#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

				ION AND TRANSMITTAL ID: 9177			
	ART I - TO BE COMP			E SURVEY AGENCY		Facility ID: 00348	
<ol> <li>MEDICARE/MEDICAID PROVIDER NO.</li> <li>(L1) 245114</li> </ol>	3. NAME AND ADDE (L3) HARMONY R				4. TYPE OF ACT	TON: <u>7 (</u> L8)	
2.STATE VENDOR OR MEDICAID NO.	(L4) 1555 SHERWO			ST	1. Initial	<ol> <li>Recertification</li> <li>CHOW</li> </ol>	
(L2) <b>927400000</b>	(L5) HUTCHINSON	N, MN		(L6) <b>55350</b>	3. Termination 5. Validation	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	7. PROVIDER/SUPP	LIER CATEGORY	r	<u>02</u> (L7)	7. On-Site Visit	9. Other	
(L9) <b>01/01/2008</b>	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Af	îter Complaint	
6. DATE OF SURVEY 09/29/2016 (L34	) 02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENI	DING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11. LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS	CERTIFIED AS:					
From (a):	X A. In Compliance	e With		And/Or Approved Waivers O	f The Following Requirement	ts:	
To (b):	Program Requ			2. Technical Personn	el 6. Scope of	f Services Limit	
	Compliance B	lased On:		3. 24 Hour RN	7. Medical	Director	
12. Total Facility Beds 120 (L18		ceptable POC		4. 7-Day RN (Rural S	SNF) 8. Patient R	loom Size	
13.Total Certified Beds 120 (L17)		iance with Program		5. Life Safety Code	9. Beds/Roo	om	
	-	d/or Applied Waive		* Code: A*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS			
18 SNF 18/19 SNF 19 S	NF ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
120							
(L37) (L38) (L3	9) (L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS (IF APPLICAT	BLE SHOW LTC CANCELLA	TION DATE):					
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:	
Kathy Serie, Unit Superv	visor 09	9/292016	(L19)	Kate JohnsTon, Program Specialist 10/19/2016 (L20)			
PART II -	TO BE COMPLETED	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	FATE AGENCY		
19. DETERMINATION OF ELIGIBILITY	20. COMP	LIANCE WITH CI	VIL	21. 1. Statement of Fi	inancial Solvency (HCFA-257	2)	
<b>X</b> 1. Facility is Eligible to Participate	RIGHT	TS ACT:		<ol> <li>Ownership/Cor</li> <li>Both of the Abo</li> </ol>	ntrol Interest Disclosure Stmt ( ove :	(HCFA-1513)	
2. Facility is not Eligible							
(L2	1)						
22. ORIGINAL DATE 23. LTC AGR	EEMENT 24.	. LTC AGREEME	NT	26. TERMINATION ACTION	۹:	(L30)	
OF PARTICIPATION BEGINN	ING DATE	ENDING DATE		VOLUNTARY	<u>00</u> <u>INVO</u>	LUNTARY	
03/15/1967				01-Merger, Closure	05-Fail	to Meet Health/Safety	
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimburg		l to Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNA	ATIVE SANCTIONS			03-Risk of Involuntary Terminat	OTHE	R	
A. Susper	sion of Admissions:			04-Other Reason for Withdrawa	07-F10	vider Status Change	
(L27) B Rescin	d Suspension Date:	(L44)			00-Act	live	
D. Resen	a Suspension Dute.	(L45)					
28. TERMINATION DATE:	29. INTERMEDIARY/CA			30. REMARKS			
20. TERMINITON DATE.		RULK NO.		50. REMINICO			
(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF <b>09/28/2016</b>	F APPROVAL DAT	Έ	Posted 10/31/2016 Co.			
(L32)	07/20/2010		(L33)	DETERMINATION APP	PROVAL		



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.

Harmony River Living Center October 19, 2016 Page 2

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



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.

Harmony River Living Center October 19, 2016 Page 2

Sincerely,

ate Comston X

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

### **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245114 <sub>Y1</sub>	B. Wing	Y2	9/29/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMONY RIVER LIVING CENTE	R	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	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 09/21/2016	ID Prefix <u>F0314</u> Reg. # LSC	Correction Completed	ID Prefix F0329 Reg. # 483.25(I) 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 REVIEWED BY (INITIALS)		SIGNATURE OF SURVEYOR 03 TITLE ANY UNCORRECTED DEFICIENCIES ED DEFICIENCIES (CMS-2567) SEN		DATE 09/29/2016 DATE

### **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 02 - NEW BLDG			
245114 <sub>Y1</sub>	B. Wing	Y2	9/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMONY RIVER LIVING CENTE	R	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).

ITE	м	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC	K0018	09/21/2016				
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/KJ	date 10/19/2016	SIGNATURE OF SURVEYOR	2424	date 09/21/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWI 8/23/2010	JP TO SURVEY CO	OMPLETED ON		ANY UNCORRECTED DEFICIENCIES ED DEFICIENCIES (CMS-2567) SEN		

DEPARTMENT OF HEALTI	HAND HUMA	N SERVICES			<b>CENTERS FOR MEE</b>	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 9IT7
	PART I -	TO BE COMPI	LETED BY T	ГНЕ STAT	TE SURVEY AGENCY	Facility ID: 00348
1. MEDICARE/MEDICAID PROVIDE NO.(L 1) 245114	ER	3. NAME AND AD (L3) <b>HARMONY</b>			ER	4. TYPE OF ACTION: <u>2(</u> L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID (L 2) <b>927400000</b>	NO.	(L4) <b>1555 SHERV</b> (L5) <b>HUTCHINS</b>		ET SOUTH	IEAST (L6) 55350	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF ( (L9) 01/01/2008	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
<ol> <li>DATE OF SURVEY 08/2</li> <li>ACCREDITATION STATUS: 0 Unaccredited 1 TJC</li> </ol>	<b>5/2016</b> <sup>(L34)</sup> (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
2 AOA 3 Other		04 5111	00 01 1/51	12 MIC	10 HOSI ICE	
11LTC PERIOD OF CERTIFICATION	1	10.THE FACILITY	' IS CERTIFIED	AS:		
From (a):		A. In Complia			And/Or Approved Waivers Of	
To (b) :		Program Re Compliance	equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
		_	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	<ul><li>F) Medical Director</li><li>F) 8. Patient Room Size</li></ul>
12. Total Facility Beds	120 (L18)	1. A	cceptable FOC		5. Life Safety Code	
13.Total Certified Beds	120 (L17)	X B. Not in Com			5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied	Waivers:	* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
120						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM.	ARKS (IF APPLICA		NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Wendy Willson, HFE	NE II	0	9/23/2016	(L19)	Kamala Fiske-Downing, I	Enforcement Specialist 09/27/2016 (L20)
PAI	RT II - TO BE	COMPLETED H	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBIL	ITY	20. COM	PLIANCE WIT	H CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)
1. Facility is Eligible to P	articipate	RIGH	ITS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible					5. Bour of the Hoove	· · · · · · · · · · · · · · · · · · ·
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	5 DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
03/15/1967					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
	B. Rescind St	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
				DATE		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	LDATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



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:

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

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

<u>Remedies</u> - 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;

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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: <u>Kathryn.serie@state.mn.us</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala Fiske Downing

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

		AND HUMAN SERVICES			ORM APPROVED
		& MEDICAID SERVICES	1		NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION (XS	3) DATE SURVEY COMPLETED
		245114	B. WING		08/25/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
HARMON	NY RIVER LIVING CEI	NTER		1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	ſS	F 00	0	
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.			
F 282 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 28	2	9/21/16
	must be provided b	led or arranged by the facility y qualified persons in ich resident's written plan of			
	by: Based on observat review the facility fa pressure-reducing l applied to promote as directed by the o (R75) reviewed for Findings include: R75's current diagn	heel boot was consistently healing of a deep tissue injury are plan for 1 of 1 resident pressure ulcers. hoses according to her face 6 included a right hip fracture,		Harmony River Living Center will prop identify, assess and monitor residents whose clinical conditions increase the for impaired skin integrity and pressur injuries; to implement preventative measures; and to provide appropriate treatment modalities for pressure injur according to standards of care. In an effort to continue this practice, Harmo River Living Center will do the followin R75 Care plan was reviewed for curre modalities and remain appropriate. Resident Assistant Worksheets were	risk re ries ny
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

**Electronically Signed** 

09/16/2016

PRINTED: 09/23/2016

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.

