Electronically Delivered

July 1, 2025

Licensee
Harmony House
26886 143rd Street
Pierz, MN 56364

RE: Project Number(s) SL20172016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 14, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH 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 may be 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.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20172	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	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: SL20172016-0 On May 12, 2025, through May 14, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 21 residents; 21 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 12, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living facility. This had the potential to affect the licensee's current 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).	0 580		

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0 580	Continued From page 4 The findings include: During the entrance conference on May 12, 2025, at 9:55 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they did not have a "full blown" committee but look at things like food for example and review the following week to see if it has improved. The licensee's undated Quality Management - Root Cause Analysis & Goal Setting form noted falls as an area for improvement. A second undated form with the same title noted an area for improvement as missed services to be reduced by 25% by February 1, 2025. On May 14, 2025, at 10:35 a.m., regional manager (RM)-G stated they did not have any quality management in place prior to this, and no further documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 5 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). 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: R1's diagnoses included dementia and depression. R1's Service Plan dated February 17, 2025, noted R1 received services including assistance with ambulation, bathing, and medication administration. R1's Incident Report dated January 26, 2025, noted R1 was pushed by another resident and a vulnerable adult report was made. R1's IAPP dated February 17, 2025, indicated R1 was at risk to be abused. Interventions noted "Due to vulnerability r/t [related to] cognitive impairment, environment provides supervision and services to decrease the risk of being abuse.	0 630		

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0 630	Continued From page 6 Staff provide frequent well-being checks, supervision and/or assist with ADL's [activities of daily living] that are identified by individual's assessment and monitor for any signs of abuse. If abuse is suspected, immediate report is to be made to the RN [registered nurse] for investigation, intervention and further reporting as appropriate. Refer to the individuals planned services for individualized interventions. Staff receive training on the topic of vulnerable adults upon hire and at least annually. 24 hour supervision staff will monitor for and remove from potentially harmful/abusive situations. Staff with (sic) monitor resident 24/7 to ensure safety. Will check on resident frequently and offer assistance as needed." R1's IAPP lacked specific intervention related to the history of abuse from a peer. On May 13, 2025, at 12:45 p.m., licensed assisted living director (LALD)-B, clinical nurse supervisor (CNS)-A and licensed practical nurse (LPN)-H stated no specific interventions were included in the IAPP, and added the peer involved had since discharged. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, noted an individual abuse prevention plan would be developed for each vulnerable adult and would include statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 7	0 650		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel/ULP-D). 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	0 650		

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0 650	Continued From page 8 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: ULP-D was hired on November 30, 1995, to provide direct care services to residents of the facility. On May 13, 2025, at 8:35 a.m., the surveyor observed ULP-D administer medications to R2. ULP-D's employee record lacked documented evidence of the following annual training: - review of provider's policies and procedures. On May 14, 2025, at 11:05 a.m., regional manager (RM)-G and clinical nurse supervisor (CNS)-A stated the training for ULP-D had been completed, but they were unable to find the documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775		

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0 775	Continued From page 9 failed to comply with the requirements of the Minnesota State Fire Code. 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) 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). Findings include: On a facility tour on May 13, 2025, from 1:40 p.m. to 2:50 p.m., with maintenance worker (MW)-C, and director of maintenance (DM)-F, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: REQUIRED EXIT DOOR CONTROLLED EGRESS LOCKING There was a controlled egress locking system installed on all required exit doors leading out of the secured dementia care unit to the exterior exit path. The controlled egress door locking system was not provided with a device/ switch capable of deactivating the controlled egress door system hardware to the unlocked position from the nurse station or other approved location within the locked dementia care unit. It was explained the controlled egress locking system is required to be provided with a device/ switch capable of deactivating the controlled	0 775		

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0 775	Continued From page 10 egress door hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of a fire or similar emergency. During an interview on May 13, 2025, at 3:15 p.m., licensed assisted living director (LALD)-B, stated the procedures required to operate and unlock the controlled egress door locking system was not included in the Fire Safety and Evacuation Plan (FSEP) employee procedures. It was explained that the procedures required to operate and unlock the controlled egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required to be included in the FSEP in accordance with MSFC in Minnesota Rules Chapter 7511. During the facility tour and interview MW-C, and LALD-B, verified the above listed observations while accompanying on the tour. LALD-B, also stated procedures of operation of the controlled egress door locking system were not included in the FSEP employee procedures. COMMERCIAL KITCHEN EXHAUST HOOD AND DUCT CLEANING The documentation provided for verification of required cleaning of the commercial kitchen exhaust hood and duct indicated the last cleaning was completed in the spring 2022. It was explained the commercial kitchen cooking exhaust hood and duct system is required to be inspected every 6 months and grease deposits cleaned as required by MSFC in Minnesota Rules	0 775		

