



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 21, 2023

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

RE: Project Number(s) SL30810015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 24, 2023, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility.**

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

Harmony River Living Center

March 21, 2023

Page 2

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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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,



Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS: SL30810015</p> <p>On February 21, 2023, through February 24, 2023, 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 16 active residents receiving services under the Assisted Living with Dementia Care license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 480 SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the</p>	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	<p>Continued From page 1</p> <p>following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>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) 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 dated February 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 480		
0 650 SS=E	<p>144G.42 Subd. 8 Employee records</p> <p>(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</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	<p>Continued From page 2</p> <p>and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(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</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (registered nurse (RN)-B, unlicensed personnel (ULP)-E).</p> <p>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 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:</p> <p>RN-B RN-B had a hire date of March 30, 2015.</p> <p>RN-A's record lacked the following required content:</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	<p>Continued From page 3</p> <p>-records of orientation; -required annual training; and -documentation of annual performance reviews that identify areas of improvement needed and training needs.</p> <p>ULP-E ULP-E had a hire date of March 19, 2020.</p> <p>On February 22, 2023, at 8:50 a.m. the surveyor observed ULP-E administer medication to R1.</p> <p>ULP-B's record lacked the following required content: -records of orientation; -required annual training; and -documentation of annual performance reviews that identify areas of improvement needed and training needs.</p> <p>On February 22, 2023, at 1:37 p.m., RN-C verified RN-B and ULP-E's employee record lacked the above content. RN-C stated items for RN-A and ULP-B were not completed because of COVID 19.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 650		
01440 SS=D	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01440	<p>Continued From page 4</p> <p>provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.</p> <p>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-E) was supervised by a registered nurse (RN) within 30 days after providing delegated tasks.</p> <p>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).</p> <p>The findings include: ULP-E had a hire date of March 19, 2020.</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01440	<p>Continued From page 5</p> <p>On February 22, 2023, at 8:50 a.m. the surveyor observed ULP-E administer medication to R1.</p> <p>ULP-E's employee record lacked evidence of direct supervision within 30 days after beginning work and first performing delegated tasks.</p> <p>On February 22, 2023, at 1:37 p.m. RN-C confirmed the 30-day supervision was not completed.</p> <p>The licensee's MN AL Delegation and Supervision policy updated August 9, 2022, indicated that a RN will supervise staff who perform delegated nursing treatment or therapy services. The supervision by a RN will be direct supervision within 30 calendar days after the staff member begins working and first performs the delegated resident tasks.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01440		
01540 SS=D	<p>144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED</p> <p>(3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource</p>	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01540	<p>Continued From page 6</p> <p>and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one direct-care employee (ULP-E) completed at least two hours of training on topics related to dementia care for each 12 months of employment thereafter as required.</p> <p>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).</p> <p>The findings include:</p> <p>ULP-E had a hire date of March 19, 2020, to provide direct care and services to the licensee's residents under the comprehensive license, and began providing services under the assisted living with dementia care license on August 1, 2021.</p> <p>ULP-E's employee record lacked documentation ULP-E had completed two hours of annual dementia training.</p>	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01540	<p>Continued From page 7</p> <p>On February 23, 2023, at approximately 9:40 a.m. RN-C verified ULP-E's annual dementia training included only one half hour (0.5), and did not have the two required hours completed.</p> <p>The licensee's Dementia Training policy dated August 1, 2021, indicated all staff would complete training on topics related to dementia care for each 12 months of employment thereafter.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01540		
01750 SS=D	<p>144G.71 Subd. 7 Delegation of medication administration</p> <p>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:</p> <ul style="list-style-type: none"> (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-E) followed appropriate medication administration procedures during medication administration.</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	<p>Continued From page 8</p> <p>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).</p> <p>The findings include:</p> <p>On February 22, 2023, at 8:50 a.m. the surveyor entered R1's room and requested to observe ULP-E's medication pass. ULP-E began to dispense medications for R1 from a medication card and placed medications into a medication cup. ULP-E proceeded to initial each medication after setting up before the medication administration was provided. The surveyor asked if a medication was refused, how would the ULP document if the ULP signed out that the medication was already administered. ULP-E demonstrated how to do so, by circling initials for the respective medication not given, and provide an explanation under the "special remarks" section of the paper medication administration record (MAR). The surveyor asked ULP-E if signing medication administration as given, before giving, was how the ULP was trained. ULP-E stated that was not her normal practice, and not how she was trained.</p> <p>R1's paper MAR indicated ULP-E administered the following medication to R1 at 8:30 a.m.: Cholecalciferol (vitamin supplement) 1000 unit; Colace (stool softener) 100 milligrams (mg); Ferrous Sulfate (iron supplement) 325 mg; Furosemide (diuretic) 20 mg; Losartan (treats high blood pressure) 200 mg; Metoprolol</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2023
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	<p>Continued From page 9</p> <p>Succinate (heart failure) 50 mg; Move Free (dietary supplement); and Acetaminophen (pain reliever) 325 mg.</p> <p>On February 22, 2023, at 9:30 a.m. registered nurse (RN)-B and the surveyor discussed the observation regarding the setup and administration of medications to R1. RN-B stated that the ULP were trained to place a dot in the respective medication set up into the medication cup and wait to initial medication administration until after medication was witnessed as given.</p> <p>The licensee's MN AL Administration of Medication by Resident Assistant policy updated September 9, 2022, indicated ULP's that provide assistance with medication administration will be trained and competency tested by an RN on documentation, after assistance with medications or medication administration consistent with Presbyterian Homes and Services procedures for documenting in the MAR.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01750		



Type: Full
Date: 02/21/23
Time: 11:00:00
Report: 1033231029

Food and Beverage Establishment Inspection Report

Location:

Harmony River Living Center
1555 Sherwood Street SE
Hutchinson, MN55350
Mc Leod County, 43

Establishment Info:

ID #: 0026369
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Hutchinson Senior Care Service
Phone #: 3204846000
ID #: 34669

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

The following orders were issued during this inspection.