	-	AND HUMAN SERVICES				FORM	09/23/2016 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245114	B. WING			08/2	25/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARMO	NY RIVER LIVING CE	NTER			555 SHERWOOD STREET SOUTHEAST IUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R75's admission M 8/4/16 indicated se for pressure ulcers ide required the extens mobility, transfers a R75's care plan, las R75 had a pressure (unstageable suspe was at risk for furth related to cognitive surgery/hospitalizat Interventions includ mattress on the bea off feet, elevate here elevation products reduction boot on a R75's treatment sh daily skin monitorin right great toe and be removed from F daily in the morning when in bed and cr bed, 3 inch thick to pad at level of calf. During interview on registered nurse (F an ulcer on the righ not feel it required o elevating the heels R75's bed to avoid During observation was resting in bed, underneath the righ	inimum Data Set (MDS), dated vere cognitive impairment, risk development with no current entified and indicated R75 sive assistance of staff for bed and dressing. st revised 8/24/16 indicated e ulcer to the right heel ected deep tissue injury) and ler impaired skin integrity impairment, diabetes, recent tion, and immobility. ded a pressure relieving air d, bed cradle on to lift blankets els off bed using pillows/heel while in bed and blue pressure	F 2	282	updated to include pressure reducir boot application to be on at all times unless ambulating with therapy. Po Care task assignment updated to re- plan of care. ETar updated to includ pressure reduction heel boot applica- monitor. Therapy was educated to shoe on only with ambulation and e pressure reducing heel boot applied completion. All residents with pressure injury we reviewed to ensure that care plans, worksheets, POC, and ETar are up date and being followed. Skin Risk policy reviewed and rema current. Nursing staff education on following planned interventions reviewed on 9 and will be reviewed on 9/21/16. Orientation check list for all nursing reviewed and includes staff responsibilities. Random weekly audits with a minim 2 per week will be completed on the plan, RA worksheets, POC task and to ensure care plan is being followe residents with pressure injuries with results reported to QA committee at next scheduled meeting 10/28/16. committee will determine if the audi need to be continued or if other interventions should be instituted. DON responsible. Date Certain: 9/	s bint of eflect de ation have nsure d upon ere RA to ains g care 9/14/16 staff hum of e care d Etar d on t its QA ts	

Facility ID: 00348

If continuation sheet Page 2 of 15

STATE MEAN OF CORRECTION       (X1) PROVIDERSUPPLIER       (X2) AULTIPLE CONSTRUCTION       (X3) AULTIPLE       (X2) COMPLETED         AND PLAN OF CORRECTION       245114       10       10       WING			AND HUMAN SERVICES				FORM	09/23/2016 APPROVED 0938-0391
NAME OF PROVIDER ON SUPPLIER     STREET ADDRESS, CITY, STATE, 2P CODE       HARMONY RIVER LIVING CENTER     1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 53350       PAID TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MUST BE PROCEEDED BY FULL RECOLLATORY ON LISC DENTIFYING INFORMATION)     prefix PROVIDERS PLAN, OF CONFECTION (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCY)     prefix PROVIDERS PLAN, OF CONFECTION (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCY)     prefix PROVIDERS PLAN, OF CONFECTION (EACH DEFICIENCY)       F 282     Continued From page 2 the right heal to relieve pressure. R75 had an air mattress with a foot cradle in place.     F 232       During observation on 8/23/16, at 9/20 a.m. R75 was seated leaving the therapy department with therapy staft. Her right foot was resting directly on the footrest.     F 232       During observation on 8/23/16, at 11:16 a.m., R75 was noted leaving the therapy department with therapy tor walking, and the shoes shoes in therapy for walking, and the shoes 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 his time and was assisted out of bod YO CITA-A, who removed the boot and applied her shoes. COTA-A indicated the boot was usually worn in bead and seemed to be off when she was up.       During observation and interview on 8/24/16, at 7/26 a.m. R75 sheel wound was visualize	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY
HARMONY RIVER LIVING CENTER     1555 SHERWOOD STREET SUTHAAST HUTCHINSON, MN 55350       (M) ID PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     ID PREFX TAG     ID PREFX TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     ID PREFX TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCY MST BE PRECEDED BY FULL TAG     PROPONDERS FLAN OF CORRECTION (FACH DEFICIENCE)     F 282       During observation on 8/23/16, at 11:19 a.m. Physical therapis (FT) A stated RTS wore shoes in therapy department, leaving the shoes on RT5's foot.     F 7 5 100 HO MST AND AND AND AND AND A			245114	B. WING	i		08/;	25/2016
HARMONY RIVER LUNING CENTER     HUTCHINSON, MN 53350       (%) JD PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATIONY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PLUL REGULATIONY OR LSC IDENTIFYING INFORMATION)     D///// PREFX TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)     COMPLETION (SOURCE DETITY NOS INFORMATION)     D//// PREFX TAG     PROVIDER'S PLAN OF CORRECTION BELOW (EACH OPRECTIVE ACTION SHOULD BE CROSS-HEFEREDED TO THE APPROPRIATE DEFICIENCY)     COMPLETION (SOURCE DETITY NOS INFORMATION)     COMPLETION (SOURCE DETITY NOS INFORMATION) <t< td=""><td>NAME OF F</td><td>PROVIDER OR SUPPLIER</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	NAME OF F	PROVIDER OR SUPPLIER						
Pričejiki Tkoj       (EACH DEFICIENCY MUST BE PRECEDDE DY FULL REGULATORY OR LSCIDENTIFYING INFORMATION)       PRĚTK TKO       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       COMPLÉTION DEFICIENCY)         F 282       Continued From page 2 the right heel to relieve pressure. R75 had an air mattress with a foot cradle in place.       F 282         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 footests.       F 282         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 footest.       F 282         During observation 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 toot.         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 sually 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 hele wound was sisualized with licensed practical nurse (LPN)-B. The area had rolled skin about the edges and a puple center. R775 bue boot was noted to be lying to the right of her bed, on the other side of her nightstand at th	HARMON	NY RIVER LIVING CEN	NTER					
<ul> <li>the right heel to relieve pressure. R75 had an air mattress with a foot cradle in place.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>During observation and interview on 8/23/16, at 2:08 p.m. the occupational 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 R75 wore shoes in theraps. R75 heel wound was visualized with licensed practical nurse (LPN)-B. The area had rolled skin about the edges and a purple center. R75s blue boot was noted to be lying to the right of the right and mas interview on 8/24/16, at 7:36 a.m. R75s heel wound was visualized with licensed practical nurse (LPN)-B. The area had rolled skin about the edges and a purple center. R75s blue boot was noted to be lying to the right of the right of the right can be bed. A small purple intext area</li> </ul>	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
was noted as well to the medial aspect of the right great toe. LPN-A indicated she had thought	F 282	the right heel to reliminativess with a food During observation was seated in the history of the head of the bed with a shoe on the right dining room table a wound on the right dining room table a department, leaving During observation 2:08 p.m. the occup (COTA)-A indicated R75 had a blue boo assisted out of bed boot and applied her the boot was usuall be off when she wa	ieve pressure. R75 had an air t cradle in place. on 8/23/16, at 9:20 a.m. R75 hallway on the Agate Trail Unit, right foot. The right foot was he footrests. on 8/23/16, at 11:16 a.m., ving the therapy department Her right foot still had the shoe ctly resting upon the footrest. a 8/23/16, at 11:19 a.m. PT)-A stated R75 wore shoes ng, and the shoes she had on brought in by family due to a heel. PT-A placed R75 at the and walked back to the therapy g the shoe on R75's foot. and interview on 8/23/16, at bational therapy assistant d R75 wore shoes in therapy. of on at this time and was by COTA-A, who removed the er shoes. COTA-A indicated ly worn in bed and seemed to as up. and interview on 8/24/16, at el wound was visualized with burse (LPN)-B. The area had e edges and a purple center. s noted to be lying to the right other side of her nightstand at d. A small purple intact area o the medial aspect of the	F	282			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/23/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245114	B. WING		08/2	25/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMON	IY RIVER LIVING CEI	NTER		1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	not in bed. RN-A ca visualized the heel have been wearing boot while in bed ar the chair, but could RN-A stated R75 m During interview on indicated R75's right times, except when indicated she had w pulled up R75's nur which lacked instru- heel boot. RN-B sta care guide now. During interview on nursing assistant (N usually pretty coope usually remove or the During interview on director of nursing ( have expected the times when she wa and nursing to com when R75 complete boot could be put b The facility policy en Policy and Procedu to avoid positioning ulcer/injury. Use pr devices in bed and ordered.	when up in the wheelchair, but ame into the room and also area, and stated R75 should the blue pressure reduction nd was to wear it at all times in use the shoes for therapy. ay have "thrown it off." 8/24/16, at 9:42 a.m. RN-B at heel boot should be on at all walking with therapy. RN-B written R75's care plan and sing assistant care guide, ction with regard to the right ated she would add this to the 8/25/16, at 10:29 a.m. VA)-A indicated R75 was erative with cares, and did not hrow off her heel boot. 8/25/16, at 1:34 p.m. the DON) indicated she would boot to be left on R75 at all s not walking, and for therapy municate with each other ed her treatments so that the ack on. htitled Pressure Ulcer/Injury re, last revised 5/16 indicated the resident on a pressure otective pressure reducing wheelchair sitting surface as	F 282			
F 314 SS=D	483.25(c) TREATM PREVENT/HEAL P		F 314	L		9/21/16

