Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2024

Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

RE: CCN: 245528
Cycle Start Date: February 29, 2024

Dear Administrator:

On February 29, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 29, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 29, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/26/24 to 2/29/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55281020C (MN99597) H55281022C (MN98333) H55281021C (MN96227) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F 578		3/28/24

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

Electronically Signed | 03/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in the medical record in a timely manner for 1 of	F 578	F578: Gundersen Harmony Care Center will continue to ensure all residents have the right to request, refuse, and/or discontinue treatment, to participate in or	

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F 578	Continued From page 2 16 (R184) resident reviewed for advanced directives. Findings include: R184's Provider Orders for Scope of Treatment (POST) indicated "Do not attempt resuscitation/DNR" dated by the medical provider on 2/26/24 at 12:16 p.m. R184's electronic medical record (EMR) review on 2/26/23 at 5:36 p.m., lacked indication of code status in the identification banner. R184's Progress notes indicate R184 admitted to the facility on 2/21/24 at 11:15 without resident representation present. At 4:51 p.m., Social Worker (SW)-A attempted to reach R184's power of attorney Family member (FM)-A. At 7:49 p.m., RN-B left message for FM-A requesting immediate call back for direction regarding resident's care. On 2/22/24 at 2:46 a.m., facility staff left message for FM-A to return call. R184's Progress note dated 2/22/24 11:59 p.m.. indicated FM-A returned call and stated R184 is to be a do not resuscitate (DNR) however, was not available to sign POST. R184's Progress notes indicate FM-A signed POST on 2/24/24. Although on 2/27/24 at 9:02 a.m., R184's EMR continued to lacked indication of code status in the identification banner. During an interview on 2/27/24 at 01:39 p.m., LPN-A stated it is facility policy to verify code status with POST in the resident's hard chart. The first lace LPN-A would look at is the EMR	F 578	refuse to participate in experimental research, and to formulate an advance directive. R184's code status is a DNR per the activated Power of Attorney for Healthcare's wishes. Code status was updated for resident in Matrix immediately upon discovery of omission. All other residents were reviewed to ensure their code status aligns with their wishes and no discrepancies were found. All licensed nurses were re-educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders to include inputting this changed data appropriately and timely. Provider will be notified with any order change requests. The Social Worker will audit code statuses on residents monthly x 6 months. Results of audits will be reported to the QAPI committee monthly. Completion Date: 3/28/24	

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F 578	Continued From page 3	F 578		

identification banner for code status and then the hard chart if the EMR banner was not updated. LPN-A confirmed there was no indication of code status on R184's EMR identification banner. LPN-A stated not having a code status could lead to a resident having CPR performed when they "didn't want it". LPN-A stated the nurse manager enters a resident's code status.

During an interview on 2/28/24 at 2:45 p.m., the director of nursing (DON) stated advanced directives and code statuses are established at admission. She stated the facility had difficulty reaching R184's power of attorney to confirm R184's code status. DON stated R184 "fell through the cracks" due to the difficulty reaching the power of attorney.

During interview on 2/29/24 at 9:53 a.m., SW-A stated she is not always the first person to see the residents upon admission to the facility. Code status is established by the nursing department in most cases. SW-A stated R184's health care directive from the hospital lacked indication of code status. SW-A stated facility policy indicates residents are considered full code until the POST form is signed for "legal reasons" to avoid potential for miscommunication. SW-A stated R184's power of attorney was informed R184 would be a full code until the form was signed. R184's POST was signed on 2/24/24 by FM-A and SW-A.