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0 775	Continued From page 11 Chapter 7511. FIRE RESISTANT RATED DOOR MAINTENANCE During the tour it was observed the public bathroom near the front entrance in the center corridor had the closer removed from the fire-resistant rated door. It was explained that fire resistant rated doors in corridors are required to be maintained to automatically close and latch as designed and installed at the time of construction. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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) staff 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 or unusual resident needs for movement or evacuation. (c) Staff 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	0 810		

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0 810	Continued From page 12 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 staff 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, interview and record review, the licensee failed to, provide required training for residents and fire evacuation drills. 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) 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). The findings include: On May 13, 2025, at 2:50 p.m., licensed assisted living director (LALD)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 13 TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by providing documentation residents took part in a fire evacuation drill. The documentation provided did not indicate the residents were provided training based on the required resident procedures in the Fire Safety and Evacuation Plan (FSEP). During an interview on May 13, 2025, at 2:50 p.m., LALD-B, stated the only documentation available was the fire evacuation drill indicating the residents were included in the drill. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation indicating fire evacuation drills were completed in November 2024 and December 2024 only. No further information was provided. During an interview on May 13, 2025, at 2:50 p.m., LALD-B, stated they will provide drill documentation by email on or before May 14, 2025, at 12:00 p.m. An email was received on May 14, 2025, at 12:43 p.m., and indicated fire evacuation drills were completed in November and December of 2024 during a false fire alarm activation. No further information was provided.	0 810		

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0 810	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the facility to document agreement on the services to be provided for two of three residents (R1, R2). This practice resulted in a level two violation (a	01640		

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01640	Continued From page 15 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included dementia and depression. R1's Service Plan dated February 17, 2025, noted R1 received services including assistance with ambulation, meals, bathing, and medication administration. However, it lacked a signature or other authentication by the facility documenting agreement on the services to be provided. R2 R2's diagnoses included dementia. R2's Service Plan dated March 4, 2025, noted R2 received services including assistance with dressing, grooming, and ambulation. However, it lacked a signature or other authentication by the facility documenting agreement documenting agreement on the services to be provided. On May 13, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they were not sure why the service plans were not signed. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any	01640		

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01640	Continued From page 16 revision would include a signature or other authentication by the site, the resident, or resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those	02170		

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02170	Continued From page 17 that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan based on the evaluation for one of two residents (R1) who resided in an assisted living with 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 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: The licensee had an Assisted Living with Dementia Care license effective February 1, 2025. R1's diagnoses included dementia and depression. On May 13, 2025, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-D	02170		

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02170	Continued From page 18 administer medications to R1 in her apartment. R1's Service Plan dated February 17, 2025, noted R1 received services including assistance with ambulation, meals, bathing, and medication administration. R1's Activity Preferences dated November 23, 2022, and Assessment dated February 17, 2025, included an evaluation of past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, and adaptations necessary for the resident to participate. However, R1's record lacked an individualized activity plan based on this evaluation. On May 13, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated an individualized activity plan had not been completed for R1. The licensee's Life Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2021, noted an individualized activity plan must be developed for each resident based on their activity evaluation, and must reflect their preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living	02180		

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02180	Continued From page 19 facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms identified were addressed on the service plan for one of two residents (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, 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: The licensee had an Assisted Living with	02180		

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02180	Continued From page 20 Dementia Care license effective February 1, 2025. R2's diagnoses included dementia. R2's Service Plan dated March 4, 2025, noted R2 received services including assistance with dressing, grooming, and ambulation. R2's Resident Notes included the following: - March 8, 2025, "resident spent a lot of time wandering around the facility walking independently with walker"; - March 15, 2025, "resident was wandering around hallways in wheelchair and watched some tv beginning of shift:; - March 19, 2025, "resident trying to get out of building had to redirect him 20 times on shift kept sitting in front of the front door trying to get out of building, resident going into everyone's rooms, had to redirect him. Resident wandering hallways all shift.'" - March 28, 2025, "Resident wandering into peoples (sic) rooms, writer and co staff would redirect, writer caught resident self transferring into his bed, resident sitting by front door wanting to leave the building"; - March 29, 2025, "Resident was found in room 223 arguing with that resident writer calmed it down and got resident out of the room"; - March 30, 2025, "resident wandering in building today in wheelchair, residents (sic) wheelchair scraping up the hallways, going into other residents (sic) rooms, staff would intervene and take out of co residents (sic) rooms, resident would go up to the front door and try pushing the bar to open the door, resident self transferred in the living room on the couch co staff and writer helped resident adjust"; - April 2, 2025, "Resident wandering halls, trying	02180		

