foot. The right foot was resting directly on the footrests. During observation on 8/23/16, at 11:16 a.m., R75 was noted leaving the therapy department with therapy staff. Her right foot still had the shoe on it, and was directly resting upon the footrest. During interview on 8/23/16, at 11:19 a.m. physical therapist (PT)-A stated R75 wore shoes in therapy for walking, and the shoes she had on now were new and brought in by family due to a wound on the right heel. PT-A placed R75 at the dining room table and walked back to the therapy department, leaving the shoe on R75's foot. During observation and interview on 8/23/16, at 2:08 p.m. the occupational therapy assistant (COTA)-A indicated R75 wore shoes in therapy. R75 had a blue boot on at this time and was assisted out of bed by COTA-A, who removed the boot and applied her shoes. COTA-A indicated the boot was usually worn in bed and seemed to be off when she was up. During observation and interview on 8/24/16, at 7:36 a.m. R75's heel wound was visualized with licensed practical nurse (LPN)-B. The area had rolled skin about the edges and a purple center. R75's blue boot was noted to be lying to the right of her bed, on the other side of her nightstand at the head of the bed. A small purple intact area was noted as well to the medial aspect of the	2 565		

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2 565	Continued From page 4 right great toe. LPN-A indicated she had thought R75 wore the boot when up in the wheelchair, but not in bed. RN-A came into the room and also visualized the heel area, and stated R75 should have been wearing the blue pressure reduction boot while in bed and was to wear it at all times in the chair, but could use the shoes for therapy. RN-A stated R75 may have "thrown it off." During interview on 8/24/16, at 9:42 a.m. RN-B indicated R75's right heel boot should be on at all times, except when walking with therapy. RN-B indicated she had written R75's care plan and pulled up R75's nursing assistant care guide, which lacked instruction with regard to the right heel boot. RN-B stated she would add this to the care guide now. During interview on 8/25/16, at 10:29 a.m. nursing assistant (NA)-A indicated R75 was usually pretty cooperative with cares, and did not usually remove or throw off her heel boot. During interview on 8/25/16, at 1:34 p.m. the director of nursing (DON) indicated she would have expected the boot to be left on R75 at all times when she was not walking, and for therapy and nursing to communicate with each other when R75 completed her treatments so that the boot could be put back on. The facility policy entitled Pressure Ulcer/Injury Policy and Procedure, last revised 5/16 indicated to avoid positioning the resident on a pressure ulcer/injury. Use protective pressure reducing devices in bed and wheelchair sitting surface as ordered. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	2 565		

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2 565	Continued From page 5 review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a pressure-reducing heel boot was consistently applied to promote healing of a deep tissue injury for 1 of 1 resident (R75) reviewed for pressure	2 900	"Corrected"	9/21/16

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2 900	Continued From page 6 ulcers. Findings include: R75's current diagnoses according to her face sheet, dated 8/25/16 included a right hip fracture, dementia and diabetes. R75's admission Minimum Data Set (MDS), dated 8/4/16 indicated severe cognitive impairment, risk for pressure ulcer development with no current pressure ulcers identified and indicated R75 required the extensive assistance of staff for bed mobility, transfers and dressing. R75's Care Area Assessment (CAA) for pressure ulcers, dated 8/11/16 indicated R75 was at risk for pressure ulcer development due to a recent hip fracture, complicating diagnoses including dementia and diabetes and severe cognitive impairment. R75's care plan, last revised 8/24/16 indicated R75 had a pressure ulcer to the right heel (unstageable suspected deep tissue injury) and was at risk for further impaired skin integrity related to cognitive impairment, diabetes, recent surgery/hospitalization, and immobility. Interventions included a pressure relieving air mattress on the bed, bed cradle on to lift blankets off feet, elevate heels off bed using pillows/heel elevation products while in bed and blue pressure reduction boot on at all times. R75's treatment sheets, dated 8/16 indicated daily skin monitoring for a reddened area on the right great toe and indicated the bandage was to be removed from R75's right heel and checked daily in the morning, measured on Tuesday evenings each week (last completed on 8/23/16),	2 900		

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2 900	Continued From page 7 bed cradle on each shift when in bed and create a tent for sheet when in bed and a 3 inch thick towel or blanket under mattress pad at level of calf. No pressure to heels. R75's Skin Risk and Braden assessment, dated 7/30/16 indicated R75 had a moderate risk of pressure ulcer development, and was off loaded with staff assistance and with transfers. Predisposing factors for pressure ulcers included cardiovascular disease and diabetes, and a recent fracture. Friction and shearing was noted to be a problem, as well as occasionally moist skin. R75's Skin Risk and Braden assessment, dated 8/16/16 indicated R75 had a current pressure ulcer and was not able to off load so was repositioned by staff when in the chair. R75 had an air mattress in place and a wheelchair cushion, interventions included using a blue boot on the right heel, a foot cradle in bed, a wheelchair cushion, air mattress and pillows as needed. Continue to monitor the right foot on a daily basis. R75's nursing progress notes included the following entries related to the right heel ulcer and reddened toe: -8/23/16 - Right heel area now dry scabbed area, no drainage. Residual area from prior blister reddened and measures 2 x 2 cm. Blackened area 1.2 cm x 0.4 cm. The surrounding skin was blanchable and pink in color, treatment was listed as a blue boot and pillow to keep the pressure off the heel and sides of the foot. A secondary note, also dated 8/23/16 indicated R75's foot had been seen by the physician and indicated R75 had a red spot on the distal aspect of the upper right	2 900		