During interview on 2/29/24 at 11:08 a.m., RN-A stated she would look at the POST to verify code status. If the POST was not signed, she would assume resident was full code. RN-A stated verbal confirmation of code status is not sufficient and a resident would still be considered a full

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F 578	Continued From page 4 code until a POST is signed. During interview on 2/29/24 at 12:51 p.m., R184's power of attorney (FM-A) recalled having a conversation with the facility regarding R184's code status and stated he did sign code status paperwork on 2/24/24. He was unable to confirm being told R184 could be treated as full code until POST was signed. During interview on 2/29/24 at 12:59 p.m., RN-B stated she is responsible for putting the admission packet together, receipt of discharge paperwork, and inputting orders into EMR. Nursing floor staff are responsible for filling out consents for necessary equipment and going through POST with the resident or responsible party. RN-B stated she enters information into EMR. It was her understanding R184 would be enrolling in hospice upon admission and the power of attorney would be arriving with the resident. RN-B stated she entered R184's code status as DNR in the EMR, however removed it upon realizing the power of attorney would not be arriving with R184 to sign the POST. She acknowledged she should have indicated FULL CODE on the EMR banner until the POST could be signed. She stated she asked the DON and SW-A if a verbal confirmation of code status was acceptable prior to signature. They were both unsure as their policy indicates full code in the absence of a signed POST. She was also unaware hospice arrangement had not been made prior to R184's admission. RN-B stated the facility is in the process of changing their admission policy to ensure hospice arrangements and code status is established prior to or on the day of admission to ensure information is not missed in the future.	F 578		

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F 578	Continued From page 5 A policy dated 11/23 titled CPR indicates "the objective of the CPR policy is to provide basic life support based until emergency medical services arrives, consistent with the resident advanced directives, in the absence of an advance directive or do not resuscitate order and if the resident does not show signs of clinical death. Prompt initiation of CPR is essential as brain death begins four to six minutes following cardiac arrest if CPR is not initiated within that time." It continues, "Advanced directive-means according to 42C.F.R. 489.100, a written instruction, such as living will or durable power of attorney for health care, recognized under state law (whether statutory or as a recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated. Some states also recognize a documented oral instruction." "It is the policy of Gunderson Harmony Care Center to provide basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advanced directives." "Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless: A valid Do Not Resuscitate order is in place - Resident presents with obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection or decomposition) are present. -Initiating CPR could cause injury or peril to the rescuer. A facility policy dated 6/2023 titled "Advanced Directives" indicates it is facility policy to identify if the resident has an advance directive upon admission. "If an adult individual is incapacitated	F 578		

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F 578	Continued From page 6 at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, Gundersen Harmony Care Center will give advance directive information to the individual's resident representative in accordance with Minnesota State law." The section titled Cardiopulmonary Resuscitation (CPR) indicates staff are educated to initiate CPR unless a valid DNR order is in place.	F 578		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/28/2024. At the time of this survey, GUDERSEN HARMONY CARE CENTER found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/19/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GUNDERSON HARMONY CARE CENTER is a 1 story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1967 an addition was constructed and was determined to be of Type II(111) construction.	K 000		

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K 000	Continued From page 2 Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification. There are two occupancies in the building. The nursing home (I-2) and an outpatient clinic (B) with proper fire separation. The facility has a capacity of 43 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 345	K345 Gundersen Harmony Care Center	3/28/24

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.14.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/28/2024 between 10:00 AM and 1:00 PM, it was revealed by observation that the manual fire alarm pull-station located at the main exit of the facility was access obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	will continue to ensure that a fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system maintenance and testing are readily available. At the time of the walk through with the Fire Marshal the maintenance man removed the obstruction from the fire alarm pull-station. No other obstructions of fire alarm pull-stations were found during this walk through. Re-education was provided to all staff for the need to not obstruct fire alarm pull-stations. Maintenance will audit monthly x 6 months to ensure fire-alarm pull-stations are not obstructed. Results will be reported to the QAPI committee monthly. Completion date: 3/28/24	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		3/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