2-300 Personal Cleanliness

2-301.14A ** Priority 1 **

MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.

Employees do not wash their hands before putting on gloves to prepare resident food trays.

Comply By: 02/21/23

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Facility leaves a container of margarine butter blend on the counter at room temperature. Package of butter states it must be refrigerated. Person in charge discarded container.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Facility does not have a way to measure the high temperature dish machine in the assisted living side.

Comply By: 03/07/23

Type: Full
Date: 02/21/23
Time: 11:00:00
Report: 1033231029
Harmony River Living Center

Food and Beverage Establishment Inspection Report

5-200C Plumbing: Maintenance, fixture location

5-205.11AB **** Priority 2 ****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Hand wash sink is being used to discard ice.

Comply By: 02/21/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

There are no hand wash signs at sinks used by employees.

Comply By: 02/21/23

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit

Location: Dish Machine

Violation Issued: No

Quaternary Ammonium: = at Degrees Fahrenheit

Location:

Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 0> Degrees Fahrenheit - Location: Freezer

Violation Issued: No

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: Cooler

Violation Issued: No

Process/Item: Cold Holding

Temperature: Degrees Fahrenheit - Location:

Violation Issued: Yes

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	2	1

Type: Full
Date: 02/21/23
Time: 11:00:00
Report: 1033231029
Harmony River Living Center

Food and Beverage Establishment Inspection Report

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 1033231029 of 02/21/23.

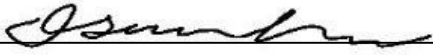
Certified Food Protection Manager Patricia A Herold

Certification Number: FM11299 Expires: 07/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Patricia A Herold

Signed:  _____

Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033231029

Food Establishment Inspection Report



No. of RF/PHI Categories Out	3	Date	02/21/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Harmony River Living Center	Address 1555 Sherwood Street SE	City/State Hutchinson, MN	Zip Code 55350	Telephone 3204846000
License/Permit # 0026369	Permit Holder Hutchinson Senior Care Service	Purpose of Inspection Full	Est Type	Risk Category M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item Mark "X" in appropriate box for COS and/or R

IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS= corrected on-site during inspection R= repeat violation

Compliance Status	Surpervision	COS	R
1 <input checked="" type="radio"/> IN <input type="radio"/> OUT	PIC knowledgeable; duties & oversight		
2 <input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A	Certified food protection manager, duties		
Employee Health			
3 <input checked="" type="radio"/> IN <input type="radio"/> OUT	Mgmt/Staff; knowledge, responsibilities & reporting		
4 <input checked="" type="radio"/> IN <input type="radio"/> OUT	Proper use of reporting, restriction & exclusion		
5 <input checked="" type="radio"/> IN <input type="radio"/> OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygienic Practices			
6 <input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/O	Proper eating, tasting, drinking, or tobacco use		
7 <input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN <input checked="" type="radio"/> OUT <input type="radio"/> N/O	Hands clean & properly washed		
9 <input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	No bare hand contact with RTE foods or pre-approved alternate procedure properly followed		
10 IN <input checked="" type="radio"/> OUT <input type="radio"/> N/A	Adequate handwashing sinks supplied/accessible		
Approved Source			
1 <input checked="" type="radio"/> IN <input type="radio"/> OUT	Food obtained from approved source		
12 IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O	Food received at proper temperature		
13 <input checked="" type="radio"/> IN <input type="radio"/> OUT	Food in good condition, safe, & unadulterated		
14 IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A <input type="radio"/> N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 <input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Food separated and protected		
16 <input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A	Food contact surfaces: cleaned & sanitized		
17 <input checked="" type="radio"/> IN <input type="radio"/> OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

Risk factors (RF) are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions (PHI)** 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" 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

Compliance Status	Safe Food and Water	COS	R
30 IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A	Pasteurized eggs used where required		
31 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Water & ice obtained from an approved source		
32 IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A	Variance obtained for specialized processing methods		
Food Temperature Control			
33 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Proper cooling methods used; adequate equipment for temperature control		
34 IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O	Plant food properly cooked for hot holding		
35 IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O	Approved thawing methods used		
36 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Thermometers provided & accurate		
Food Identification			
37 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Food properly labeled; original container		
Prevention of Food Contamination			
38 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Insects, rodents, & animals not present		
39 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Contamination prevented during food prep, storage & display		
40 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Personal cleanliness		
41 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Wiping cloths: properly used & stored		
42 <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O	Washing fruits & vegetables		

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

Food Recalls:

Person in Charge (Signature)

Date: 02/24/23

Inspector (Signature)