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02180	Continued From page 21 to get into other residents (sic) rooms", and "Resident was in the hallway hitting into the wall but pulling himself against the wall and scratching it. Resident is very difficult to redirect. Resident was pulling items around with him also hitting into other residents";, - April 16, 2025, "Resident wandering in wheelchair throughout whole shift, wandering into other resident rooms had to be redirected out, resident would push on front door a couple times today and sit and stare out door"; - April 26, 2025, "Resident up sitting in wheelchair banging walls and going into other residents rooms"; - April 30, 2025, "Resident go up six times tonight. He was very hard to redirect. He thinking it was time for work"; - May 6, 2025, "resident got bath this am [a.m.] resident slept on the chair in the living room for a couple hours. resident was in wheel chair roaming around pulling different chairs with him.". R2's Incident Report dated April 9, 2025, noted staff looked outside and saw R2 on the tar out in the open. "Resident was not on the side walk and kept wheeling himself onto the tar by all of the cars." Resident was brought in immediately and a contractor serviced the exit door to shorten the automatic lock time. R2's Assessment dated March 4, 2025, noted a behavior "Manage Behavior - Wanders / Elopement Threat:" and under "Notes" indicated "Does at times wake up with belief that he needs to complete farm chores and will seek to do this." On May 13, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated R2's record did not have any specific interventions listed for staff to utilize	02180		

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02180	Continued From page 22 when R2 was wandering. The licensee's Behavioral Symptoms, Interventions, & Nonpharmacological Approaches policy dated August 1, 2022, indicated the licensee would identify behavioral symptoms that negatively impact other residents and evaluate to determine potential interventions to minimize behaviors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement new interventions related to the root cause of falls for two of two residents (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, 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	02310		

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02310	Continued From page 23 situation has occurred only occasionally). The findings include: R2's diagnoses included dementia. On May 13, 2025, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2 in his room. R2's Service Plan dated March 4, 2025, noted R2 received services including assistance with dressing, grooming, and ambulation. R2's Incident Reports included the following: - March 5, 2025, at 2:35 p.m., R2 had an unwitnessed fall in the bathroom, found on the bathroom floor with the walker next to him. It noted education was provided on use of the walker and using a call pendant for assistance; - March 6, 2025, at 11:40 p.m., R2 had an unwitnessed fall in the bedroom, found on the floor near his bed and a blanket on the floor. It noted education was provided on use of the walker and using a call pendant for assistance; - March 14, 2025, at 12:43 p.m., R2 had an unwitnessed fall in the bathroom. It noted education was provided on use of the walker and using a call pendant for assistance; - March 18, 2025, at 3:00 p.m., R2 had an unwitnessed fall in his room. Resident was heard calling for help. It noted "Resident forgets to use call pendant prior to attempts to ambulate". It noted education was provided on use of the walker and using a call pendant for assistance; - March 20, 2025, at 7:00 p.m., R2 had an unwitnessed fall in the dining room. R2 was wearing socks and shoes. It noted R2 ambulated from the living room to the dining room without an assistive device and did not use the call pendant	02310		

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02310	Continued From page 24 for help. It noted "More education on importance of using call pendant for assistance transfers. Also needs to use assistive devices at all times for ambulation."; - March 23, 2025, at 1:00 p.m., R2 had an unwitnessed fall in the bathroom, and was heard yelling for help. No interventions were listed; - April 9, 2025, at 1:15 p.m., R2 had an unwitnessed fall in his room having slipped when trying to wheel himself to the bathroom. "More education on importance of using call pendant for assistance in transfers. Also needs to use assistive devices at all times for ambulation"; - April 15, 2025, at 10:00 a.m., R2 had an unwitnessed fall in the doorway to his room. "More education on importance of using call pendant for assistance in transfers. Also needs to use assistive devices at all times for ambulation"; - April 15, 2025, at 3:00 p.m., R2 had an unwitnessed fall in his room, trying to self-ambulate to the bathroom. "Reeducated on use of call pendant and assistive devices for ambulation"; - April 20, 2025, at 8:00 p.m., R2 had an unwitnessed fall in the hallway in front of the door. R2 was wearing shoes. "More education on importance of using call pendant for assistance in transfers. Also needs to use assistive devices at all times for ambulation"; - April 27, 2025, at 11:13 p.m., R2 had an unwitnessed fall in his bedroom, found on the floor next to his door. R2 was wearing gripper socks. "Continue to reeducate on pendant use and waiting on staff before ambulating"; and - May 3, 2025, at 9:30 a.m., R2 had an unwitnessed fall in his room, found on the floor between his bed and wheelchair. R2 was wearing shoes. "More education on importance of using call pendant for assistance in transfers. Also needs to use assistive devices at all times for	02310		

