Electronically Delivered

January 9, 2023

Licensee
Harmony Place
455 Main Avenue North
Harmony, MN 55939

RE: Project Number(s) SL21518015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 30, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500

The total amount you are assessed is $500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit

Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21518015 On November 29, 2022, through November 30, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were residents twenty-seven (27), twenty-four (24) residents were receiving services under the provider's Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents in the Assisted Living Dementia Care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report,	0 480		

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0 480	Continued From page 2 dated November 23, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon	0 490		

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0 490	Continued From page 3 individual and group interests or physical, mental, and psychosocial needs for four of four residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 29, 2022, at 10:30 a.m., registered nurse (RN)-A stated that residents did engage in activity programs in both the assisted living area as well as the licensee's memory care area. During a tour of licensee's establishment on November 29, 2022, at 11:45 a.m., the surveyor observed a calendar of activities posted on a cork board for the assisted living portion of the building. When touring the memory care area, the surveyor did not observe an activity calendar posted anywhere on the unit. During an observation in the memory care area on November 29, 2022, from 12:45 p.m. to 3:30 p.m., residents sat in the common area in chairs sleeping after being served lunch. There were no activities conducted during this time. A television projecting the local news was on and there were no residents viewing the television. During an interview on November 29, 2022, at 1:15 p.m., assisted living director (ALD)-C stated there should always be an activity calendar for	0 490		

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0 490	Continued From page 4 the memory care posted. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 510		

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0 510	Continued From page 5 or has the potential to affect all staff, residents and visitors.) The findings include: On November 29, 2022, at 11:48 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication and treatment administration to R1, which included blood glucose testing and insulin administration. ULP-B did not perform hand hygiene when donning (putting on) and doffing (taking off) gloves. During observation on November 29, 2022, at 11:55 a.m., ULP-B obtained R1's blood glucose meter from resident's locked medication drawer in the kitchen. ULP-B sanitized hands with hand sanitizer then proceeded to get a pair of gloves from a box on top of the resident's refrigerator. ULP-B donned gloves to both hands, took a needle from a box and applied to a finger lancet auto injector. ULP-B took two alcohol wipes, the blood glucose meter, and the finger lancet auto injector to R1. ULP-B obtained R1's blood glucose level then proceeded to return to the kitchen, removed needle from finger lancet injector, placed it in a hazardous waste container, removed gloves and sanitized hands with hand sanitizer. ULP-B went to get another pair of gloves from on top of the refrigerator. ULP-B placed the pair of gloves onto the kitchen counter next to the sink and put her hand into her pant pocket and grabbed a set of keys. ULP-B used keys to open medication drawer, took a container of prescription cream from the medication drawer and ULP-B then donned the pair of gloves that she had placed on the kitchen counter. ULP-B did not wash or sanitize hands when donning gloves. After administering cream to R1's back, ULP-B returned to the kitchen and doffed gloves.	0 510		

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0 510	Continued From page 6 ULP-B returned cream to medication drawer, locked medication drawer and placed keys back into ULP-B's pant pocket. ULP-B then sanitized hands with hand sanitizer. On November 29, 2022, at 2:20 p.m., registered nurse (RN)-A was notified of ULP-B not performing hand hygiene before or after application of donning or doffing gloves. RN-A stated all ULPs had been trained and instructed to wash hands. The licensee's Handwashing policy dated January 20, 2020, indicated handwashing would be performed before and after any gloving. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640		

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0 640	Continued From page 7 by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information to contact 911 emergency number in common areas and near telephones provided by the assisted living dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a building tour on November 29, 2022, at approximately 11:45 a.m., the surveyor noted the facility's common areas had no posting of the 911 emergency number. During an interview on November 29, 2022, at 1:05 p.m., assisted living director (ALD)-C stated she believed the information was posted and was not aware there was no information about 911 information. The licensee's Emergency/911 policy dated August 1, 2021, identified the procedure to contact 911 emergency services in the event of an emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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0 650	Continued From page 8	0 650		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of one employee (registered nurse (RN)-A).	0 650		

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0 650	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A had a hire date of January 3, 2022. RN-A's record lacked records of orientation and infection control training, On November 29, 2022, at 11:12 a.m., assisted living director (ALD)-C indicated she believed RN-A had a record of orientation and infection control training. ALD-C stated she would need to look for the paperwork. ALD-C stated she could not find RN-A's orientation and infection control record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 10 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 29, 2022, at 10:40 a.m., the surveyor requested to review the facility TB risk assessment. Assisted living director (ALD)-C stated a facility TB risk	0 660		

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0 660	Continued From page 11 assessment was completed by a regional employee and would need to obtain the completed assessment. During record review on November 29, 2022, at 1:25 p.m., RN-A's employee record lacked evidence of a completed two-step TST test or other evidence of TB screening. On October 20, 2022, at 1:28 p.m., ALD-C stated to the surveyor they could not find a current TB risk assessment for licensee. During interview on November 29, 2022, at 2:15 p.m., RN-A stated she did not have a test for tuberculosis completed because her Iowa border state RN license did not require her to have one. RN-A stated she now understands that she is working in Minnesota, and she is required to have one. RN-A stated she would immediately be going to the local clinic for testing. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated the licensee would maintain a current community TB risk assessment and the assessment would be updated annually. The policy also indicated all staff are required to be screened and tested for tuberculosis at the time of hire. The Minnesota Department of Health (MDH) guidelines, Regulations for TB Control in Minnesota Health Care Settings dated June 10, 2019, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment performed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 12 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the	0 680		