Facility ID: 00348

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/23/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY PLETED
		245114	B. WING			08/2	25/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARMON	IY RIVER LIVING CEN	ITER			555 SHERWOOD STREET SOUTHEAST IUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	REGULATORY OR LA Continued From pa Based on the comp resident, the facility who enters the facil does not develop pa individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observat review the facility fa pressure-reducing f applied to promote for 1 of 1 resident (fu ulcers. Findings include: R75's current diagn sheet, dated 8/25/1 dementia and diabe R75's admission Mi 8/4/16 indicated set for pressure ulcers ide	ge 4 rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced ion, interview and document iled to ensure a neel boot was consistently healing of a deep tissue injury R75) reviewed for pressure oses according to her face 6 included a right hip fracture,	TAG		CROSS-REFERENCED TO THE APPROPRIA	operly ts le risk ure any are risk are s. On d	DATE
	ulcers, dated 8/11/1 for pressure ulcer d hip fracture, compli	nd dressing. sessment (CAA) for pressure 6 indicated R75 was at risk evelopment due to a recent cating diagnoses including etes and severe cognitive			pressure reducing heel boot applicat be on at all times unless ambulating therapy. Point of Care task assignm updated to reflect plan of care. ETar updated to include pressure reduction heel boot application monitor. Thera was educated to have shoe on only	with ient r on apy	

Facility ID: 00348

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · ·	E SURVEY PLETED
		245114	B. WING			08/3	25/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/1	
HARMO	NY RIVER LIVING CEI	NTER	1555 SHERWOOD STREET SOUTHEAS HUTCHINSON, MN 55350			T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 314	impairment. R75's care plan, las R75 had a pressure (unstageable suspe- was at risk for furth related to cognitive surgery/hospitalizat Interventions includ mattress on the bea- off feet, elevate hea- elevation products reduction boot on a R75's treatment sh daily skin monitorin right great toe and be removed from F daily in the morning evenings each wea- bed cradle on each a tent for sheet what towel or blanket un- calf. No pressure t R75's Skin Risk an 7/30/16 indicated F pressure ulcer deve- with staff assistanc Predisposing factor cardiovascular dise- recent fracture. Fri to be a problem, as- skin. R75's Skin Risk an- 8/16/16 indicated F ulcer and was not a	st revised 8/24/16 indicated e ulcer to the right heel ected deep tissue injury) and her impaired skin integrity impairment, diabetes, recent tion, and immobility. ded a pressure relieving air d, bed cradle on to lift blankets els off bed using pillows/heel while in bed and blue pressure at all times. eets, dated 8/16 indicated of for a reddened area on the indicated the bandage was to 875's right heel and checked g, measured on Tuesday ek (last completed on 8/23/16), a shift when in bed and create en in bed and a 3 inch thick der mattress pad at level of	F 3	14	ambulation and ensure pressure re- heel boot applied upon completion. All residents with pressure injury we reviewed to ensure that care plan, worksheets, POC, and ETar are up date and being followed. Skin Risk policy reviewed and rema- current. Staff Education on following care p interventions reviewed on 9/14/16 a be reviewed on 9/21/16. Orientation check list for all nursing staff review and includes staff responsibilities. Random weekly audits with a minir 2 per week will be completed on th plan, RA worksheets, POC task an to ensure care plan being followed residents with pressure injuries. Re will be reported to the QA committee 10/28/16. The QA committee will determine if the audits need to be continued or if other interventions s be instituted. DON Responsible. Date Certain 9/	ere RA a to ains lanned and will on ved num of e care d ETar for esults ee on should	

If continuation sheet Page 6 of 15

		AND HUMAN SERVICES				FORM	09/23/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245114	B. WING			08/;	25/2016
NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARMO	NY RIVER LIVING CEI	NTER			555 SHERWOOD STREET SOUTHEAST IUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	an air mattress in p cushion, interventio on the right heel, a wheelchair cushion needed. Continue daily basis. R75's nursing progr following entries rel reddened toe: -8/23/16 - Right hee no drainage. Resid reddened and meas area 1.2 cm x 0.4 c blanchable and pinl as a blue boot and the heel and sides of also dated 8/23/16 seen by the physici red spot on the dist great toe, which the from the bed sheets R75's bed. -8/18/16 - Physiciar pressure sores on t area was not debrid and open to area. 0 create a tent for the thick towel or blank the level of the calf, Return to clinic if do -8/17/16 - Faxed or heel ulcer indicated loading and to cush frequent repositioni	lace and a wheelchair ons included using a blue boot foot cradle in bed, a , air mattress and pillows as to monitor the right foot on a ress notes included the ated to the right heel ulcer and el area now dry scabbed area, fual area from prior blister sures 2 x 2 cm. Blackened m. The surrounding skin was k in color, treatment was listed pillow to keep the pressure off of the foot. A secondary note, indicated R75's foot had been an and indicated R75 had a al aspect of the upper right e physician felt was pressure s. A foot cradle was applied to the great toe and heel and ded, no need for a bandage Orders were indicated to e sheets and place a three inch et under the mattress pad at , allow no pressure to heels.	F	314			

Facility ID: 00348

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		AND HUMAN SERVICES				FORM	09/23/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245114	B. WING			08/:	25/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMO	NY RIVER LIVING CEI	NTER			555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	should be evaluate progress note, date responsible party w and that R75 would evaluate the areas. on R75's recently a fracture, a blue pre bed cradle for bland larger size shoes for to be scheduled wit diabetic diagnosis a -8/16/16 - R75 had The whole reddene measures 4.2 cm x 2.2 cm x 2.4 cm. O measures 1 cm x 0 blanch-able and firr that measures 0.8 c closed, surrounding Tegaderm foam dre cradle on bed, more A dietary note dated a heel ulcer that nu pressure and treatif high nutrient dense per day. During interview on registered nurse (R an ulcer on the righ not feel it needed d elevating the heels R75's bed to avoid During observation was resting in bed,	age 7 d by provider. A secondary ed 8/17/16 indicated R75's vas notified of the ulcerations d be seeing a physician to . The ulcers were noted to be diffected side with the hip ssure relief boot was in place, kets, and family brought in or R75. An appointment was th a podiatrist due to R75's and new foot concerns. a pressure ulcer on right heel. ed/black area/blister area a rom. Blister area measures Center of heel blackened area 0.6 cm. Resident has a non m area on the right great toe x 0.6 cm. The wound bed was g skin intact and blanch-able. essing applied and a foot ning shift to contact family. d 8/15/16, indicated R75 had trising was monitoring, relieving ng per orders and was on a e supplement up to 12 ounces a supplement up to 12 ounces a supplement. Staff were and had applied a tent on pressure from the bed sheets. on 8/23/16, at 7:21 a.m., R75 with a towel rolled up at calf. A blue boot was in	F	314			