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2 900	Continued From page 8 great toe, which the physician felt was pressure from the bed sheets. A foot cradle was applied to R75's bed. -8/18/16 - Physician examined R75's foot, noted pressure sores on the great toe and heel and area was not debrided, no need for a bandage and open to area. Orders were indicated to create a tent for the sheets and place a three inch thick towel or blanket under the mattress pad at the level of the calf, allow no pressure to heels. Return to clinic if does not improve. -8/17/16 - Faxed order received regarding the heel ulcer indicated the physician agreed with off loading and to cushion R75's heel with a boot and frequent repositioning, continue to monitor, if wound increases in size or redness extends should be evaluated by provider. A secondary progress note, dated 8/17/16 indicated R75's responsible party was notified of the ulcerations and that R75 would be seeing a physician to evaluate the areas. The ulcers were noted to be on R75's recently affected side with the hip fracture, a blue pressure relief boot was in place, bed cradle for blankets, and family brought in larger size shoes for R75. An appointment was to be scheduled with a podiatrist due to R75's diabetic diagnosis and new foot concerns. -8/16/16 - R75 had a pressure ulcer on right heel. The whole reddened/black area/blister area measures 4.2 cm x 7 cm. Blister area measures 2.2 cm x 2.4 cm. Center of heel blackened area measures 1 cm x 0.6 cm. Resident has a non blanch-able and firm area on the right great toe that measures 0.8 x 0.6 cm. The wound bed was closed, surrounding skin intact and blanch-able. Tegaderm foam dressing applied and a foot cradle on bed, morning shift to contact family.	2 900		

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2 900	Continued From page 9 A dietary note dated 8/15/16, indicated R75 had a heel ulcer that nursing was monitoring, relieving pressure and treating per orders and was on a high nutrient dense supplement up to 12 ounces per day. During interview on 8/22/16, at 5:56 p.m. registered nurse (RN)-A indicated that R75 had an ulcer on the right heel, and the physician did not feel it needed debridement. Staff were elevating the heels and had applied a tent on R75's bed to avoid pressure from the bed sheets. During observation on 8/23/16, at 7:21 a.m., R75 was resting in bed, with a towel rolled up underneath the right calf. A blue boot was in place on the foot, which had a cutout area over the right heel to relieve pressure. R75 had an air mattress with a foot cradle in place. During observation on 8/23/16, at 9:20 a.m. R75 was seated in the hallway on the Agate Trail Unit, with a shoe on the right foot. The right foot was resting directly on the footrests. No boot was evident. During observation on 8/23/16, at 11:16 a.m., R75 was noted leaving the therapy department with therapy staff. Her right foot still had the shoe on it, and was directly resting on the footrest. During interview on 8/23/16, at 11:19 a.m. physical therapist (PT)-A stated R75 wore shoes in therapy for walking, and that the shoes she had on now were new and brought in by family due to a wound on the right heel. PT-A placed R75 at the dining room table and walked back to the therapy department, leaving the shoe on R75's foot.	2 900		

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2 900	Continued From page 10 During observation and interview on 8/23/16, at 2:08 p.m. the occupational therapy assistant (COTA)-A indicated R75 wore shoes in therapy. R75 had a blue boot on at this time and was assisted out of bed by COTA-A, who removed the boot and applied her shoes. COTA-A indicated the boot was usually worn in bed and seemed to be off when she was up. During observation and interview on 8/24/16, at 7:36 a.m. R75's heel wound was visualized with licensed practical nurse (LPN)-B. The area had rolled skin about the edges and a purple center. A paper wound measurement strip was noted to by lying in the bed next to R75's foot. LPN-B stated "maybe they forgot it last night," as R75's wound had been measured then. R75's blue boot was noted to be lying to the right of her bed, on the other side of her nightstand at the head of the bed. A small purple intact area was noted as well to the medial aspect of the right great toe. LPN-A indicated she had thought R75 wore the boot when up in the wheelchair, but not in bed. RN-A came into the room and also visualized the heel area, and stated R75 should have been wearing the blue pressure reduction boot in bed and was to wear it at all times in the chair, but could use the shoes for therapy. RN-A stated R75 may have "thrown it off." During interview on 8/24/16, at 9:42 a.m. RN-B indicated R75's right heel boot should be on at all times, except when walking with therapy. RN-B indicated she had written R75's care plan and pulled up R75's nursing assistant care guide, which lacked instruction with regard to the right heel boot. RN-B stated she would add this to the care guide now.	2 900		

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2 900	Continued From page 11 During interview on 8/25/16, at 10:29 a.m. nursing assistant (NA)-A indicated R75 was usually pretty cooperative with cares, and did not usually remove or throw off her heel boot. During interview on 8/25/16, at 1:34 p.m. the director of nursing (DON) indicated she would have expected the boot to be left on R75 at all times when she was not walking, and for therapy and nursing to communicate with each other when R75 completed her treatments so that the boot could be put back on. The facility policy entitled Pressure Ulcer/Injury Policy and Procedure, last revised 5/16 indicated to avoid positioning the resident on a pressure ulcer/injury. Use protective pressure reducing devices in bed and wheelchair sitting surface as ordered. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen	21535		9/21/16

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21535	Continued From page 12 must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a clear indication for the ongoing use of Remeron (antidepressant used for sleep) and it's effectiveness was assessed for 1 of 5 residents (R59) reviewed for unnecessary medications. Findings include: Review of R59's annual Minimum Data Set (MDS) assessment dated 5/19/16, identified R59 received a antidepressant 7 days per week. The MDS also identified R59 was free of mood or behavior indicators.	21535	"Corrected"	

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21535	Continued From page 13 Documentation in the physician orders, dated 8/24/16, identified R59 with the following diagnoses: unspecified dementia without behavioral disturbance, Major depressive disorder-recurrent, insomnia-unspecified, sleep apnea, stupor and chronic pain. R59's physician orders, dated 8/24/16, included Remeron 15 milligrams (mg) by mouth at bedtime to promote sleep and Zoloft (antidepressant) 25 mg by mouth in the afternoon related to depressive disorder. During review of R59's care plan, dated 5/24/16, the care plan identified R59 had diagnoses of depression, insomnia and sleep apnea and also identified R59's PHQ-9 (depression scale) indicated minimal signs of depression. The care plan identified interventions to include: 1. Monitor/document for side effects and effectiveness per policy. 2. Monitor medications for sleep and side effects. 3. Address pain concerns. 4. Encourage daytime activities to promote sleep at night. 5. Observe and report to physician signs and symptoms of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, negative statements and tearfulness. R59's care plan further identified there was a trial reduction of Zoloft on 9/11/15 but identified no reduction attempt of the Remeron which was being used for sleep disturbance. The care plan also failed to identify the Remeron being utilized as a sleep aide. On 4/6/16, the pharmacy consultant documented on the Review of Consultant Pharmacist Communication to Physician form that there was	21535		

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21535	Continued From page 14	21535		

no concern of depression noted for R59 since the Zoloft was decreased in 9/2015 to 25 mg daily. The pharmacist also identified R59 continued on Remeron 15 mg at bedtime. The pharmacy consultant documented that an attempt to reduce the Zoloft would be possible now and asked if the physician would consider a reduction. The pharmacist identified if a reduction was not appropriate the physician should document ongoing need for both Remeron and Zoloft. On 7/7/16, the pharmacy consultant documented the same irregularity as identified on the 4/6/16, pharmacy consult note as there was no evidence the physician had responded. On 8/10/16 the physician identified on the pharmacy consultant form "Keep same" with no indication of why the reduction should not be attempted.

R59's Psychoactive Drug Assessment, completed 5/15/16, identified R59 was taking Remeron 15 mg every night and Zoloft 25 mg every day. The Zoloft was reduced from 50 mg to 25 mg on 9/11/2015 per R59's request. The assessment further identified within the first year of psychopharmacological medication use an attempted gradual dose reduction must be attempted annually and two separate quarters with one month between attempts unless clinically contraindicated. After the first year of use a gradual dose reduction must be attempted annually unless clinically contraindicated. The assessment also identified Hypnotics/sedatives used routinely beyond manufacturer recommendations should be tapered quarterly after consideration of sleep study and sleep routines.

During interview with registered nurse (RN)-C on 8/24/16, at 9:56 a.m. RN-C stated that R59 sleep pattern was not a problem so staff did not assess

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21535	Continued From page 15	21535		

her response to the use of the Remeron for sleep purposes.

On 8/24/16, at 10:20 a.m. the director of nursing (DON) was interviewed and verified there was no sleep assessment for the use of the remeron and that a gradual dose reduction had been attempted since R59 was admitted 8/2014. The DON verified the Remeron was being utilized for the diagnosis of sleep problem and verified there was not a good assessment of R59's sleep pattern as it was not really noted as a concern.

The facility policy for psychoactive medications titled, "Psychoactive Medication and Unnecessary Medication Use Policy" dated 5/2016 identified the following:
1. Each resident's drug regimen must be free form unnecessary drugs. Unnecessary drugs are any drugs when used:
* In excessive duration.
* Without adequate Monitoring.
* Without adequate indications for its use
* In the presence of adverse consequences, which indicate the dose should be reduced or discontinued.
2. If the drug is used outside the guidelines as identified. in paragraph 1 above, justification for the use of such drugs must include:
a. Physician's note indicating why it is clinically appropriate and that the physician has carefully considered the risk/benefit to the resident.
b. A medical/psychiatric evaluation to confirm the physician's judgment.

SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff related to the appropriate assessments required for sleep studies and/or the need to monitor medication effectiveness. An audit could be developed to

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21535	Continued From page 16 monitor the medications utilized for sleep. The results could be reported to the quarterly quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		