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K 353	Continued From page 4 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.1, 5.2.1.1.2(2), 5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/28/2024 between 10:00 AM and 1:00 PM, it was revealed during documentation review that the documentation presented for review did not confirm that quarterly inspection of the system occurred in the second quarter of 2023. On 02/28/2024 between 10:00 AM and 1:00 PM, it was revealed by observation that the sprinkler head located in the Kitchen / Dishwashing area exhibited signs of oxidation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	K353: Gundersen Harmony Care Center will continue to ensure that maintenance and testing automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing and Maintaining of Water-Based Fire Protection Systems is completed. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. Re-education was provided to the Facilities Mechanic for the need to complete the quarterly inspection for the system and the need to monitor sprinkler heads for oxidization. This quarterly inspection for the system was also put on the Facilities Mechanic's calendar so that it would automatically pop-up on his calendar to complete when it was due. The sprinkler head in the kitchen/dishwashing area was replaced on 3/28/24. All other sprinkler heads were checked and no signs of oxidization were observed. Administrator will audit for completion of the quarterly inspection x6 months. Results will be reported to the QAPI committee quarterly. Completion Date: 3/28/24	
K 712 SS=D	Fire Drills CFR(s): NFPA 101	K 712		3/28/24

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 5 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/28/2024 between 10:00 AM and 1:00 PM, it was revealed by review of available documentation that documentation presented for review revealed that form(s) were missing timestamps, were incomplete in data capture, and no documentation was provided to confirm that 1st shift - 1st Quarter was conducted. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712	K712: Gundersen Harmony Care Center will continue to ensure that fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. The facilities mechanic was re-educated on K712, the need for a monthly fire drill and the need to ensure complete documentation and timestamps. Fire Drills were added to the Facilities Mechanic's calendar to automatically pop-up when the fire drill is due to be completed. Administrator will conduct an audit monthly x 6 months of ensuring fire drills are completed monthly and documentation is complete. Results will be reported to the QAPI committee monthly. Completion Date: 3/28/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2024**

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2024

Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

Re: State Nursing Home Licensing Orders
Event ID: CQRS11

Dear Administrator:

The above facility was surveyed on February 26, 2024 through February 29, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00125	A. BUILDING: _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/26/24 to 2/29/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55281020C (MN99597) H55281022C (MN 98333) H55281021C (MN96227) and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic	2 000		

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2 000	Continued From page 2 State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21840	4. F578: Gundersen Harmony Care	3/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21840	Continued From page 3 facility failed to ensure resident current wishes for resuscitation status were accurately documented in the medical record in a timely manner for 1 of 16 (R184) resident reviewed for advanced directives. Findings include: R184's Provider Orders for Scope of Treatment (POST) indicated "Do not attempt resuscitation/DNR" dated by the medical provider on 2/26/24 at 12:16 p.m. R184's electronic medical record (EMR) review on 2/26/23 at 5:36 p.m., lacked indication of code status in the identification banner. R184's Progress notes indicate R184 admitted to the facility on 2/21/24 at 11:15 without resident representation present. At 4:51 p.m., Social Worker (SW)-A attempted to reach R184's power of attorney Family member (FM)-A. At 7:49 p.m., RN-B left message for FM-A requesting immediate call back for direction regarding resident's care. On 2/22/24 at 2:46 a.m., facility staff left message for FM-A to return call. R184's Progress note dated 2/22/24 11:59 p.m.. indicated FM-A returned call and stated R184 is to be a do not resuscitate (DNR) however, was not available to sign POST. R184's Progress notes indicate FM-A signed POST on 2/24/24. Although on 2/27/24 at 9:02 a.m., R184's EMR continued to lacked indication of code status in the identification banner. During an interview on 2/27/24 at 01:39 p.m., LPN-A stated it is facility policy to verify code status with POST in the resident's hard chart.	21840	Center will continue to ensure all residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. R184's code status is a DNR per the activated Power of Attorney for Healthcare's wishes. Code status was updated for resident in Matrix immediately upon discovery of omission. All other residents were reviewed to ensure their code status aligns with their wishes and no discrepancies were found. All licensed nurses were re-educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders to include inputting this changed data appropriately and timely. Provider will be notified with any order change requests. The Social Worker will audit code statuses on residents monthly x 6 months. Results of audits will be reported to the QAPI committee monthly. Completion Date: 3/28/24	