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	21518	A. BUILDING: _____ B. WING _____	11/30/2022

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0 680	Continued From page 13 potential to impact all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 29, 2022, at approximately 11:00 a.m., during a tour of the licensee's establishment, the surveyor did not observe an emergency plan prominently posted in a common area. Assisted living director (ALD)-C provided a binder with fire, flood, and escape policies, and indicated the binder was the licensee's emergency preparedness plan. The plan lacked risk assessments as required by Appendix Z. On November 29, 2022, at approximately 2:00 p.m., ALD-C acknowledged the licensee's emergency preparedness plan lacked required content for Appendix Z and would need to be revised and posted in the common area. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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	21518	A. BUILDING: _____ B. WING _____	11/30/2022

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0 790	Continued From page 14 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain fire extinguishers in accordance to MNSFC provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed in the Kitchen, Memory Care Unit, and Elevator Room that inspection tags were missing monthly inspection dates ULP-B verbally confirmed survey staff	0 790		

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0 790	Continued From page 15 observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 800		

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0 800	Continued From page 16 1. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that in the Storage Room adjacent to the Salon, med gas (O2) cylinder was found not secured or racked 2. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that in the Storage Room adjacent to the Salon, extension cord in use 3. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that in the Storage Room adjacent to the Salon, high current appliance (refrigerator) connected to a power strip 4. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that in RM 202, power-strips were daisy-chained together 5. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that in the 1st FL Nurses Station that a 1-to-3 multi-tap adapter was connected to an extension cord 6. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that emergency lighting fixtures, #17 and #19 did not function and illuminate properly upon testing 7. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that the 1st FL North and South Mechanical Rooms contained excess combustible storage	0 800		

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0 800	Continued From page 17 8. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that in the Kitchen the manual pull station for the Ansul Type Suppression System was access obstructed 9. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during the tour of the facility that in RM 104 an extension cord was connected to a 1-to-3 multi-tap adapter 10. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed that no documentation was presented during documentation review, to confirm that the facility is current on their 5 year sprinkler system inspection ULP-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 18 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 810		

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0 810	Continued From page 19 1. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed that no documentation was presented during documentation review to confirm that fire drills have occurred since 05/11/2022 2. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed during documentation review that the Fire Plan document(s) reviewed did not identify directive to call 9-1-1 in the event of a fire 3. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed that no documentation was presented during documentation review to confirm that staff are receiving initial fire and evacuation training upon hire and twice per year annual training 4. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed that no documentation was presented during documentation review to confirm that residents of the facility are being offered annual training of evacuation procedures 5. On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed that no documentation was presented during documentation review to confirm that evacuation drills are being conducted ULP-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors	01460		

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01460	Continued From page 20 All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one employee (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A began providing direct care services to residents on January 3, 2022. RN-A's employee record lacked the required orientation to assisted living licensing requirements and regulations with the required content. On November 29, 2022, at 2:30 p.m., assisted living director (ALD)-C verified the lack of	01460		

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01460	Continued From page 21 employee records for RN-A. ALD-C stated they were unable to verify RN-A's orientation to the assisted living licensing requirements and regulations. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated all staff will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have hazard vulnerability assessment and safety risk confirming documentation. This deficient condition has the	02040		

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02040	Continued From page 22 ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On 11/30/2022 between 02:30 PM TO 04:00 PM, survey staff observed that no documentation was presented to confirm that a hazard vulnerability assessment or safety risk assessment has been completed or is current ULP-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

DEPARTMENT OF HEALTH

Type: Full
Date: *11/30/22*
Time: 09:20:07
Report: 7920221252

Food and Beverage Establishment Inspection Report

Location:
Harmony Place
455 Main Avenue North
Harmony, MN55939
Fillmore County, 23

Establishment Info:
ID #: 0038501
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 1507886651
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Quaternary Ammonia: = 300 ppm at Degrees Fahrenheit
Location: Third sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 162 Degrees Fahrenheit - Location: Green beans & bacon
Violation Issued: No

Process/Item: Hot Holding
Temperature: 155 Degrees Fahrenheit - Location: Mashed potatoes
Violation Issued: No

Process/Item: Hot Holding
Temperature: 185 Degrees Fahrenheit - Location: Salisbury steak
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Fruit, cheese, lettuce, salad dressing
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 39 Degrees Fahrenheit - Location: Milk, juice
Violation Issued: No

Type: Full
Date: *11/30/22*
Time: 09:20:07
Report: 7920221252
Harmony Place

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: -1 Degrees Fahrenheit - Location: Meat, pizza
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -6 Degrees Fahrenheit - Location: Vegetables, breakfast foods
Violation Issued: No

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 7920221252 of 11/30/22.

Certified Food Protection Manager: Brandon Olson

Certification Number: FM113143 Expires: 08/29/25

Signed: _____
Establishment Representative

Signed: _____

Sam Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us