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		AND HUMAN SERVICES				FORM	09/23/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245114	B. WING	i		08/2	25/2016
NAME OF I	PROVIDER OR SUPPLIER	-	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMON	NY RIVER LIVING CEI	NTER			555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	the right heel to relimattress with a food During observation was seated in the h with a shoe on the resting directly on the resting directly on the evident. During observation R75 was noted leave with therapy staff. If on it, and was direct During interview on physical therapist (R in therapy for walkin on now were new a a wound on the righthe dining room tab therapy department foot. During observation 2:08 p.m. the occup (COTA)-A indicated R75 had a blue boot assisted out of bed boot and applied he the boot was usuall be off when she wa During observation 7:36 a.m. R75's hea licensed practical n rolled skin about the A paper wound mea	<ul> <li>which had a cutout area over eve pressure. R75 had an air t cradle in place.</li> <li>on 8/23/16, at 9:20 a.m. R75 had an air t cradle in place.</li> <li>on 8/23/16, at 9:20 a.m. R75 had an air t rail unit, right foot. The right foot was the footrests. No boot was</li> <li>on 8/23/16, at 11:16 a.m., ving the therapy department Her right foot still had the shoe therapy department.</li> <li>8/23/16, at 11:19 a.m.</li> <li>PT)-A stated R75 wore shoes had and brought in by family due to hat heel. PT-A placed R75 at the and walked back to the t, leaving the shoe on R75's</li> <li>and interview on 8/23/16, at pational therapy assistant therapy assistant therapy assistant therapy.</li> <li>by COTA-A, who removed the er shoes. COTA-A indicated y worn in bed and seemed to</li> </ul>	F	314			

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		AND HUMAN SERVICES				FORM	09/23/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245114	B. WING	i		08/:	25/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMO	NY RIVER LIVING CEI	NTER			555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	stated "maybe they wound had been m was noted to be lyin the other side of he bed. A small purple to the medial aspect indicated she had th when up in the whe came into the room area, and stated R7 the blue pressure re to wear it at all time the shoes for therap have "thrown it off." During interview on indicated R75's right times, except when indicated she had w pulled up R75's nur which lacked instru- heel boot. RN-B sta care guide now. During interview on nursing assistant (N usually pretty coope usually remove or the During interview on director of nursing ( have expected the times when she wa and nursing to com when R75 complete boot could be put b The facility policy en	forgot it last night," as R75's easured then. R75's blue boot og to the right of her bed, on r nightstand at the head of the e intact area was noted as well et of the right great toe. LPN-A hought R75 wore the boot elchair, but not in bed. RN-A and also visualized the heel 75 should have been wearing eduction boot in bed and was as in the chair, but could use py. RN-A stated R75 may 8/24/16, at 9:42 a.m. RN-B th heel boot should be on at all walking with therapy. RN-B written R75's care plan and rsing assistant care guide, ction with regard to the right ated she would add this to the 8/25/16, at 10:29 a.m. NA)-A indicated R75 was erative with cares, and did not hrow off her heel boot. 8/25/16, at 1:34 p.m. the (DON) indicated she would boot to be left on R75 at all s not walking, and for therapy municate with each other ed her treatments so that the	F	314			

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TID		NO. 0938-039
	F CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245114	B. WING		08/25/2016
NAME OF F	PROVIDER OR SUPPLIER	l	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	
HARMON	IY RIVER LIVING CE	INTER		1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 314	Continued From p	age 10	F 314		
	ulcer/injury. Use p	g the resident on a pressure protective pressure reducing d wheelchair sitting surface as			
F 329 SS=D	483.25(I) DRUG R UNNECESSARY I	EGIMEN IS FREE FROM DRUGS	F 329		9/21/16
	drug when used in duplicate therapy); without adequate r indications for its u adverse conseque	s. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose or discontinued; or any e reasons above.			
	resident, the facilit who have not used given these drugs therapy is necessa as diagnosed and record; and reside drugs receive grad behavioral interver	ehensive assessment of a y must ensure that residents d antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical nts who use antipsychotic dual dose reductions, and ntions, unless clinically an effort to discontinue these			
	by: Based on interview facility failed to ens	ENT is not met as evidenced w and document review the sure a clear indication for the meron (antidepressant used for		Harmony River Living Center recogni and ensures that a resident has a clea indication for the ongoing use of an	

Facility ID: 00348

If continuation sheet Page 11 of 15

CORRECTION OVIDER OR SUPPLIER RIVER LIVING CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From page leep) and it's effec of 5 residents (R59)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350 PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR	TION JLD BE	25/2016
RIVER LIVING CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From page (leep) and it's effect of 5 residents (R59)	ITER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350 PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR	TION JLD BE	(X5) COMPLETIO
RIVER LIVING CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From page (leep) and it's effect of 5 residents (R59)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	TION JLD BE	COMPLETIC
SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa leep) and it's effec f 5 residents (R59)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	HUTCHINSON, MN 55350 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	TION JLD BE	COMPLETIC
(EACH DEFICIENCY REGULATORY OR LS Continued From particles leep) and it's effect of 5 residents (R59)	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETIC
leep) and it's effec f 5 residents (R59)	ge 11		DEFICIENCY)		DATE
of 5 residents (R59)		F 329	9		
<ul> <li>sleep) and it's effectiveness was assessed for 1 of 5 residents (R59) reviewed for unnecessary medications.</li> <li>Findings include:</li> <li>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</li> </ul>			antidepressant and its effectiver and effort to continue this practic Harmony River Living Center wil following:	ce, I do the	
			antidepressant Remeron 15mg reviewed. On 8/25/16 order was to reduce Remeron to 7.5mg qh Resident care plan reviewed and	qhs were s obtained s. d updated	
ehavior indicators. Documentation in th /24/16, identified F liagnoses: unspec pehavioral disturbar	ne physician orders, dated 859 with the following ified dementia without nce, Major depressive		outcome of reduction. On 9/14/ Resident Psychoactive Drug Ass was completed. Psychoactive Medication and Unnecessary Medication Use Po reviewed and found to be curren	15 sessment blicy was it.	
pnea, stupor and c R59's physician ord Remeron 15 milligra o promote sleep ar ng by mouth in the	chronic pain. ers, dated 8/24/16, included ams (mg) by mouth at bedtime ad Zoloft (antidepressant) 25 afternoon related to		antidepressants on a monthly ba request physician documented s the unnecessary medications ar indication for use. Per Psychoa Use Policy, reduction attempts v requested within the 1st year of two separate quarters with one r	asis and support for id clear ctive Drug vill be use on nonth	
he care plan identif lepression, insomn dentified R59's PH0 ndicated minimal si plan identified interv . Monitor/documer effectiveness per po 2. Monitor medicatio 3. Address pain con	tied R59 had diagnoses of ia and sleep apnea and also Q-9 (depression scale) igns of depression. The care ventions to include: ht for side effects and blicy. ons for sleep and side effects. incerns.		contraindicated. After the first y a gradual dose reduction will be annually unless clinically contrai All residents on antidepressants reviewed to ensure that they hav indication for use. Care plans re and reflect appropriate intervent Physician rounding on all reside continue to address those reside are on antidepressant and quali	ear of use attempted ndicated. were ve a clear eviewed ions. nts will ents who y per	
ALAN DELL ARCTI OFFER SEVEN	Review of R59's an MDS) assessment aceived a antidepro IDS also identified ehavior indicators. Pocumentation in th /24/16, identified F iagnoses: unspec ehavioral disturban isorder-recurrent, pnea, stupor and o 59's physician ord ace and a stupor and o 59's physician ord a stupor and o 59's physician ord a stupor and o 59's physician ord a stupor and a stupor ace and ace and a stupor ace and a stupor ace and a stupor ace and a stupor ace and ace a	<ul> <li>Review of R59's annual Minimum Data Set MDS) assessment dated 5/19/16, identified R59 eceived a antidepressant 7 days per week. The MDS also identified R59 was free of mood or ehavior indicators.</li> <li>Pocumentation in the physician orders, dated /24/16, identified R59 with the following iagnoses: unspecified dementia without ehavioral disturbance, Major depressive isorder-recurrent, insomnia-unspecified, sleep pnea, stupor and chronic pain.</li> <li>859's physician orders, dated 8/24/16, included temeron 15 milligrams (mg) by mouth at bedtime o promote sleep and Zoloft (antidepressant) 25 ng by mouth in the afternoon related to epressive disorder.</li> <li>Puring review of R59's care plan, dated 5/24/16, he care plan identified R59 had diagnoses of epression, insomnia and sleep apnea and also lentified R59's PHQ-9 (depression scale) ndicated minimal signs of depression. The care lan identified interventions to include:</li> <li>Monitor/document for side effects and ffectiveness per policy.</li> <li>Monitor medications for sleep and side effects.</li> <li>Address pain concerns.</li> <li>Encourage daytime activities to promote sleep</li> </ul>	<ul> <li>Review of R59's annual Minimum Data Set MDS) assessment dated 5/19/16, identified R59 eceived a antidepressant 7 days per week. The IDS also identified R59 was free of mood or ehavior indicators.</li> <li>Pocumentation in the physician orders, dated /24/16, identified R59 with the following iagnoses: unspecified dementia without ehavioral disturbance, Major depressive isorder-recurrent, insomnia-unspecified, sleep pnea, stupor and chronic pain.</li> <li>R59's physician orders, dated 8/24/16, included temeron 15 milligrams (mg) by mouth at bedtime o promote sleep and Zoloft (antidepressant) 25 mg by mouth in the afternoon related to epressive disorder.</li> <li>Puring review of R59's care plan, dated 5/24/16, he care plan identified R59 had diagnoses of epression, insomnia and sleep apnea and also lentified R59's PHQ-9 (depression scale) idicated minimal signs of depression. The care lan identified interventions to include:</li> <li>Monitor medications for sleep and side effects.</li> <li>Address pain concerns.</li> <li>Encourage daytime activities to promote sleep t night.</li> <li>Observe and report to physician signs and</li> </ul>	<ul> <li>indings include:</li> <li>Resident R59 physician orders f antidepressant Remeron 15mg q reviewed. On 8/25/16 order was to reduce Remeron 15.5mg qh Resident care plan reviewed and to reflect sleep hygiene interveni outcome of reduction. On 9/14/ Resident Psychoactive Drug Ass was completed.</li> <li>Psychoactive Medication Use Pc reviewed and found to be currer Pharmacy Consultant will review antidepressant and on the physician orders, dated /24/16, identified R59 with the following iagnoses: unspecified dementia without ehavioral disturbance, Major depressive isorder-recurrent, insomnia-unspecified, sleep pnea, stupor and chronic pain.</li> <li>159's physician orders, dated 8/24/16, included temeron 15 milligrams (mg) by mouth at bedtime op promote sleep and Zoloft (antidepressant) 25 g by mouth in the afternoon related to epressive disorder.</li> <li>up provide in the respension, insomnia and sleep apnea and also tentified R59's PHQ-9 (depression scale) dicated minimal signs of depression. The care lan identified interventions to include:</li> <li>Monitor medications for sleep and side effects.</li> <li>Address pain concerns.</li> <li>Encourage daytime activities to promote sleep t night.</li> <li>Observe and report to physician signs and</li> </ul>	<ul> <li>indings include:</li> <li>Resident R59 physician orders for antidepressant Remeron 15mg dhs were reviewed a antidepressant 7 days per week. The IDS also identified R59 was free of mood or ehavior indicators.</li> <li>bocumentation in the physician orders, dated /24/16, identified R59 with the following iagnoses: unspecified dementia without ehavioral disturbance, Major depressive isorder-recurrent, insomnia-unspecified, sleep prea, stupor and chronic pain.</li> <li>IS9's physician orders, dated 8/24/16, included temeron 15 milligrams (mg) by mouth at bedtime o promote sleep and Zoloft (antidepressant) 25 regressive disorder.</li> <li>Isorder-recurrent, insomnia-unspecified, sleep preas, stupor and chronic pain.</li> <li>Iso's physician orders, dated 5/24/16, included temeron 15 milligrams (mg) by mouth at bedtime o promote sleep and Zoloft (antidepressant) 25 regressive disorder.</li> <li>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 or two separate quarters with one month between attempts unless clinically contraindicated.</li> <li>Address pain concerns.</li> <li>Encourage daytime activities to promote sleep tright.</li> <li>Observe and report to physician signs and</li> </ul>

Facility ID: 00348

If continuation sheet Page 12 of 15

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			<u> </u>	IB NO.	APPROVE[ 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()		SURVEY PLETED
		245114	B. WING			08/2	25/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HARMO	NY RIVER LIVING CEI	NTER			555 SHERWOOD STREET SOUTHEAST IUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIOI DATE
F 329	anorexia, negative R59's care plan fur reduction of Zoloft of reduction attempt of being used for slee also failed to identif as a sleep aide. On 4/6/16, the phar on the Review of C Communication to no concern of depro Zoloft was decrease The pharmacist als Remeron 15 mg at consultant docume the Zoloft would be physician would con pharmacist identified appropriate the phy ongoing need for be 7/7/16, the pharmacist same irregularity as pharmacy consult r the physician had ru physician identified form "Keep same" reduction should no R59's Psychoactive 5/15/16, identified F mg every night and Zoloft was reduced 9/11/2015 per R59's further identified wit psychopharmacolog attempted gradual	ety, sadness, insomnia, statements and tearfulness. ther identified there was a trial on 9/11/15 but identified no of the Remeron which was p disturbance. The care plan by the Remeron being utilized macy consultant documented onsultant Pharmacist Physician form that there was ession noted for R59 since the ed in 9/2015 to 25 mg daily. o identified R59 continued on bedtime. The pharmacy nted that an attempt to reduce possible now and asked if the nsider a reduction. The ed if a reduction was not visician should document oth Remeron and Zoloft. On cy consultant documented the s identified on the 4/6/16, note as there was no evidence esponded. On 8/10/16 the on the pharmacy consultant with no indication of why the ot be attempted.	F3	29	utilized to track on-going reviews and reductions per policy. Audits of medication indication, care planned interventions and reduction be competed on a random basis with minimum of 10% per week. Results of the audits will be forwarde the QA committee on 10/28/16. The committee will determine if the audits need to be continued or if other interventions should be instituted. Education will be completed by 9/21/ all RN/LPN staff. Plan of correction will be reviewed wi QA committee on 10/28/16. DON Responsible. Date Certain: 9/2	will h a ed to e QA s /16 for <i>r</i> ith	

If continuation sheet Page 13 of 15

CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245114	. ,	ING		FORM MB NO. (X3) DATE COM	09/23/2016 APPROVED 0938-0391 E SURVEY PLETED 25/2016
	NY RIVER LIVING CEN	NTER		1	555 SHERWOOD STREET SOUTHEAST IUTCHINSON, MN 55350		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	contraindicated. Aft gradual dose reduct annually unless clim assessment also id used routinely beyor recommendations is after consideration routines. During interview wit 8/24/16, at 9:56 a.m pattern was not a p her response to the purposes. On 8/24/16, at 10:2 (DON) was interview sleep assessment f that a gradual dose attempted since R5 DON verified the Re the diagnosis of sle was not a good ass pattern as it was no The facility policy for titled, "Psychoactive Medication Use Pol the following: 1. Each resident's c form unnecessary c any drugs when use * In excessive c * Without adequ * Without adequ * In the present	ween attempts unless clinically er the first year of use a tion must be attempted nically contraindicated. The entified Hypnotics/sedatives and manufacturer should be tapered quarterly of sleep study and sleep th registered nurse (RN)-C on n. RN-C stated that R59 sleep roblem so staff did not assess a use of the Remeron for sleep 0 a.m. the director of nursing wed and verified there was no for the use of the remeron and reduction had been 9 was admitted 8/2014. The emeron was being utilized for ep problem and verified there assment of R59's sleep of really noted as a concern. or psychoactive medications e Medication and Unnecessary licy" dated 5/2016 identified drug regimen must be free drugs. Unnecessary drugs are ed:	F	329			

Facility ID: 00348

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		AND HUMAN SERVICES			FORM	: 09/23/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245114	B. WING _		08/	25/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMON	NY RIVER LIVING CEI	NTER		1555 SHERWOOD STREET SOUTHEAS HUTCHINSON, MN 55350	I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	identified. in paragr the use of such dru a. Physician's note appropriate and the considered the risk	d outside the guidelines as raph 1 above, justification for igs must include: indicating why it is clinically at the physician has carefully /benefit to the resident. iatric evaluation to confirm the	F 3	29		

Facility ID: 00348

ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	CONSTRUCTION 2 - NEW BLDG	(X3) DATE SURVEY COMPLETED
		245114	B. WING		08/23/2016
	PROVIDER OR SUPPLIER	NTER	15	REET ADDRESS, CITY, STATE, ZIP CODE 55 SHERWOOD STREET SOUTHEAST JTCHINSON, MN 55350	×
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETI
K 000	INITIAL COMMEN	rs	K 000		
	FIRE SAFETY				
	ALLEGATION OF ( DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.			
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	Minnesota Departn Fire Marshal Divisi time of this survey,	Survey was conducted by the nent of Public Safety, State on, on August 23, 2016. At the Harmony River Living Center ubstantial compliance with the			
	483.70(a), Life Saf edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association afety Code (LSC), Chapter 18			

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUC	CTION		TE SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	ABUILDI	NG 02 - NEW BL	_DG		
		245114	B, WING				8/23/2016
NAME OF F	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP C		
HARMON	NY RIVER LIVING CE	NTER			OOD STREET SOUTHE DN, MN 55350	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF COF CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	Continued From p By email to: Marian.Whitney@s Angela.Kappenma	state.mn.us and	K 0	00			
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:					
	1. A description of to correct the defice	what has been, or will be, done ciency.					
	2. The actual, or p	roposed, completion date.					
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency					
	2012, is two-storie basement, is fully	ving Center was constructed in es in height, has a partial fire sprinkler protected, and b be of Type II(111) construction					
	with smoke detect open to the corrido automatic fire dep Resident Room is single-station smo	a automatic fire alarm system tion in the corridors and spaces ors, which is monitored for partment notification. Each equipped with hard-wired, oke detectors. The facility has a eds and had a census of 116 at					
K 018 SS=F	NOT MET as evid NFPA 101 LIFE S	at 42 CFR, Subpart 483.70(a) is lenced by: AFETY CODE STANDARD corridor openings shall be	ĸ	18		, X	9/21/16
	constructed to res	sist the passage of smoke. en bottom of door and floor ceeding 1 inch. There is no					

Event ID: 9IT721

Facility ID: 00348

PRINTED: 09/20/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY IPLETED
			A: BUILDING	02 - NEW BLDG	
		245114	B, WING		23/2016
NAME OF I	PROVIDER OR SUPPLIEI	R		STREET ADDRESS, CITY, STATE, ZIP CODE	
HARMON	NY RIVER LIVING C	ENTER		555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
К 018	devices that relea pulled are permitt positive latching h 18.3.6.3.6 are per prohibited. 18.3.6.3 This STANDARD Based on observ facility failed to m 3 corridor doors a section 18.3.6.3.1 affect the safety of an undetermined smoke from a fire access corridors Findings include: On the facility tou on 08/23/2016, of revealed that in e door on a closet t doors do not posi includes 8 doors This deficient cor	e closing of the doors. Hold open ise when the door is pushed or ed. Doors shall be provided with hardware. Dutch doors meeting mitted. Roller latches shall be is not met as evidenced by: ration and staff interview, the aintain the smoke resistance of according to NFPA 101 LSC (00) . This deficient practice could of 116 of the 116 residents and amount of staff and visitors, if e were allowed to enter the exit making it untenable. It between 12:15 PM to 3:30 PM bservations and staff interview ach household there is a bi-fold hat is open to the corridor, these tively latch. This deficiency	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 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 closet are empty and out of use until new closet doors are installed. Findings will b reported to our QA committee for further suggestions.	V

Facility ID: 00348



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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,

Kumalu Fiske Downing

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

## PRINTED: 09/23/2016 FORM APPROVED

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00348	B. WING		08/2	25/2016
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
2 000	000 Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
Vinnesota Department of Health ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Electronically Signed						(X6) DATE 09/16/16

Electronically Signed

6899

If continuation sheet 1 of 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00348	B. WING		08/25/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HARMON	NY RIVER LIVING CE	NIFR	ERWOOD STF NSON, MN 55	REET SOUTHEAST 350		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic cess, under the heading the date your orders will be electronically submitting to the nent of Health.				
	the following correct Please indicate in y correction that you	5, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, the when they will be completed				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/21/16
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review the facility fa pressure-reducing applied to promote	heel boot was consistently healing of a deep tissue injury care plan for 1 of 1 resident	,	"Corrected"		
	Findings include:					
	R75's current diagr	noses according to her face				

STATE FORM

6899

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
		00348	B. WING		08/25/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• • • • •	
HARMON	IY RIVER LIVING CE	NIFR	ERWOOD STR NSON, MN 553	REET SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 2	2 565		, 	
	sheet, dated 8/25/1 dementia and diab	16 included a right hip fracture, etes.				
	8/4/16 indicated set for pressure ulcer of pressure ulcers ide	linimum Data Set (MDS), dated evere cognitive impairment, risk development with no current entified and indicated R75 sive assistance of staff for bed and dressing.				
	R75 had a pressur (unstageable susp- was at risk for furth related to cognitive surgery/hospitaliza Interventions include mattress on the be off feet, elevate he	st revised 8/24/16 indicated e ulcer to the right heel ected deep tissue injury) and her impaired skin integrity e impairment, diabetes, recent tion, and immobility. ded a pressure relieving air id, bed cradle on to lift blankets els off bed using pillows/heel while in bed and blue pressure at all times.				
	daily skin monitorir right great toe and be removed from F daily in the morning when in bed and co bed, 3 inch thick to	neets, dated 8/16 indicated ng for a reddened area on the indicated the bandage was to R75's right heel and checked g, bed cradle on each shift reate a tent for sheet when in wel or blanket under mattress No pressure to heels.				
	registered nurse (F an ulcer on the righ not feel it required elevating the heels	n 8/22/16, at 5:56 p.m. RN)-A indicated that R75 had ht heel, and the physician did debridement. Staff were and had applied a tent on pressure from the bed sheets.				
		on 8/23/16, at 7:21 a.m. R75 with a towel rolled up				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00348	B. WING		08/25/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HARMO	NY RIVER LIVING CE	NIER		REET SOUTHEAST		
		HUTCHI	NSON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 3	2 565			
	place on the foot, w	nt calf. A blue boot was in vhich had a cutout area over ieve pressure. R75 had an air t cradle in place.				
	was seated in the h	on 8/23/16, at 9:20 a.m. R75 hallway on the Agate Trail Unit, right foot. The right foot was he footrests.				
	R75 was noted leave with therapy staff.	on 8/23/16, at 11:16 a.m., ving the therapy department Her right foot still had the shoe ctly resting upon the footrest.				
	physical therapist ( in therapy for walki now were new and wound on the right dining room table a	n 8/23/16, at 11:19 a.m. PT)-A stated R75 wore shoes ng, and the shoes she had on brought in by family due to a heel. PT-A placed R75 at the and walked back to the therapy g the shoe on R75's foot.				
	2:08 p.m. the occup (COTA)-A indicated R75 had a blue bod assisted out of bed boot and applied he	and interview on 8/23/16, at pational therapy assistant d R75 wore shoes in therapy. ot on at this time and was by COTA-A, who removed the er shoes. COTA-A indicated ly worn in bed and seemed to as up.	,			
	7:36 a.m. R75's he licensed practical n rolled skin about th R75's blue boot wa of her bed, on the o the head of the beo	and interview on 8/24/16, at el wound was visualized with nurse (LPN)-B. The area had e edges and a purple center. Is noted to be lying to the right other side of her nightstand at d. A small purple intact area to the medial aspect of the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00348	B. WING		08/25/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		23/2010
	NY RIVER LIVING CE	1555 SH		EET SOUTHEAST		
		HUTCHI	NSON, MN 55	350		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	R75 wore the boot not in bed. RN-A c visualized the heel have been wearing boot while in bed a the chair, but could RN-A stated R75 n During interview or indicated R75's rig times, except wher indicated she had pulled up R75's nu which lacked instru	N-A indicated she had thought when up in the wheelchair, but came into the room and also area, and stated R75 should g the blue pressure reduction and was to wear it at all times in d use the shoes for therapy. hay have "thrown it off." In 8/24/16, at 9:42 a.m. RN-B ht heel boot should be on at all n walking with therapy. RN-B written R75's care plan and rsing assistant care guide, uction with regard to the right ated she would add this to the				
	nursing assistant ( usually pretty coop	n 8/25/16, at 10:29 a.m. NA)-A indicated R75 was erative with cares, and did not throw off her heel boot.				
	director of nursing have expected the times when she wa and nursing to com	n 8/25/16, at 1:34 p.m. the (DON) indicated she would boot to be left on R75 at all as not walking, and for therapy municate with each other red her treatments so that the back on.				
	Policy and Procedu to avoid positioning ulcer/injury. Use p	entitled Pressure Ulcer/Injury ure, last revised 5/16 indicated g the resident on a pressure rotective pressure reducing I wheelchair sitting surface as				
		THOD OF CORRECTION: sing (DON) or designee could				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00348	B. WING		08/25/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IARMO	NY RIVER LIVING CE	NIFR	RWOOD STI	REET SOUTHEAST 3350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 5	2 565			
	to ensuring the card resident is followed designee could dev and develop a mon are providing care a of care. TIME PERIOD FOI	oolicies and procedures related e plan for each individual . The director of nursing or relop a system to educate staff itoring system to ensure staff as directed by the written plan				
	(21) days.					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			9/21/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessar	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observat review the facility fa pressure-reducing applied to promote	ent is not met as evidenced ion, interview and document ailed to ensure a heel boot was consistently healing of a deep tissue injury R75) reviewed for pressure		"Corrected"		

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		00348	B. WING		08/2	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HARMO	NY RIVER LIVING CEI	NTER	RWOOD ST SON, MN 55	REET SOUTHEAST 5350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 6	2 900			
	ulcers.					
	Findings include:					
		oses according to her face 6 included a right hip fracture, etes.				
	8/4/16 indicated set for pressure ulcer of pressure ulcers ide	inimum Data Set (MDS), dated vere cognitive impairment, risk levelopment with no current ntified and indicated R75 ive assistance of staff for bed and dressing.				
	ulcers, dated 8/11/1 for pressure ulcer c hip fracture, compli	essessment (CAA) for pressure 6 indicated R75 was at risk levelopment due to a recent cating diagnoses including etes and severe cognitive				
	R75 had a pressure (unstageable suspe- was at risk for furth related to cognitive surgery/hospitalizat Interventions includ mattress on the bea off feet, elevate hee elevation products reduction boot on a	et revised 8/24/16 indicated e ulcer to the right heel ected deep tissue injury) and er impaired skin integrity impairment, diabetes, recent ion, and immobility. ed a pressure relieving air d, bed cradle on to lift blankets els off bed using pillows/heel while in bed and blue pressure t all times. eets, dated 8/16 indicated				
	daily skin monitorin right great toe and i be removed from R daily in the morning	g for a reddened area on the ndicated the bandage was to 75's right heel and checked , measured on Tuesday k (last completed on 8/23/16),				

9IT711

If continuation sheet 7 of 17

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00348	B. WING		08/	25/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HARMO	NY RIVER LIVING CEI	NIER	ERWOOD STR NSON, MN 55:	EET SOUTHEAST 350		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 7	2 900			
	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.					
	7/30/16 indicated R pressure ulcer deve with staff assistanc Predisposing factor cardiovascular dise recent fracture. Fri	d Braden assessment, dated 175 had a moderate risk of elopment, and was off loaded e and with transfers. rs for pressure ulcers included ease and diabetes, and a ction and shearing was noted s well as occasionally moist				
	8/16/16 indicated R ulcer and was not a repositioned by stat an air mattress in p cushion, interventio on the right heel, a wheelchair cushion	d Braden assessment, dated 175 had a current pressure able to off load so was ff when in the chair. R75 had lace and a wheelchair ons included using a blue boot foot cradle in bed, a , air mattress and pillows as to monitor the right foot on a				
		ress notes included the lated to the right heel ulcer and	ł			
	no drainage. Resic reddened and mea- area 1.2 cm x 0.4 c blanchable and pini as a blue boot and the heel and sides also dated 8/23/16 seen by the physici	el area now dry scabbed area, dual area from prior blister sures 2 x 2 cm. Blackened m. The surrounding skin was k in color, treatment was listed pillow to keep the pressure off of the foot. A secondary note, indicated R75's foot had been an and indicated R75 had a al aspect of the upper right				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00348	B. WING		08/2	25/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HARMO	NY RIVER LIVING CE	NIFR	ERWOOD STR ISON, MN 553	EET SOUTHEAST 350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 8	2 900			
		e physician felt was pressure s. A foot cradle was applied to				
	pressure sores on area was not debrid and open to area. create a tent for the thick towel or blank	n examined R75's foot, noted the great toe and heel and ded, no need for a bandage Orders were indicated to e sheets and place a three inch et under the mattress pad at , allow no pressure to heels. bes not improve.				
	heel ulcer indicated loading and to cush frequent repositioni wound increases in should be evaluate progress note, date responsible party w and that R75 would evaluate the areas. on R75's recently a fracture, a blue pre bed cradle for bland larger size shoes for to be scheduled with	der received regarding the I the physician agreed with off nion R75's heel with a boot and ng, continue to monitor, if size or redness extends d by provider. A secondary ed 8/17/16 indicated R75's vas notified of the ulcerations I be seeing a physician to The ulcers were noted to be ffected side with the hip ssure relief boot was in place, kets, and family brought in or R75. An appointment was th a podiatrist due to R75's and new foot concerns.				
	The whole reddener measures 4.2 cm x 2.2 cm x 2.4 cm. C measures 1 cm x 0 blanch-able and firr that measures 0.8 closed, surrounding Tegaderm foam dre	a pressure ulcer on right heel. d/black area/blister area 7 cm. Blister area measures center of heel blackened area .6 cm. Resident has a non n area on the right great toe x 0.6 cm. The wound bed was g skin intact and blanch-able. essing applied and a foot ning shift to contact family.				

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00348	B. WING		08/	08/25/2016	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
NY RIVER LIVING CEI	NTER					
	HUICHIN	-				
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI		(X5) COMPLET DATE	
Continued From pa	ge 9	2 900				
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.						
was resting in bed, underneath the righ place on the foot, w the right heel to reli	with a towel rolled up It calf. A blue boot was in rhich had a cutout area over eve pressure. R75 had an air					
was seated in the h with a shoe on the	allway on the Agate Trail Unit, right foot. The right foot was					
R75 was noted leave with therapy staff.	ving the therapy department Her right foot still had the shoe					
physical therapist (I in therapy for walkin on now were new a a wound on the righ the dining room tab	PT)-A stated R75 wore shoes ng, and that the shoes she had ind brought in by family due to nt heel. PT-A placed R75 at le and walked back to the					
	OF CORRECTION PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY) REGULATORY OR L Continued From pa A dietary note dated a heel ulcer that nu pressure and treatin high nutrient dense per day. During interview on registered nurse (R an ulcer on the righ not feel it needed d elevating the heels R75's bed to avoid During observation was resting in bed, underneath the righ place on the foot, w the right heel to reli mattress with a foo During observation was seated in the h with a shoe on the right resting directly on the resting directly on the resting directly on the with therapy staff. I on it, and was direct During interview on physical therapist (I in therapy for walking on now were new and a wound on the right the dining room tab	OF CORRECTION       IDENTIFICATION NUMBER:         00348       00348         PROVIDER OR SUPPLIER       STREET AD         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00348       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         VT RIVER LIVING CENTER       1555 SHERWOOD STR HUTCHINSON, MN 553         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 9       2 900         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.       2 900         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 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 b	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00348     B. WING       *ROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       YRIVER LIVING CENTER     1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350       SUMMARY STATEMENT OF DEFICIENCIES     ID REQULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDERS PLAN OF IEACH CORRECTIVE ACT (EACH CORRECTIVE ACT CONSTREPENDEND OF DEFICIENCIES)       Continued From page 9     2 900       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. 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WING     08/       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     1555 SHERWOOD STREET SOUTHEAST       INTROPT CENCY MUST BE PROCEEDED BY FULL     ID     PROVIDERS PLAN OF CORRECTION       SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDERS PLAN OF CORRECTION       IEEQLATORY ON LSC IDENTIFYING WROTMATON)     ID     PREVENCY       Continued From page 9     2 900     2 900   A dietary note dated 8/15/16, indicated R75 had an hely 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 au loer 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 was resting in bed, with a tower folled up underneath the right call. A blue boot was in place on the foot, which had a cutout area over the right heel. A blue boot was in place on the foot. 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WING     08/       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     1555 SHERWOOD STREET SOUTHEAST       INTROPT CENCY MUST BE PROCEEDED BY FULL     ID     PROVIDERS PLAN OF CORRECTION       SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDERS PLAN OF CORRECTION       IEEQLATORY ON LSC IDENTIFYING WROTMATON)     ID     PREVENCY       Continued From page 9     2 900     2 900   A dietary note dated 8/15/16, indicated R75 had an hely 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 au loer 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 was resting in bed, with a tower folled up underneath the right call. A blue boot was in place on the foot, which had a cutout area over the right heel. A blue boot was in place on the foot. 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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/25/2016	
		00348	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
IARMO	NY RIVER LIVING CEI	NIFR	ERWOOD STR ISON, MN 55:	EET SOUTHEAST 350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 10	2 900			
	2:08 p.m. the occup (COTA)-A indicated R75 had a blue boo assisted out of bed boot and applied he the boot was usuall be off when she wa During observation 7:36 a.m. R75's he licensed practical n rolled skin about the A paper wound mea by lying in the bed r stated "maybe they wound had been m was noted to be lyin the other side of he bed. A small purple to the medial aspect indicated she had the when up in the whe came into the room area, and stated R7 the blue pressure re to wear it at all time the shoes for theraj have "thrown it off." During interview on indicated she had v pulled up R75's nur which lacked instru	and interview on 8/24/16, at el wound was visualized with urse (LPN)-B. The area had e edges and a purple center. asurement strip was noted to next to R75's foot. LPN-B forgot it last night," as R75's easured then. R75's blue boot ng to the right of her bed, on er nightstand at the head of the e intact area was noted as well to of the right great toe. LPN-A hought R75 wore the boot elchair, but not in bed. RN-A and also visualized the heel 75 should have been wearing eduction boot in bed and was as in the chair, but could use py. RN-A stated R75 may				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00348	B. WING		08/2	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HARMO	NY RIVER LIVING CEI	NTER	ERWOOD ST ISON, MN 5	REET SOUTHEAST 5350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	0	2 900			
	nursing assistant (Nusually pretty coope	8/25/16, at 10:29 a.m. NA)-A indicated R75 was erative with cares, and did not hrow off her heel boot.				
	director of nursing ( have expected the times when she wa and nursing to com	8/25/16, at 1:34 p.m. the (DON) indicated she would boot to be left on R75 at all s not walking, and for therapy municate with each other ed her treatments so that the ack on.				
	Policy and Procedu to avoid positioning ulcer/injury. Use pr	ntitled Pressure Ulcer/Injury ire, last revised 5/16 indicated the resident on a pressure rotective pressure reducing wheelchair sitting surface as				
	The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. The designee, could con delivery of care; to	to prevent pressure ulcers d to promote healing of he director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary ral	21535			9/21/16
	-	al. A resident's drug regimen				
Minnesota D STATE FORI	epartment of Health M		6899	9IT711	If continuatio	n sheet 12 of 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00348	B. WING		08/25/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
HARMON	NY RIVER LIVING CE	NIER	ERWOOD ST ISON, MN 5	REET SOUTHEAST 5350		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21535	Continued From pa	age 12	21535			
	unnecessary drug i A. in excessive therapy; B. for excessive C. without ade D. in the prese which indicate the discontinued. In addition to the c part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finance This standard is inter available through the	quate indications for its use; or ence of adverse consequences dose should be reduced or drug regimen review required in the nursing home must comply he Interpretive Guidelines for egulations, title 42, section a Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary Ioan ate Law Library. It is not				
	by: Based on interview facility failed to ens ongoing use of Ren sleep) and it's effect	tent is not met as evidenced y and document review the sure a clear indication for the meron (antidepressant used for ctiveness was assessed for 1 a) reviewed for unnecessary		"Corrected"		
	(MDS) assessmen received a antidep	nnual Minimum Data Set t dated 5/19/16, identified R59 ressant 7 days per week. The d R59 was free of mood or s.				

STATE FORM

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00348		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 08/25/2016	
				08/		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HARMON	NY RIVER LIVING CE	NIER	ERWOOD STR NSON, MN 553	REET SOUTHEAST 350		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 13	21535			
	8/24/16, identified diagnoses: unspe- behavioral disturba disorder-recurrent, apnea, stupor and R59's physician or Remeron 15 milligu to promote sleep a	ders, dated 8/24/16, included rams (mg) by mouth at bedtime nd Zoloft (antidepressant) 25 a afternoon related to	9			
	the care plan ident depression, insom identified R59's PF indicated minimal s plan identified inter 1. Monitor/docume effectiveness per p 2. Monitor medicat 3. Address pain co 4. Encourage dayti at night. 5. Observe and rep symptoms of depre hopelessness, anx anorexia, negative R59's care plan fur reduction of Zoloft reduction attempt of being used for slee	ions for sleep and side effects. ncerns. me activities to promote sleep port to physician signs and				
	on the Review of C	rmacy consultant documented Consultant Pharmacist Physician form that there was				

STATE FORM

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00348		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 08/25/2016	
				08/		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IARMO	NY RIVER LIVING CE	NIER	ERWOOD STR	REET SOUTHEAST 350		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 14	21535			
	Zoloft was decreas The pharmacist als Remeron 15 mg at consultant docume the Zoloft would be physician would co pharmacist identifie appropriate the phy ongoing need for b 7/7/16, the pharma same irregularity as pharmacy consult the physician identified form "Keep same" reduction should ne R59's Psychoactive 5/15/16, identified 1 mg every night and Zoloft was reduced 9/11/2015 per R59' further identified wi psychopharmacolo attempted gradual attempted annually with one month be contraindicated. Af gradual dose reduce annually unless clin assessment also ic used routinely beyo	e Drug Assessment, complete R59 was taking Remeron 15 I Zoloft 25 mg every day. The I from 50 mg to 25 mg on I's request. The assessment ithin the first year of ogical medication use an dose reduction must be and two separate quarters tween attempts unless clinicall ter the first year of use a ction must be attempted nically contraindicated. The dentified Hypnotics/sedatives	e e d			
	8/24/16, at 9:56 a.r	th registered nurse (RN)-C on n. RN-C stated that R59 sleep problem so staff did not assess				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00348					(X3) DATE SURVEY COMPLETED	
		B. WING		08/	08/25/2016	
			DDRESS, CITY, S	DDRESS, CITY, STATE, ZIP CODE		
ARMO	NY RIVER LIVING CE	NTFR	ERWOOD STR NSON, MN 553	REET SOUTHEAST 350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From page 15		21535			
	her response to the purposes.	e use of the Remeron for sleep				
	(DON) was intervie sleep assessment that a gradual dose attempted since RS DON verified the R the diagnosis of sle was not a good ass pattern as it was no The facility policy for titled, "Psychoactiv Medication Use Po the following: 1. Each resident's of form unnecessary of any drugs when us * In excessive of * Without adeq * Without adeq * Without adeq * Without adeq * In the presen which indicate the of discontinued. 2. If the drug is use identified, in parage the use of such dru a. Physician's note appropriate and tha considered the risk b. A medical/psych physician's judgme	duration. uate Monitoring. uate indications for its use ce of adverse consequences, dose should be reduced or ed outside the guidelines as raph 1 above, justification for ugs must include: indicating why it is clinically at the physician has carefully /benefit to the resident. iatric evaluation to confirm the ent.	y y e			
	the appropriate ass studies and/or the	could inservice staff related to sessments required for sleep need to monitor medication audit could be developed to				

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		00348	B. WING		08/25/2016			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
HARMONY RIVER LIVING CENTER       1555 SHERWOOD STREET SOUTHEAST         HUTCHINSON, MN 55350								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
21535	Continued From pa	age 16	21535					
	monitor the medica results could be rep assurance committ	tions utilized for sleep. The ported to the quarterly quality ree.						
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one						
Minnesota D	epartment of Health							