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21840	Continued From page 4 The first lace LPN-A would look at is the EMR identification banner for code status and then the hard chart if the EMR banner was not updated. LPN-A confirmed there was no indication of code status on R184's EMR identification banner. LPN-A stated not having a code status could lead to a resident having CPR performed when they "didn't want it". LPN-A stated the nurse manager enters a resident's code status. During an interview on 2/28/24 at 2:45 p.m., the director of nursing (DON) stated advanced directives and code statuses are established at admission. She stated the facility had difficulty reaching R184's power of attorney to confirm R184's code status. DON stated R184 "fell through the cracks" due to the difficulty reaching the power of attorney. During interview on 2/29/24 at 9:53 a.m., SW-A stated she is not always the first person to see the residents upon admission to the facility. Code status is established by the nursing department in most cases. SW-A stated R184's health care directive from the hospital lacked indication of code status. SW-A stated facility policy indicates residents are considered full code until the POST form is signed for "legal reasons" to avoid potential for miscommunication. SW-A stated R184's power of attorney was informed R184 would be a full code until the form was signed. R184's POST was signed on 2/24/24 by FM-A and SW-A. During interview on 2/29/24 at 11:08 a.m., RN-A stated she would look at the POST to verify code status. If the POST was not signed, she would assume resident was full code. RN-A stated verbal confirmation of code status is not sufficient and a resident would still be considered a full	21840		

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21840	Continued From page 5 code until a POST is signed. During interview on 2/29/24 at 12:51 p.m., R184's power of attorney (FM-A) recalled having a conversation with the facility regarding R184's code status and stated he did sign code status paperwork on 2/24/24. He was unable to confirm being told R184 could be treated as full code until POST was signed. During interview on 2/29/24 at 12:59 p.m., RN-B stated she is responsible for putting the admission packet together, receipt of discharge paperwork, and inputting orders into EMR. Nursing floor staff are responsible for filling out consents for necessary equipment and going through POST with the resident or responsible party. RN-B stated she enters information into EMR. It was her understanding R184 would be enrolling in hospice upon admission and the power of attorney would be arriving with the resident. RN-B stated she entered R184's code status as DNR in the EMR, however removed it upon realizing the power of attorney would not be arriving with R184 to sign the POST. She acknowledged she should have indicated FULL CODE on the EMR banner until the POST could be signed. She stated she asked the DON and SW-A if a verbal confirmation of code status was acceptable prior to signature. They were both unsure as their policy indicates full code in the absence of a signed POST. She was also unaware hospice arrangement had not been made prior to R184's admission. RN-B stated the facility is in the process of changing their admission policy to ensure hospice arrangements and code status is established prior to or on the day of admission to ensure information is not missed in the future.	21840		

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(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
21840	Continued From page 6 A policy dated 11/23 titled CPR indicates "the objective of the CPR policy is to provide basic life support based until emergency medical services arrives, consistent with the resident advanced directives, in the absence of an advance directive or do not resuscitate order and if the resident does not show signs of clinical death. Prompt initiation of CPR is essential as brain death begins four to six minutes following cardiac arrest if CPR is not initiated within that time." It continues, "Advanced directive-means according to 42C.F.R. 489.100, a written instruction, such as living will or durable power of attorney for health care, recognized under state law (whether statutory or as a recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated. Some states also recognize a documented oral instruction." "It is the policy of Gunderson Harmony Care Center to provide basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advanced directives." "Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless: A valid Do Not Resuscitate order is in place - Resident presents with obvious signs of clinical death (e.g.rigor mortis, dependent lividity, decapitation, transection or decomposition) are present. -Initiating CPR could cause injury or peril to the rescuer. A facility policy dated 6/2023 titled "Advanced Directives" indicates it is facility policy to identify if the resident has an advance directive upon admission. "If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00125	A. BUILDING: _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21840	Continued From page 7 has executed an advance directive, Gundersen Harmony Care Center will give advance directive information to the individual's resident representative in accordance with Minnesota State law." The section titled Cardiopulmonary Resuscitation (CPR) indicates staff are educated to initiate CPR unless a valid DNR order is in place. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records a re consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents to ensure accuracy of code status and audit any newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21840		