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HARMONY HOUSE	26886 143RD STREET PIERZ, MN 56364

(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
02310	Continued From page 25 ambulation." On May 13, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they had been attempting to get a bed alarm for R2 from the United States Department of Veterans Affairs. They also noted a fall mat was in place. However, they stated no new interventions had been included on the 14 incidents of falls resident had during this time. The licensee's Fall Prevention & Management policy dated June 15, 2024, noted the registered nurse "evaluates fall data to measure and analyze falls and reviews potential contributing factors and follow-up actions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Harmony House
26886 143rd Street
Pierz, MN 56364
Morisson County
Parcel:

Phone:

License Info

License: HFID 20172

Risk:
License:
Expires on:
CFPM: ANNETTE LYNN HAMMARSTEDT
CFPM #: 55444; Exp: 1/5/2028

Inspection Info

Report Number: F1037251018
Inspection Type: Full - Single
Date: 5/12/2025 Time: 11:30:37 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: QUATERNARY AMMONIUM SANITIZER TEST KIT AVAILABLE ONSITE. PROVIDE A CHLORINE TEST KIT FOR MEASURING THE DISHWASHER'S SANITIZING SOLUTION CONCENTRATION. A FEW CHLORINE TEST STRIPS WERE LEFT ONSITE.
Comply By: 5/16/2025 Originally Issued On: 5/12/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C1 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.
COMMENT: LOW TEMPERATURE CHLORINE DISHWASHER MEASURED A CONCENTRATION OF 10 PPM CHLORINE AT THE TIME OF THE INSPECTION. SANITIZE DISHES IN THE 3 COMPARTMENT SINK UNTIL THE DISHWASHER IS ADJUSTED OR REPAIRED TO MAINTAIN THE DISHWASHER'S CHLORINE RINSE CONCENTRATION AT 50-100 PPM.
Comply By: 5/12/2025 Originally Issued On: 5/12/2025

! **New Order: 5-400 Sewage**
5-402.11A *Priority Level: Priority 1 CFP#: 52*
MN Rule 4626.1190A Provide an indirect connection between the sewage system and any drain originating from equipment in which food, portable equipment or utensils are placed, such as manufacturing and retail display equipment, portable equipment, ice bins, salad bars, cocktail stations and dipper wells.
COMMENT: ICE MAKER DRAIN LINE WAS OBSERVED ON THE FLOOR DRAIN. PROVIDE A MINIMUM OF A 2 INCH AIR GAP BETWEEN THE ICE MAKER'S DRAIN LINE AND THE FLOOR DRAIN.
Comply By: 6/12/2025 Originally Issued On: 5/12/2025

Food & Beverage General Comment

DISCUSSED MENU, BARE HAND CONTACT, COOLING, EMPLOYEE ILLNESS RECORDING, AND ORDERS WITH TRACY, MORGAN, AND KEVIN.
BARE HAND CONTACT AND COOLING FACT SHEETS LEFT ONSITE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans

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

I acknowledge receipt of the St Cloud District Office inspection report number F1037251018 from 5/12/2025

Establishment Representative

Michelle Hovanes,
Public Health Sanitarian 1
320-223-7307
michelle.hovanes@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Harmony House
Pierz
County/Group: Morisson County

Inspection Info

Report Number: F1037251018
Inspection Type: Full
Date: 5/12/2025
Time: 11:30:37 AM

Food Temperature: Product/Item/Unit: NOODLES**; Temperature Process:** Hot-Holding
Location: Serving Line at 162 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MEATBALLS IN ALFREDO**; Temperature Process:** Hot-Holding
Location: Serving Line at 157 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MEATBALLS IN BBQ**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK JUG**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: DINING AREA
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Harmony House
Pierz
County/Group: Morisson County

Inspection Info

Report Number: F1037251018
Inspection Type: Full
Date: 5/12/2025
Time: 11:30:37 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 10 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 10 PPM
Comment: RECHECK - PRIMED SANITIZER LINE ON DISH MACHINE
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1037251018

Food Establishment Inspection Report

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	1	Date: 5/12/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:30:37 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Harmony House	26886 143rd Street	Pierz, MN	56364	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 20172		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	N/A	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52	X	Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Michele L Thomas

Follow-up: Follow-up Date: