### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	_	-	_		AND TRANSMITTAL FE SURVEY AGENCY			HUFX lity ID: 00125
1. MEDICARE/MEDICAID PROV (L1) 245528 2.STATE VENDOR OR MEDICAI (L2) 978740200		3. NAME AND ADDRESS OF FACILITY (L3) GUNDERSEN HARMONY CARE C (L4) 815 MAIN AVENUE SOUTH (L5) HARMONY, MN			CENTER (L6) 55939	<ol> <li>Initial</li> <li>Termi</li> <li>Valida</li> </ol>	nation ation	7(L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE (L9) 6. DATE OF SURVEY <b>Q</b> 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Oth	4/06/2015 (L34) — (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEGO   05 HHA   06 PRTF   07 X-Ray   08 OPT/SP	GORY  09 ESRD  10 NF  11 ICF/IID  12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	FISCAL YE	EAR ENDING	
11LTC PERIOD OF CERTIFICAT From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	43 (L18) 43 (L17)	Complianc1. A B. Not in Con		gram	And/Or Approved Waivers  2. Technical Personn 3. 24 Hour RN 4. 7-Day RN (Rural 5. Life Safety Code  * Code: A	nel6. So 7. M SNF)8. P	Requirements cope of Service dedical Directo attient Room Siz Beds/Room	es Limit or
14. LTC CERTIFIED BED BREAK  18 SNF 18/19 SP  43  (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(	L15)	
16. STATE SURVEY AGENCY R	EMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE  Gary Nederhoff, Unit S	Supervisor	Date : 0	04/06/2015	(L19)	18. STATE SURVEY AGEN Kamala Fiske-Downing		nt Specialis	Date: st 04/242015 (L20)
]	PART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE	STATE AGE	NCY	
19. DETERMINATION OF ELIGI  _X 1. Facility is Eligible 2. Facility is not Elig	to Participate		IPLIANCE WITH	H CIVIL	<ul><li>21. 1. Statement of Fi</li><li>2. Ownership/Coi</li><li>3. Both of the Abore</li></ul>	ntrol Interest Discle		CFA-1513)
22. ORIGINAL DATE  OF PARTICIPATION  04/01/1988  (L24)	23. LTC AGREEI BEGINNING (L41)		4. LTC AGREEN ENDING DA' (L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimbu	00 ursement	(L30 INVOLUNTA 05-Fail to Mee 06-Fail to Mee	RY t Health/Safety
25. LTC EXTENSION DATE: (L27)	•	VE SANCTIONS  n of Admissions:  uspension Date:	(L44) (L45)		03-Risk of Involuntary Termina 04-Other Reason for Withdraw	al	OTHER 07-Provider St 00-Active	tatus Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				

(L33)

DETERMINATION APPROVAL

03/31/2015

(L32)



#### Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245528

April 24, 2015

Mr. Timothy Samuelson, Administrator Gundersen Harmony Care Center 815 Main Avenue South Harmony, Minnesota 55939

Dear Mr. Samuelson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 31, 2015 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds located in rooms.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 6, 2015

Mr. Timothy Samuelson, Administrator Gundersen Harmony Care Center 815 Main Avenue South Harmony, Minnesota 55939

RE: Project Number S5528025

Dear Mr. Samuelson:

On March 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 20, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 6, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 2, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 31, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 20, 2015, effective March 31, 2015 and therefore remedies outlined in our letter to you dated March 10, 2015, will not be imposed.

However, as we notified you in our letter of March 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from NO DATA.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Gundersen Harmony Care Center April 6, 2015 Page 2

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245528	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/6/2015
Name	e of Facility		Street Address, City, State, Zip Code	
Gl	JNDERSEN HARMONY CARE CENT	ER	815 MAIN AVENUE SOUTH HARMONY, MN 55939	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	-		Correction Completed 03/31/2015	ID Prefix	-		Correction Completed 03/31/2015		ID Prefix			Correction Completed 03/31/2015
Reg. # LSC	483.15(h)(2)			Reg. # LSC	483.20(d)(3), 483	3.10(k)(2	·)		Reg. # LSC	483.20(k)(3)(i	i)	
ID Prefix Reg. # LSC	F0311 483.25(a)(2)		Correction Completed 03/31/2015	ID Prefix Reg. # LSC	F0312 483.25(a)(3)	(	Correction Completed 03/31/2015		ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 03/31/2015
ID Prefix Reg. # LSC	F0318 483.25(e)(2)		Correction Completed 03/31/2015	ID Prefix Reg. # LSC	F0329 483.25(I)	(	Correction Completed 03/31/2015			F0428 483.60(c)		Correction Completed 03/31/2015
	F0431 483.60(b), (d	), (e)	Correction Completed 03/31/2015		400.05		Correction Completed 03/31/2015		Reg. #	F0465 483.70(h)		Correction Completed 03/31/2015
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC			Correction Completed					
Reviewed E	Зу	Reviewed	Ву	Date:	Signature	e of Surv	/eyor:				Date:	
State Agen	су	GPN/k	fd	04/06/202			•	5822			04/06	5/2015
Reviewed E	Зу	Reviewed		Date:	Signature	e of Surv		. <u> </u>			Date:	U, <b>= U 1</b> U
Followup t	o Survey Cor 2/20/	npleted or '2015	1:		Check for an Uncorrected					Summary of the Facility?	YES	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245528	(Y2) Multiple Con A. Building B. Wing	IN BUILDING	(Y3) Date of Revisit 4/2/2015
Name of Facility		Street Address, City, State, Zip Code	
GUNDERSEN HARMONY CARE CENT	ΓER	815 MAIN AVENUE SOUTH	
		HARMONY MN 55939	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(	Y4)	Item		(Y5)	Date
		Correction			Correcti	on					Correction
ID Prefix		Completed 03/31/2015	ID Prefix		Complete 03/31/20	ed 15		ID Prefix			Completed 03/31/2015
Reg. #	NFPA 101		Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0050		LSC	K0062				LSC	K0144		
		Correction			Correcti	on					Correction
		Completed			Comple	ed					Completed
		03/31/2015									
•	NFPA 101 K0147		Reg. #					Reg. # LSC			
		Correction			Correcti	on					Correction
ID Prefix		Completed	ID Prefix		Comple	ed		ID Prefix			Completed
Reg. #			Reg. #					Reg. #			
LSC								LSC			
		Correction			Correcti	on					Correction
		Completed			Comple						Completed
ID Prefix			ID Prefix								
Reg. # LSC			Reg. # LSC					Reg. #			
			200								
		Correction			Correcti	on					Correction
ID Profiv		Completed	ID Profix		Comple	ed		ID Profix			Completed
Reg. #			Reg. #					Reg. #			
								LSC			
Reviewed I	By Rev	viewed By	Date:	Signature	of Surveyor:					Date:	
State Agen	cy PS	S/kfd	04/06/20	)15		2	258	22		04/	02/2015
Reviewed I	By Rev	viewed By	Date:		of Surveyor:					Date:	
Followup t	o Survey Comple			Check for any Uncorrected	y Uncorrected I ed Deficiencies	eficio (CMS	enci	es. Was a (7) Sent to	Summary of the Facility	of ? YES	NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HUFX Facility ID: 00125

		10 22 00::111			ESCHIEFICE	ruemity 12.00	120
1. MEDICARE/MEDICAID PROVID (L1) 245528 2.STATE VENDOR OR MEDICAID (L2) 978740200		3. NAME AND AI (L3) GUNDERSE (L4) 815 MAIN A (L5) HARMONY	EN HARMON AVENUE SOU'	Y CARE C	EENTER (L6) 55939	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recerti 3. Termination 4. CHOW 5. Validation 6. Comple	7
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY <b>02</b> /2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	OWNERSHIP  20/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY  09 ESRD  10 NF  11 ICF/IID  12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint  FISCAL YEAR ENDING DATE:  09/30	(L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds  13.Total Certified Beds  14. LTC CERTIFIED BED BREAKDO	43 (L18) 43 (L17)	Complianc1. A  X B. Not in Con	equirements be Based On:	gram ied Waivers:	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director	
(L37) (L38)  16. STATE SURVEY AGENCY REM	(L39) IARKS (IF APPLICA	(L42) ABLE SHOW LTC CA	(L43) ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :	03/23/2015		18. STATE SURVEY AGENCY		
Josephine Hassinger,				(L17)		Enforcement Specialist 03/2	7/2015 (L20)
19. DETERMINATION OF ELIGIBIES 1. Facility is Eligible to 2. Facility is not Eligible	LITY Participate	20. COM	MPLIANCE WITH			ncial Solvency (HCFA-2572) bl Interest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE  OF PARTICIPATION  04/01/1988  (L24)  25. LTC EXTENSION DATE:  (L27)	A. Suspension		4. LTC AGREEM ENDING DAY (L25) (L44) (L45)		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimburs  03-Risk of Involuntary Termination  04-Other Reason for Withdrawal	INVOLUNTARY  05-Fail to Meet Health/S  ement  06-Fail to Meet Agreeme	nt
28. TERMINATION DATE:  31. RO RECEIPT OF CMS-1539	(L28)	0. INTERMEDIARY/ 03001 2. DETERMINATION		(L31)	30. REMARKS		
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 10, 2015

Mr. Timothy Samuelson, Administrator Gundersen Harmony Care Center 815 Main Avenue South Harmony, Minnesota 55939

RE: Project Number S5528025

Dear Mr. Samuelson:

On February 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 gary.nederhoff@state.mn.us Telephone: (507) 206-2731

Fax: (507) 206-2711

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 1, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 1, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

Gundersen Harmony Care Center March 10, 2015 Page 4

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Gundersen Harmony Care Center March 10, 2015 Page 5

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Gundersen Harmony Care Center March 10, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 03/19/2015 FORM APPROVED OMB NO. 0938-0391

AMME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939	-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE			245528	B. WING		02/20/2015	
FREFIX TAG  REQULATORY OR LSC IDENTIFYING INFORMATION)  F 000  INITIAL COMMENTS  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.  F 253  SS=B  MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview review the facility falled to ensure equipment used for hygiene assessed needs were kept in a state of good repair and clean for 4 of 4 resident (R28, R42, R53, R55) who used a portable commode and also falled to maintain wheelchair upholstery in a state of good repair for 1 of 3 residents (R24) who utilized a wheelchairs for movement. Findings include:  An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and housekeeping director (HD)-A.  Solied commodes:			E CENTER	8	315 MAIN AVENUE SOUTH		
The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.  F 253 483.15(h)(2) HOUSEKEEPING & F 253 SS=B MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview review the facility failed to ensure equipment used for hygiene assessed needs were kept in a state of good repair and clean for 4 of 4 resident (R28, R42, R53, R55) who used a portable commode and also failed to maintain wheelchair upholstery in a state of good repair for 1 of 3 residents (R24) who utilized a wheelchairs for movement. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and housekeeping director (HD)-A. Soiled commodes:	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION DATE	
as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.  F 253 483.15(h)(2) HOUSEKEEPING & F 253 SS=B MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview review the facility failed to ensure equipment used for hygiene assessed needs were kept in a state of good repair and clean for 4 of 4 resident (R28, R42, R53, R55) who used a portable commode and also failed to maintain wheelchair upholstery in a state of good repair for 1 of 3 residents (R24) who utilized a wheelchairs for movement. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and housekeeping director (HD)-A. Soiled commodes:	F 000	INITIAL COMMENT	TS .	F 000			
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maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview review the facility failed to ensure equipment used for hygiene assessed needs were kept in a state of good repair and clean for 4 of 4 resident (R28, R42, R53, R55) who used a portable commode and also failed to maintain wheelchair upholstery in a state of good repair for 1 of 3 residents (R24) who utilized a wheelchairs for movement. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and housekeeping director (HD)-A. Soiled commodes:  T Commodes have been ordered for replacement "Wheel chair cleaned and arms replaced-maintenance by March 31, 2015 "Staff will receive reminder from administrator to report problems with wheelchairs to maintenance via the maintenance request book by March 31, 2015  "DAC supervisor will be report needed repair or infection control problems related to commodes and wheelchairs to the maintenance via the maintenance request		on-site revisit of you validate that substa regulations has bee your verification. 483.15(h)(2) HOUS	ur facility may be conducted to ntial compliance with the en attained in accordance with	F 253		3/31/15	
by: Based on observation and interview review the facility failed to ensure equipment used for hygiene assessed needs were kept in a state of good repair and clean for 4 of 4 resident (R28, R42, R53, R55) who used a portable commode and also failed to maintain wheelchair upholstery in a state of good repair for 1 of 3 residents (R24) who utilized a wheelchairs for movement. Findings include: An environmental tour was completed on 2/19/15 at 1:00 p.m. with the maintenance director (MD)-A and housekeeping director (HD)-A. Soiled commodes:  " Commodes have been ordered for replacement " Wheel chair cleaned and arms replaced- maintenance by March 31, 2015 " Staff will receive reminder from administrator to report problems with wheelchairs to maintenance via the maintenance request to commodes and wheelchairs to the maintenance via the maintenance request		maintenance service	es necessary to maintain a				
		by: Based on observat facility failed to ensi hygiene assessed r good repair and cle R42, R53, R55) wh and also failed to m in a state of good re who utilized a whee Findings include: An environmental to at 1:00 p.m. with the and housekeeping of Soiled commodes:	ion and interview review the ure equipment used for needs were kept in a state of an for 4 of 4 resident (R28, o used a portable commode raintain wheelchair upholstery epair for 1 of 3 residents (R24) elchairs for movement.  Our was completed on 2/19/15 e maintenance director (MD)-A director (HD)-A.		replacement  " Wheel chair cleaned and arms replaced- maintenance by March 31, 2  " Staff will receive reminder from administrator to report problems with wheelchairs to maintenance via the maintenance request book by March 3 2015  " DAC supervisor will be report need repair or infection control problems related commodes and wheelchairs to the maintenance via the maintenance requestions."	1, ded ated	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

03/18/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION  G		E SURVEY PLETED
		245528	B. WING		02/:	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	) BE	(X5) COMPLETION DATE
F 253	commode was obsarm rests and a se soiled with debris a learned that R42 in portable commode R58 located in roor 137 used the same observed to have a areas on the legs. R55 the grab bars on the metal. During an interview HD-A stated she fe surfaces. Wheelchair uphols R24 located in in roam. had a wheel cosoiled with debris, a had vinyl missing e During an interview maintenance direct procedure to notify is unaware of this was a comprehensive of within 7 days after comprehensive assinterdisciplinary teasing that the soiled with a comprehensive assinterdisciplinary teasing the soiled with debris and the soiled with debris and winyl missing end the soiled with debris and winyl missing end with the soiled with debris and with the soiled with debris and with the soiled with a comprehensive of the soiled with	the toilet. The portable erved to have cracked plastic verely stained bucket to be and rust on metal. It was a room 121 used this same.  In 135 and R55 located in room a portable commode which was a chipped plastic seat and rusty Also in bathroom of R58 and were worn and rust was noted of on 2/19/15 at 1:30 p.m. the left these were not cleanable tery torn and soiled: from 130B on 2/17/15 at 11:40 hair that was observed to be and the arms of wheel chair exposing the foam underneath. From 130B on 2/19/15 at 1:30 p.m. the for stated staff have a him of wheelchair issues and wheelchair needing to be fixed. O(k)(2) RIGHT TO INNING CARE-REVISE CP one right, unless adjudged erwise found to be rethe laws of the State, to ing care and treatment or	F 25	" Environmental services depar will do random audits for cleanline repair problems, no less than bi-w for three months. If continued prok are noted a monthly random audit remainder of the year will be initiat " A facility Safety Inspection tha done every other month will now ir inspection of commodes and whee chairs.	ss and eekly blems for the ed. t is	3/31/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY PLETED
		245528	B. WING		02/:	20/2015
	PROVIDER OR SUPPLIER RSEN HARMONY CAF	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 815 MAIN AVENUE SOUTH HARMONY, MN 55939	)DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	disciplines as deter and, to the extent p the resident, the resident representative and revised by a te- each assessment.	ge 2 d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	80		
	by: Based on interview facility failed to revision 4 of 7 residents reviewed who had f (UTI).  Findings include: R15 experienced revision of an indiviprovide directions to management and in risk of recurrent UT R15 was admitted to the admission recoincluded neurogeni infection, urine rete The quarterly Minim 1/7/15 indicated R1 cognitive/memory, with activities of daicatheter, had a neu UTIs past 30 days, indicated R15 had experienced.	and document review, the se and update the care plan (R15, R32, R37, and R43) acility urinary tract infection ecurrent UTIs but lacked dualized plan of care to the staff regarding UTI nterventions to minimize the fis.  To the facility on 1/15/13 and red listed diagnoses that to bladder, urinary tract ntion, urinary frequency. The Data Set (MDS) dated 5 had impaired required extensive assistance ly living, had an indwelling trogenic bladder and had no However of the clinical record experienced three UTIs 14 and December 2014 that		" R15- POC will be update interventions to prevent UTI 2015 " R32- POC will be update interventions to prevent UTI 2015 " R37- resident has expire individual action will be taker " R43- POC will be update directions to minimize the ris UTI by March 20, 2015 Nurse Managers will update (POC) " Director of Nursing will in Medical Director to clarify ordurinalysis and culture of specuse of prophylactic antibiotic inappropriate use of antibiotic by March 31, 2015 " A required meeting will be nursing staff (RN, LPN and 0 meeting the following will be the Director of Nursing and Nanagers:  O Nursing staff will be re-emethods of prevention for U	by March 20, ed with by March 20, ed, no n ed with ek of recurrent plan of care neet with ders for cimens and s to eliminate c medications be held for all CNAs). In this presented by Nurse ducated on	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION		SURVEY PLETED
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		81	TREET ADDRESS, CITY, STATE, ZIP CODE 15 MAIN AVENUE SOUTH IARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	care plan noted R1 toileting and hygien indwelling Foley car identify UTIs, but di minimize the risk of R32 experienced re revision of an indiviprovide directions to identification and m to minimize the risk R32 was admitted to resident admission dysuria (painful urinurinary tract infection diarrhea, neurogen kidney disease. The quarterly MDS R32 had a BIMS (bound was 9 or moderate extensive assistance (ADLs), was frequeneurogenic bladder during the previous clinical record indiction that were identified to The care plan dated interventions that in transfer R32 to toile medical diagnosis to but did not list interrisk of recurrent UT R37 experienced re revision of an indiviprovide directions to	d 12/15/14 was reviewed. The 5 required total assistance for e. The care plan identified an theter and interventions to d not include interventions to d not include interventions to d utility.  Ecurrent UTIs but lacked dualized plan of care to the staff regarding UTI anagement and interventions of recurrent UTIs.  To the facility in 2013 and the record listed diagnoses as action) urethral discharge, on, urinary catheterization, ic bladder, stage II chronic dated 11/19/14 was reviewed. The interview of mental status impairment, required the for activities of daily living ontly incontinent, had a set, and had experienced a UTI 30 days. Review of the ated R32 had experienced July 2014 and November 2014 as facility acquired. The care plan listed a chat include renal insufficiency, wentions to help minimize the results.  Ecurrent UTIs but lacked dualized plan of care to the staff regarding UTI anagement and interventions.	F 2	80	proper peri-care, catheter care, inc fluids and food/fluids that naturally infection  Nursing staff will be re-educate signs and symptoms of UTI includit temperature, odor, dysuria, flank paconfusion/behavioral changes in sopersons  Nursing staff will be re-educate regarding appropriate nursing interventions to take if residents ex any signs of UTI and advised of up orders for UTI management  RN/LPN staff will be re-educate the use of temporary care plans for resident diagnosed with a UTI  This meeting will be held by Ma 26, 2015  A Quality Assessment Perform Improvement project will be initiate the Director of Nursing to further id any underlying systematic problem related to assessment and control urinary tract infections and plan for resolution. This will be part of an In Control Program overhaul. The probe initiated by March 31,2015	inhibit ed on ng ain and ome ed hibit dated ed in any arch ance d by entify s of a fection	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245528	B. WING _		02	/20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	listed on the admis III chronic kidney di urinary infection. The significant cha indicated memory i assistance, was fre and experienced not review of the clinic experienced three December 2014 that acquired. The care plan identified bladder. The care assist with toileting revised to include it to prevent UTIs. R43 experienced revision of an indiviprovide directions to identification and minterventions to mir UTIs. R43 was admitted dated 1/19/15 throuthat included chroninfection, dysuria (proceeding to the clinic experienced an UTI Review of the clinic experienced an UTI identified as facility Care plan dated 1/1/10/16/16/16/16/16/16/16/16/16/16/16/16/16/	on 6/6/14 and had diagnoses sion record as diabetes, stage isease, malaise and fatigue, ange MDS dated 10/24/14 mpairment, required extensive equently incontinent of urine, of UTI is previous 30 days. Fall record reviewed R37 had uTIs between June and at were identified as facility diat was incontinent of plan directed R37 needed dated 8/1/14 but was not dentification and interventions decurrent UTIs but lacked dualized plan of care to on the staff regarding UTI management and to mimize the risk of recurrent but lated diagnoses ic diarrhea, urinary tract pain with urination) dated 11/5/14 was reviewed. In R43 had no cognitive dependent with all activities of ways continent, and had not during the previous 30 days. Fall record revealed R43 had in December 2014 that was acquired.	F 28	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		OATE SURVEY COMPLETED	
		245528	B. WING		02/20/2015
	PROVIDER OR SUPPLIER	E CENTER	8	TREET ADDRESS, CITY, STATE, ZIP CODE 115 MAIN AVENUE SOUTH HARMONY, MN 55939	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	related to a diagnos	ge 5 care plan did have a problem sis of diarrhea, but the t include minimizing the risk of	F 280		
F 282 SS=E	UTIs. During an interview registered nurse (R temporary care plai residents that had using it. At 5:10 p.r (RN)-C stated the comost current for R1 483.20(k)(3)(ii) SER PERSONS/PER CATThe services provided by the services	on 2/19/15 at 2:36 p.m. N)-C stated she did have a nather that could be used for JTIs, but she had not been not not 2/19/15 registered nurse hare plans provided were the 5, R32, R37, and R43. RVICES BY QUALIFIED	F 282		3/31/15
	by: Based on observatoreview, the facility for 3 of 26 residents each resident ident Findings included: R23 failure to provious registered dietician On 2/18/15, at 12:2 have very long fingunderneath nails are showed broken jagen R23's quarterly Min 1/23/15 included the mellitus, psychotic of the service o	ion, interview and document ailed to follow the plan of care is (R23, R21, R56) to meet ified need and services.  de nail care and follow is recommendations.  7 p.m. R23 was observed to er nails with light brown debris and at least one of ten nails ged sharp edges. imum Data Set (MDS) dated is diagnoses of diabetes disorder, and stage four open-angle glaucoma. The		" (R23) Director of Nursing and Dieta Nurse Managers met with Dietician to review and revise methods of documentation of food/fluids within the facility March 13, 2015 o Guidelines will be devised for the appropriate practice of documentation be March 31, 2015 o Director of nursing and Dietary manager will provide education to all nursing and dietary through writing and face to face instruction of the improved plan for documentation by March 31, 20 o Dietary manager will pull a weekly documentation report for 6 weeks to monitor for compliance following staff	у

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245528	B. WING		02/20/2015		
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	with a Brief Intervie score of 15. The MI required extensive activities of daily living hygiene. R23's care plan prorelated to grooming as needed for dreat transfers and toileti as able-but needs at thoroughness. " C were on Tuesday add not address how often, or by who na During an interview registered nurse (R was performed by a During an interview director of nursing (was not specifically was the person that finger nails. DON a care planned. R23's care plan p 2/19/15 related to n fluid intake was bet centimeters (cc's) meal and fluid intake R23's fluid intake re 2/19/15 was review twelve meal fluid intoluring an interview DON confirmed mis explained strict inta only if the registerer recommendation. During an interview	ed no cognitive impairment w of Mental Status (BIMS) DS also indicated R23 assist from staff to performing (ADLs) of dressing and wided by the facility on 2/19/15 and hygiene read, "Assist essing, personal hygiene, ng. Encourage independence supervision and checks for are plan indicated bath days nd Thursday. R23's care plan w nail care was provided, how ill care should be provided by. on 2/18/15, at 5:54 p.m. N)-B stated diabetic nail care a nurse on bath days. on 2/19/15, at 10:38 a.m., DON) explained if nail care care planned the expectation to gave the bath would check also stated nail care should be rovided by the facility on utrition indicated R23's ideal ween 1800-2000 cubic and directed staff to record	F 2	282	instruction. A random audit of documentation will be done over th year, no less than once each month followed by re-education of staff as needed starting the week following education, April 6, 2015.  " (R23, R24, R56) Bathing protoce be written and all staff providing babe educated in the protocol includin proper care of nails and care of fact by March 31, 2015  o All newly hired CNA staff will reorientation to the bathing protocol aspend time with a trained CNA to puthese skills  o The protocol will include a meth reporting to nurses when a resident requires nursing action for nail care Diabetics)  o Random audits will be performal least once per month throughout the year to see that bathing protocol is followednails clean and trimmed a facial hair shaved as appropriate to individual. The Director of Nursing perform or assign the audits to ano nurse. Re-education will be perforn any noted problems.  " (R21) A plan for monitoring the any psychoactive medication has a been initiated within the facility consof a committee of Nurse Managers Director of Nursing and Consulting Pharmacist with consultation by the Medical Director. Monitoring of target behaviors (moods) was outlined at meeting with our consulting pharma January and initiated February 19, preparation for our meeting March	staff col will ths will ng the ial hair ceive and will ractice nod of t e (i.e. ed at e next being and the will ther ned for use of lready sisting et the acist in 2015 in	

PRINTED: 03/19/2015 FORM APPROVED OMB NO. 0938-0391

AND DIAN OF CODDECTION INDESTRUCTION NUMBERS	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
	A. BUILDING	ŝ	(X3) DATE SURVEY COMPLETED	
245528	B. WING		02/20/2015	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
CUNDEDCEN HARMONY CARE OFNIER		815 MAIN AVENUE SOUTH		
GUNDERSEN HARMONY CARE CENTER		HARMONY, MN 55939		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 282 Continued From page 7 fluid intake had been recommended because R23 was on diuretics and had a urinary catheter. R24 on 2/17/15, at 10:15 a.m. and on 2/18/15, at 12:46 p.m. and at 6:39 p.m. R24 was observed to have long facial hair on her upper lip. R24 's quarterly MDS dated 11/26/14 included diagnoses of dementia and anxiety disorder. The assessment indicated severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 6. The MDS also indicated R24 required extensive assist of one staff member to perform activities of daily living (ADL's) of dressing and hygiene. R24's care plan provided by the facility on 2/19/15 read, "ADL: dressing, sponge bath, grooming: requires set up and moderate-max assist/check for thoroughness twice a day AM and PM. Assist [R24] with personal hygiene. [R24] would like to be offered assist with shaving chin hair weekly on bath day. Family has been notified that they need to bring in an electric razor." The care plan indicated bath day was Wednesday.  During an interview on 2/18/15, at 5:44 p.m. RN-B confirmed R24 did have bath and R24 's facial hair should have been removed.  During an interview on 2/18/15, at 6:39 p.m., R24 stated she had not been aware of the facial hair, did not wish for it to be there, and wanted it removed.  During an interview on 2/18/15, at 6:40 p.m., nursing assistant (NA)-A confirmed R24 had facial hair.  A policy on shaving female resident 's facial hair was requested and was not provided by the facility. On 2/18/15, at 7:50 p.m. the DON stated the facility did not have a policy related to female facial hair.	F 282	2015. Data on moods/target behave be collected on-going or as sample collections for each individual utilizing of these types of medications within facility. This data will be collected wour Electronic Health Record.  o The resident (R21) is slated for at our April 8, 2015 meeting.  o (R21) POC will be updated to rearranget behavior/mood monitoring by March 20, 2015  o The Consulting Pharmacist will continue to meet with designated members of the nursing staff to reveach resident is medication regime monthly and this team will make on recommendations related to the couse, a request for change in orders additional information from the medicational information from the medication regime.	ng any n the vithin review eflect / iew e-going ntinued or	

R21's care plan dated 6/27/12 identified a

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING _		02	2/20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939		, 20, 2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Approaches dated with R21 to and fro walker, lower extre exercises-marches 15 times each once standing exercises heel raises 15 time approaches dated and balance programorning and goal va week; restorator minutes; restorative quarterly and as net R21's care plan dare problem of at risk fisight and variable to 8/1/14, included: act walker with ambulain falls and balancing reach, and keep round the received 12 processes and ambulain falls and balancing reach, and keep round discharge sum analysis of function significant progressing goals. "Will continual with a functional materials and safety."  Document review of a processing significant progressing significant progressing safety. "Document review of a processing safety."	or losing strength in legs. 2/10/15, included: ambulate m all meals with 4 wheel mity seated, kicks, knee bends, toe taps a day; lower extremity marches, squats, sidekicks, as each once a day. Care plan 8/1/14, included: invite to falls am led by activity staff once a was R21 to attend three times or recumbent bike 10-15 are program will be reviewed eded.  Ited 5/31/12 identified a program will be reviewed ended.  Ited 5/31/12 identified a program w	F 28	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245528	B. WING	·····	0	2/20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZII 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	Lower extremity se 2 pounds (#) 15 tim knee bends with blittimes, ball squeeze Lower extremity state active range of motion 15 of motion 15 times, motion 15 times, motion 15 times, with R21 to/from all and contact guard wheelchair due to contact guard assis hallway. Please has 5-7 days per week participate. Please department with an Document review of sheet dated 2/1/15 following: Falls and balance, attend three times a session out of 19 d Restorator or recurday, Sunday through minutes, R21 refus 1 session out of 19 Falls and balance of Friday, R21 attended. The restorative nurany of the physical exercises dated 1/3 During interview on verified the physical restorative nursing interview on verified the physical restorative nursing	ated exercises: marches with res, kicks with 2# 15 times, ue band 15 times, toe taps 30 s 30 times; unding exercises: marches ion 15 times, squats active times, sidekicks active range heel raises active range of Ambulation: Please ambulate meals with 4 wheel walker assistance and follow with lizziness. R21 is to have stance with all ambulation in ve R21 perform all exercises as tolerates and is willing to contact physical therapy y questions or concerns.  If restorative nursing flow to 2/19/15, revealed the invite once a morning, will a week, R21 attended 1 ays; nbent bike 10-15 minutes a sh Saturday, goal to pedal 15 ed two sessions and attended days; once a day Monday through ed one session out of 19 days.  Sing flow sheet did not identify therapy recommended	F 2	82		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245528	B. WING		02/	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, Z 815 MAIN AVENUE SOUTH HARMONY, MN 55939	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	care plan directed in none were provided balance program we but was actually the activity staff whene verified R21 receive program and the bit 19 days. She verified restorative therapy by physical therapy by physical therapy. During interview on director of nursing short staffed and the restorative aides to nursing verified the provide restorative.	restorative nursing exercises, d. RN-B stated the falls and ras on the flow sheet two times a same program offered by ver they can do it. RN-B and the falls and balance ke exercise one session out of ed R21 had not received exercises as recommended	F 2	282		
	problem of psychot received lorazepam Approaches identification response to medicate R21 was identified Minimum Data Set 1/7/15, to have cog 15 including mood depressed, trouble feel bad about self, antianxiety medicate Document review of for mood dated 1/2	ated 3/5/14 identified a ropic medication use due to a for diagnosis of anxiety. Ided included monitor mood and ations.  on the significant change (MDS), an assessment dated nition intact, moods score of s of little interest, feeling sleeping, tired, poor appetite, no behaviors, and received				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
	<b>245528</b> B. WING		0	2/20/2015		
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, Z 815 MAIN AVENUE SOUTH HARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	change anything at improving, " and " plan d/t (due to) more psychotropic medic Psychotropic med ((due to) ativan (lora anxiety problems." on antidepressant respectoropic medic the care plan due to antidepressant use.  Document review of 1/19/15 to 2/19/15, 0.5 milligrams daily start date of 6/13/14; and lora day as needed for a date of 10/20/14. Treport had physicia milligrams once an start date of 1/16/15.  Document review of administration recorrevealed R21 receivordered.  During interview on	this time as she feels mood is Mood is addressed in care ood issues. " CAA for cation dated 1/20/15, stated, " medication) use triggered d/t azepam) use for longstanding CAA identified R21 started medication. CAA identified cation use was addressed in antianxiety and .  If physician orders report dated revealed orders for lorazepam for anxiety disorder, with a 4; lorazepam 1 milligram two iety disorder, with a start date izepam 0.5 milligrams twice a agitation or anxiety, with a start he same physician order norders for Zoloft 50 evening for anxiety, with a 5.  If facility medication rd dated 1/1/15 to 1/30/15, eved lorazepam and Zoloft as 2/19/15, at 10:45 a.m., RN-B	F 2	82		
	target moods or res stated the facility kr effective by just talk stated the facility qu charting on the MD monitoring of mood					
	uring interview on	2/19/15, at 4:15 p.m., director				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	E CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 15 MAIN AVENUE SOUTH IARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	of nursing stated th related policies.  FACIAL HAIR: R56 was identified one staff for activitic document review of 2/7/15, 2/12/15, and R56 was admitted the according to review sheet.  During observations 2/18/15, at 6:00 p.m. R56 was observed.  Document review on the dated, directed hair and nail care beneeded.  Document review of start date of 2/9/15, with grooming and directed hair and nail care beneeded.  During interview on verified R56 has lor female resident's faday shift. RN-A verified R56 has lor female resident's faday shift.	by the facility as dependent on es of daily living, according to facility progress notes dated d 2/17/15.  To the facility on 2/4/15, of R56's medical record face as on 2/17/15, at 3:19 p.m., n., and 2/18/15, at 7:40 p.m., with long chin hairs.  If R56's interim plan of care, staff to check for chin hairs, y staff, oral care assist as  If facility resident profile with directed staff to assist R56 hygiene as needed.  2/18/15, at 7:40 p.m., RN-A and chin hairs. RN-A stated acial hair was shaved on the rified R56 did not shave own	F 2	282			
	of nursing stated sh	ne expected female facial hair nay and offered as needed.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245528	B. WING		02/20/20	015
	PROVIDER OR SUPPLIER	RE CENTER	8	STREET ADDRESS, CITY, STATE, ZIP CODE S15 MAIN AVENUE SOUTH HARMONY, MN 55939		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	(X5) PLETION DATE
F 282 F 311 SS=D	She stated the facilishaving facial hair.	lity did not have a policy for  TMENT/SERVICES TO	F 282 F 311		3/31	/15
	services to maintai	the appropriate treatment and n or improve his or her abilities aph (a)(1) of this section.				
	by: Based on observareview, the facility for care and services for maintain or improved.  Findings include: R21 was identified change Minimum Eassessment dated intact, transfers, was self-performance was support was one perform support was corridor support was corridor support was corridor support was corridor support was balance during transteady but able the assistance, no imprin range of motion and received physical 1/5/15.  Document review of dated 1/20/15, reveals	tion, interview, and document ailed to provide the necessary or 1 of 1 resident (R21) to help a ability to ambulate.  by the facility on the significant pata Set (MDS), an 1/7/15, to have cognition alk in room and walk in corridor was supervision; transfer erson physical assist, walk in as no set up help only, and walk in as no set up help or physical falls since last assessment, asitions and walking was o stabilize without human airment in functional limitation of upper and lower extremity, cal therapy with start date of of falls care area assessment ealed falls triggered due to injury and some balance		" (R21) Care plan will be updated nurse manager to show intervention be taken should the resident refuse recommended restorative program March 20, 2015 " Nurse Manager will further eval R21 s acceptance and participation her program by March 31, 2015 and to continue, change or discontinue program based on the resident so and response to the program. Addit review will occur at the resident so quarterly care conference or soone should a significant change occur.  " All nursing staff will be educated Director of Nursing and Nurse Manain the rationale for Restorative Care expectations for other staff on duty provide Restorative services if a Restorative Aid is not scheduled by 31, 2015  O Persons working with the Reston Nursing program will meet and initial Quality Assessment Performance Improvement project for the program include better definition of the program include better definition in the program include better definition in the program include better definition of the program include in the program	uate n in d plan the hoice ional next r d by agers and to March orative ate a m to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		81	TREET ADDRESS, CITY, STATE, ZIP CODE 15 MAIN AVENUE SOUTH ARMONY, MN 55939	, , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 311	Document review of 1/19-2/19/15, reveal ambulate independ wheel walker, and fonce a day Monday. During observations R21 sat in room rectime, R21 transferrowheeled out of the R21's care plan dat problem of at risk for Approaches dated with R21 to and frow walker, lower extreses-marches 15 times each once standing exercises heel raises 15 times Approaches dated and balance programorning and goal was week; restorator of minutes; restorative quarterly and as ne R21's care plan dat problem of at risk for sight and variable is 8/1/14, included: ac walker with ambula	shard of hearing, had poor ssist of staff, used wheelchair.  If physician orders dated alled the following orders: may ently in room and halls with 4 alls and balance program through Friday.  Is on 2/17/15, at 2:00 p.m., cliner with feet up. At that ed by self to wheelchair and room to church service.  It de 6/27/12 identified a per losing strength in legs. 2/10/15, included: ambulate and mall meals with 4 wheel mity seated and with the entry seated and wi	F3	311	itself, a plan for back-up and identif of persons responsible for review a evaluation of the program, including resident response, on a weekly to biweekly basis. The first meeting wheld by March 31, 2015	nd g	
	reach, and keep roo	ng program, keep items within om free of clutter.  f past three months of falls					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING _		02	/20/2015	
	NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939		. 20, 20 10	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 311	1/2015. The following two of Document review of 2/14/15, revealed of and got up on her was within reach. Seen by a provider symptoms and councy and got up on feet a walk in hallways.  Document review or revealed R 21 was chair, trying to most stated was just we clear. R212 had a for cough, was see cough and weakner R21 was reeducated was alert and orier.  Document review of dated 1/5/15, identify 1/5/15, reason for decline in ambulationset of the flu. R approximately 2 we resulted in the patimore assistance for and ambulation. Trequires skilled phystrengthening, balain order to regain patherapy to discharg potential with long.	age 15 12/2014, and no falls in falls occurred in 2/2015: of the event report dated R21 stated had fall in bathroom own, c/o back pain, and call lite The report identified R21 was on 2/13/15 for respiratory ugh. Interventions were to ask at or wait for assist. fied R21 had been more nd was to have assistance to of event report dated 2/18/15, on floor in front of roommates we her bedside table. R21 ak, denied pain, lung sounds cough, was seen on 2/13/15 en after fall on 2/18/15 for ess and started on antibiotic. ed to use the call light. R21 ated and made own decisions. of physical therapy plan of care ified start of care date of referral: R21 presents with a on and transfers due to recent 21 started noticing a decline eeks ago which has since eent now requiring significantly or the completion of transfers therapy necessity: R21 ysical therapy at this time for ance training, gait and transfer orior level of function. Physical ge with patient at maximum term plan in place. Short term of feet with 4 wheeled walker on	F 3				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING				ATE SURVEY DMPLETED		
		245528	B. WING _		0:	2/20/2015
	NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 815 MAIN AVENUE SOUTH HARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 311	Goal: will ambulate walker on even surt to regain prior funct will be able to safely wheeled walker thromodified independent prior level of function physician for 1/5/15 for 4 weeks.	ge 16 iring contact guard assistance. 100 feet safely with 4 wheeled faces with supervision in order ional level. Long term goal: y ambulate with use of her 4 bughout the facility with ence in order to return to her on. Plan of care was signed by to 2/1/15, for 3 times a week	F3	11		
	treatment notes rev 1/16/15, revealed R ambulation today a getting stronger. 1/23/15, R21 ambu walker and contact demonstrated impre independence with 1/30/15, R21 reque physical therapy du R21 agreed to resto	realed the following: 121 was proud of her 121 nd reports she can tell she is 122 lated 320 feet with 4 wheeled 123 guard assistance. R21 124 poved ambulation distance and				
	exercises and ambin 1/30/15.  Document review of and discharge sum analysis of function made significant protherapy goals. R21 ongoing deficits with program directed by	rysical therapy visits for ulation between 1/5/15 and f physical therapy progress mary dated 1/30/15, revealed al outcome included R21 ogress towards physical will continue to address h a functional maintenance y facility staff.				

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	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 815 MAIN AVENUE SOUTH HARMONY, MN 55939	•	
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F 311	exercises: Lower extremity see 2# 15 times, kicks with blue band 15 squeezes 30 times lower extremity state active range of morange of motion 15 of motion 15 times; with R21 to/from a and contact guard wheelchair due to contact guard assi hallway. Please has 5-7 days per week participate. Please department with an Document review sheet dated 2/1/15 following: Falls and balance, attend three times session out of 19 credit Restorator or recurday, Sunday throughinutes, R21 refus 1 session out of 15 Falls and balance Friday, R21 attend During interview or registered nurse (Fitherapy recommer were not part of the sheet. RN-B verification of the sheet. RN-B verification of the sheet.	eated exercises: marches with with 2# 15 times, knee bends times, toe taps 30 times, ball s; anding exercises: marches tion 15 times, squats active itimes, sidekicks active range, heel raises active range of Ambulation: Please ambulate II meals with 4 wheel walker assistance and follow with dizziness. R21 is to have stance with all ambulation in ave R21 perform all exercises as tolerates and is willing to econtact physical therapy by questions or concerns.  Of restorative nursing flow to 2/19/15, revealed the invite once a morning, will a week, R21 attended 1 days; mbent bike 10-15 minutes a gh Saturday, goal to pedal 15 sed two sessions and attended	F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING _		02	/20/2015	
NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 311	program was on the actually the same program was on the actually the same program was exercised the falls at bike exercise one so verified R21 had not exercises as recommended and the factual of the fa	ated the falls and balance of flow sheet two times but was program offered by activity staff do it. RN-B verified R21 and balance program and the design out of 19 days. She put received restorative therapy amended by physical therapy prefiled the recommendations do to the restorative flow sheet. Collity had two restorative aides designed by the sectorative exercises.  12/19/15, at 10:56 a.m., NA)-C (NA-C) stated she demity exercise bike for 10 R21 would go to the exercise do not aware of the physical ded restorative program tated restorative aides work on the floor and the	F 3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING		02/	/20/2015	
NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		JLD BE	(X5) COMPLETION DATE	
F 311 F 312 SS=D	director of nursing s short staffed and th restorative aides to nursing verified the provide restorative restorative aides we floor.  During interview on stated R21 had ded 12/2015 and worse R21 requested to d 1/30/15, because s not want to continue declined as she no 483.25(a)(3) ADL CDEPENDENT RES  A resident who is un daily living receives	stated the facility had been been have rescheduled work on the floor. Director of facility had no plan in place to therapy exercises when ere rescheduled to work the 12/19/15, at 3:10 p.m., RN-B clined due to influenza in ming eye sight. RN-B stated lischarge from physical therapy he did not like therapy and did e. RN-B verified R21 had longer walked to meals.	F 3			3/31/15	
	by: Based on observat review, the facility for 3 residents (R24 dependent of staff t living (ADL).  Findings included: R24 on 2/17/15, at	NT is not met as evidenced tion, interview, and document ailed to provide services for 3, R23 and R56) who were to meet their activities of daily 10:15 a.m. and on 2/18/15, at 6:39 p.m. was observed to ir on her upper lip.		" (R23, R24, R56) Bathing probe written and all staff providing be educated in the protocol incluproper care of nails and care of by Director of Nursing by March o All newly hired CNA staff will orientation to the bathing protoc spend time with a trained CNA to these skills o The protocol will include a nail	baths will ding the facial hair 31, 2015 receive of and will o practice		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ULD BE COMPLÉTION		
F 312	R24's quarterly MD diagnoses of demonstrated with a (BIMS) score of 6. required extensive perform ADLs inclu R24's care plan progread, "ADL: dressing requires set up and for thoroughness to R24 with personal offered assist with bath day. Family hat to bring in an elect indicated bath day. During an interview registered nurse (Fath and R24's fact removed. During an interview stated she had not did not wish for it to removed. During an interview nursing assistant (facial hair.  A policy on shaving was requested and facility. On 2/18/15 the facility did not infacial hair.  R23 on 2/18/15, at have very long fing underneath nails a showed broken jag R23's quarterly MD diagnoses of perip	or 2/18/15, at 6:39 p.m., R24 been aware of the facial hair, or be there, and wanted it was not provided by the facial hair, at 7:50 p.m. the DON stated nave a policy related to female at 12:27 p.m. was observed to ger nails with light brown debris and at least one of ten nails	F3	312	reporting to nurses when a resident requires nursing action for nail care Diabetics)  o Random audits will be performe least once per month throughout the year to see that bathing protocol is followednails clean and trimmed a facial hair shaved as appropriate to individual. The Director of Nursing welform or assign the audits to another nurse. Re-education will be performed any noted problems.	ed at e next being and the will ther		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED		
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NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 815 MAIN AVENUE SOUTH HARMONY, MN 55939				
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F 312	PROVIDER OR SUPPLIER  RSEN HARMONY CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F3	12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245528	B. WING			02/	20/2015
NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER				815	REET ADDRESS, CITY, STATE, ZIP CODE MAIN AVENUE SOUTH RMONY, MN 55939		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 312	Continued From paneeded.	ge 22	F 3	12			
	start date of 2/9/15	f facility resident profile with directed staff to assist R56 hygiene as needed.					
	verified R56 long cl resident's facial hai	2/18/15, at 7:40 p.m., RN-A nin hairs. RN-A stated female r was shaved on the day shift. did not shave own facial hair.					
		2/18/15, at 7:45 p.m., NA-A ents ' facial hair was shaved					
F 315 SS=E	of nursing stated sh was shaved on bath She stated the facil shaving facial hair.	2/18/15, at 7:50 p.m., director ne expected female facial hair n day and offered as needed. ity did not have a policy for HETER, PREVENT UTI, ER	F 3	:15			3/31/15
	assessment, the fa resident who enters indwelling catheter resident's clinical or catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a sthe facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.					
	by:	NT is not met as evidenced and record review, the facility			" R51-POC-resident has been		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION		SURVEY PLETED
		245528	B. WING		02/2	20/2015
	PROVIDER OR SUPPLIER  RSEN HARMONY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE B15 MAIN AVENUE SOUTH HARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	failed to assess urithen develop intervious from developing for R43, R16, R15, R3 or history of having a resident following continence for 1 of urinary incontinence for 1 of urinary frequency. The 60-day Minimus 12/26/14 indicated required extensive daily living (ADLs), of bladder and had previous 30 days. The observation rewas reviewed. The resident was alway extensive assistant (urge and stress) in assess/evaluate th UTIs. The care plan date urinary incontinence interventions include encourage fluid, error for the fail of the	nary tract infections (UTIs), rentions to prevent further UTIs r 7 of 7 residents (R51, R37, 82, R23) identified with having g a UTI, Also failed to reassess g a decline in urinary 3 residents (R33) reviewed for	F 315	discharged, no individual action witaken  "R37- POC-resident has expire individual action will be taken  "R43- POC will be updated with directions to minimize the risk of re UTI and the management of UTIs March 20, 2015  "R16- POC-resident has expire individual action will be taken  "R15- POC will be updated with interventions to prevent UTI by Ma 2015  "R32- POC will be updated with interventions to prevent UTI by Ma 2015  "R23-POC will be updated with interventions to prevent UTI by Ma 2015  "R23-POC will be updated with interventions to prevent UTI by Ma 2015  "R23, prophylactic use of antibi has been discontinued.  Nurse Mangers will be responsible update all POC  "Director of Nursing will meet w Medical Director to clarify orders for urinalysis and culture of speciment use of prophylactic antibiotics to el inappropriate use of antibiotics to el inappropriate use of antibiotic med by March 31, 2015  "A required meeting will be held nursing staff (RN, LPN and CNAs) meeting the following will be prese Director of Nursing:  o Nursing staff will be re-educate methods of prevention for UTI incliproper peri-care, catheter care, includes and food/fluids that naturally infection  o Nursing staff will be re-educated.	ed, no necurrent by ed, no necurrent by ed, no necurch 20, nech 20, etch 20	

Name of Provider or supplier   Street Address, city, State, zip Code   Street Address, city, Street   Street Address, city, Street   Street Address, city, Street   Street Address, city, Street   Street Ad		FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	E SURVEY PLETED	
AMME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 315  Continued From page 24 assist staff to identify the resident's symptoms of UTIs.  Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated with antibiotics. The UTIs were treated based on the dip stick result, but not a culture.  R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs.  R37 was admitted on 6/6/14 and had diagnoses  STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939  STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939  DPREFIX TAG  PROVIDER'S PLAN OF CORRECTION (CS)  (EACH OCRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 315  Signs and symptoms of UTI including temperature, odor, dysuria, flank pain and confusion/behavioral changes in some persons  O Nursing staff will be re-educated regarding appropriate nursing interventions to take if residents exhibit any signs of UTI and advised of updated orders for UTI management  O RIVLPN staff will be re-educated in the use of temporary care plans for any resident diagnosed with a UTI on This meeting will be held by March 26, 2015  "A Quality Assessment Performance Improvement project will be initiated by Improvement project will be in			245528	B. WING		02/2	20/2015
(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 315  Continued From page 24 assist staff to identify the resident 's symptoms of UTIs.  Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated with antibiotics. The UTIs were treated based on the dip stick result, but not a culture.  R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs.  R37 was admitted on 6/6/14 and had diagnoses    Nammony, Mn 55939    PROVIDER'S PLAN OF CORRECTION (X5) (X5) (PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (PACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    SUMMARY STATEMENT OF DEFICIENCY   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    SUMMARY STATEMENT OF DEFICIENCY   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    SIGN and symptoms of UTI including temperature, odor, dysuria, flank pain and confusion/behavioral changes in some persons   Nursing staff will be re-educated regarding appropriate nursing interventions to take if residents exhibit any signs of UTI and advised of updated orders for UTI management or RNI/LPN staff will be re-educated in the use of temporary care plans for any resident diagnosed with a UTI on This meeting will be held by March 26, 2015   A Quality Assessment Performance Improvement project will be initiated by	NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 315  Continued From page 24 assist staff to identify the resident 's symptoms of UTIs.  Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated based on the dip stick result, but not a culture.  R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs.  R37 was admitted on 6/6/14 and had diagnoses  R37 was admitted on 6/6/14 and had diagnoses  R37 was admitted on 6/6/14 and had diagnoses					315 MAIN AVENUE SOUTH		
F 315  Continued From page 24 assist staff to identify the resident 's symptoms of UTIs. Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated with antibiotics. The UTIs were treated based on the dip stick result, but not a culture.  R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs.  R37 was admitted on 6/6/14 and had diagnoses  R37 Continued From page 24 assist staff to identify the resident 's symptoms of UTI including temperature, odor, dysuria, flank pain and confusion/behavioral changes in some persons o Nursing staff will be re-educated regarding appropriate nursing interventions to take if residents exhibit any signs of UTI and advised of updated orders for UTI management o RN/LPN staff will be re-educated in the use of temporary care plans for any resident diagnosed with a UTI o This meeting will be held by March 26, 2015  " A Quality Assessment Performance Improvement project will be initiated by	GUNDEF	RSEN HARMONY CA	RE CENTER	1	HARMONY, MN 55939		
assist staff to identify the resident 's symptoms of UTIs. Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated with antibiotics. The UTIs were treated based on the dip stick result, but not a culture.  R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs.  R37 was admitted on 6/6/14 and had diagnoses  signs and symptoms of UTI including temperature, odor, dysuria, flank pain and confusion/behavioral changes in some persons  o Nursing staff will be re-educated regarding appropriate nursing interventions to take if residents exhibit any signs of UTI and advised of updated orders for UTI management  o RN/LPN staff will be re-educated in the use of temporary care plans for any resident diagnosed with a UTI  o This meeting will be held by March 26, 2015  " A Quality Assessment Performance Improvement project will be initiated by	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
UTIs.  Registered nurse (RN)-C was interviewed on 2/19/15 at 2:36 p.m. RN-C stated only one culture was done even though R23 had three UTIs and 3 were treated with antibiotics. The UTIs were treated based on the dip stick result, but not a culture.  R37 experienced recurrent UTIs (3 UTIs in 6 months) but lacked an assessment of the risk to develop UTIs, lacked identification of symptoms prior to treatment, and lacked revision of care plan to include management and prevention of UTIs.  R37 was admitted on 6/6/14 and had diagnoses  temperature, odor, dysuria, flank pain and confusion/behavioral changes in some persons  o Nursing staff will be re-educated regarding appropriate nursing interventions to take if residents exhibit any signs of UTI and advised of updated orders for UTI management  o RN/LPN staff will be re-educated in the use of temporary care plans for any resident diagnosed with a UTI  o This meeting will be held by March 26, 2015  " A Quality Assessment Performance Improvement project will be initiated by	F 315		_	F 315			
Ill chronic kidney disease, malaise and fatigue, urinary infection.  The significant change MDS dated 10/24/14 indicated memory impairment, required extensive assistance, was frequently incontinent of urine, and experienced no UTI is previous 30 days. R37's observation report/ evaluation dated 10/20/14 for bowel and bladder significant change, identified R37 as frequently incontinent, requiring extensive assistance with toileting use, experiencing mixed (urge and stress) incontinence, but did not assess R37's risk factors to develop UTIs.  The care plan dated 11/3/14 was reviewed. The care plan identified R37 as at time incontinent of bladder. The care plan directed R37 needed assist with toileting dated 8/1/14 but was not revised to include identification and management of UTIs.  Ill chronic kidney disease, malaise and fatigue, urinderlying systematic problems related to assessment and control of urinary tract infections and plan for a resolution. The project will be initiated by March 31, 2015  "R33-an elimination assessment was performed on February 20, 2015 and a referral to occupational therapy was initiated. Resident is currently participating in the therapy.  "Further assessment of a change in condition is a standard process. Completing the elimination assessment is part of our standard practice, and should drive the continued process of further data collection and care planning as needed. In this case a step was missed. Resources and protocol for accurate completion of this process are already available within the facility; therefore, Nurse Managers	F 313	assist staff to ident UTIs. Registered nurse (2/19/15 at 2:36 p.n culture was done of UTIs and 3 were tr UTIs were treated but not a culture. R37 experienced r months) but lacked develop UTIs, lack prior to treatment, plan to include ma UTIs. R37 was admitted listed on the admis III chronic kidney of urinary infection. The significant chaindicated memory assistance, was from the admissistance, was from the care plan dentified requiring extensive experiencing mixed incontinence, but of factors to develop The care plan date care plan identified hospice. The care incontinent of blade R37 needed assist was not revised to	ify the resident 's symptoms of RN)-C was interviewed on n. RN-C stated only one even though R23 had three eated with antibiotics. The based on the dip stick result,  ecurrent UTIs (3 UTIs in 6 d an assessment of the risk to ed identification of symptoms and lacked revision of care nagement and prevention of on 6/6/14 and had diagnoses sion record as diabetes, stage isease, malaise and fatigue, ange MDS dated 10/24/14 impairment, required extensive equently incontinent of urine, o UTI is previous 30 days. report/ evaluation dated and bladder significant R37 as frequently incontinent, assistance with toileting use, d (urge and stress) lid not assess R37's risk UTIs. d 11/3/14 was reviewed. The I C37 as being admitted to plan identified R37 as at time der. The care plan directed with toileting dated 8/1/14 but include identification and	F 315	signs and symptoms of UTI included temperature, odor, dysuria, flank confusion/behavioral changes in persons  o Nursing staff will be re-educate regarding appropriate nursing interventions to take if residents of any signs of UTI and advised of corders for UTI management or RN/LPN staff will be re-educate the use of temporary care plans for resident diagnosed with a UTI or This meeting will be held by 126, 2015  "A Quality Assessment Perform Improvement project will be initiated Director of Nursing to further ider underlying systematic problems reassessment and control of urinar infections and plan for a resolution project will be initiated by March 13. "R33-an elimination assessment performed on February 20, 2015 referral to occupational therapy winitiated. Resident is currently part in the therapy.  "Further assessment of a chancondition is a standard process wormpleting the RAI process. Conthe elimination assessment is part standard practice, and should driccontinued process of further data collection and care planning as not this case a step was missed. Resident process are already availables this process are already availables.	pain and some atted exhibit updated atted in for any warch mance ted by ntify any related to by tract on. The 31, 2015 ent was and a vas rticipating rt of our ve the attention of exition of exiting	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 15 MAIN AVENUE SOUTH IARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	determine risk to de failed to have a rev include UTI management. The physicial through 2/19/14 list chronic diarrhea, ur (pain with urination). The MDS dated 11/1 indicated R43 had independent with a always continent, a during the previous Care plan dated 1/1 of bladder and independent with a laways continent. The related to a diagnost interventions did not direct staff relat management. The related to a diagnost interventions did not UTIs.  R16 lacked consist urinary tract infection treatment and lacked recurrent UTIs (5 Uprophylactic antibio R16 was admitted disted on the admissipsychosis, anxiety, proteinuria, and pal The infection control urinary tract infection?/31/14 and 10/24/1 noted R16 started pror UTIs. Event rep 1) 8/14/14 for UTI behaviors, and flan 2) 10/22/14 for UT	evelop recurrent UTIs, and ision of the care plan to ement.  5/1/14 according to the face in orders dated 1/19/15 ed diagnoses that included rinary tract infection, dysuria by the cognitive impairment, was all activities of daily living, was not had not experienced a UTI 30 days.  13/15 noted R43 was continent pendent with toileting but did ed to UTI risk or care plan did have a problem sis of diarrhea, but the of include minimizing the risk of identification of symptoms of in prior to initiation of ed a UTI risk assessment with the include minimizing the risk of itic.  3/17/13 and had diagnoses sion sheet of diabetes, urinary incontinence, liative care.  5/17/14 Incontinence, liative care.  6/18/13/14 Incontinence, liative care.  6/18/13/14 Incontinence, liative care.  6/18/13/15 Incontinence, liative care.	F3	315	revise the process if needed or to be reminded/re-educated of the steps required to complete the process accurately by March 31, 2015		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY MPLETED
		245528	B. WING		02	/20/2015
	PROVIDER OR SUPPLIER	RE CENTER	STREET ADDRESS, CITY, STATE, ZI 815 MAIN AVENUE SOUTH HARMONY, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 315	transfer, and assist restorative nursing exercise. The card 11/7/13 which read infection related to interventions noted antibiotics, educate encourage fluids, e and provide peri-ca. The quarterly MDS had a BIMS score dimpairment, had not extensive assistant received an antibio. The facility Observation dated dobservation indicate condition, urinary in required extensive had mixed form of evaluate/assess Reversible factors to developing UTIs or The physician orderindicated R16 was day with a day of 4/1/17/15. R16 had a ceftriaxone twice a 3/18/13 and a discontilization of the until Cipro connoted Cipro daily, he than resume. During an interview RN-C/infection con a prophylactic antibits top the UTIs. RN-	e with toileting (E-Z stand for with personal hygiene), had for urinary incontinence e plan had a problem dated, " At risk for urinary tract past history of UTI." The to administer prophylactic staff on proper hygiene, ncourage bladder emptying	F3	215		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	ı		E SURVEY PLETED
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 815 MAIN AVENUE SOUTH HARMONY, MN 55939	)DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 315	R16 started to self-infection. R16 was had since died.  R15 experienced rebut lacked an asserevision of care plarecurrent UTIs. R15 was admitted the admission recoincluded neurogeniinfection, urine rete Event report dated culture was compleidentified and symplethargy, and urine report dated 11/9/1 cultured and the organity of lethar urine and cloudy urine report dated 12/4/14 indiccultured and the organitation and cloudy urine report dated 12/4/14 indiccultured and the organitation and cloudy urine report dated 12/4/14 indiccultured and the organitation and cloudy urine report dated 11/9/15 cultured and the organitation and cloudy urine report dated 11/9/15 cultured and the organitation and cloudy urine report dated 11/9/15 cultured and the organitation and cloudy urine report dated 11/9/15 cultured and the organitation and cloudy urine report dated 11/9/15 cultured and the organitation and cloudy urine report dated 11/9/15 cultured and the organitation and cloudy urine report dated 11/9/15 cultured and the organitation and cloudy urine report dated 11/9/15 cul	transfer she would have an on hospice at this time and ecurrent UTIs (3 in 3 months) asment of UTI risk and in to minimize the risk of the facility on 1/15/13 and indicated diagnoses that it is bladder, urinary tract intion, urinary frequency. 8/4/14 identified a UTI. The ited, but no organisms intoms related to behaviors, changes were listed. Event 4 indicated a UTI, that was ganisms were list, and gy, decreased intake, blood in ine were noted. Event report ated R15 had a UTI that was ganism was listed and rade temp, decreased	F 3	15			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	E CENTER		STREET ADDRESS, CITY, STATE, ZI 815 MAIN AVENUE SOUTH HARMONY, MN 55939	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG		ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 315	and hygiene. The cindwelling Foley catidentify UTIs, but diminimize the risk of R32 experienced 4 identification of symassessment of UTI revision of care plan R32 was admitted tresident admission dysuria (painful urinurinary tract infection diarrhea, neurogenkidney disease. The quarterly MDS R32 had a BIMS (bwas 9 or moderate extensive assistancincontinent, had a rexperienced a UTI Event report dated cultured, but no organd symptoms of a 8/15/14 for UTI indiction to list organism symptoms of an infreport listed a UTI Escherichia coli (coas the organism. Ninfection control log 11/26/14 with E-colisymptoms were list The observation report quarterly bowel was occasionally in past assessment period of the risk of the results of the res	total assistance for toileting are plan identified an heter and interventions to d not include interventions to UTIs.  UTIs in 5 months but lacked aptoms of a UTI, lacked an risk with recurrent UTIs, and n. o the facility in 2013 and the record listed diagnoses as ation) urethral discharge, on, urinary catheterization, c bladder, stage II chronic dated 11/19/14 was reviewed. The interview of mental status impairment, required the for ADLs, frequently the record is bladder, and had during the previous 30 days. The infection. Event report dated cated a culture was done, but the sand listed no signs and the ection. The infection control for R21 on 10/24/14 with mmonly abbreviated E. coli) to symptoms were listed. The listed a UTI for R32 on as the organism and no	F3	815			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245528	B. WING		-	02/2	20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 815 MAIN AVENUE SOUTH HARMONY, MN 55939	FE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 315	mixed (urge and stinclude an assessing UTIs.) The care plan date interventions of neutransfer R32 to toil medical diagnosis but did not list interrisk of developing in R23 received proplan assessment for clinical rationale for prophylactic antibio R23 was admitted found on the reside also listed diagnosidisease, urinary traneurogenic bladde. The quarterly MDS cognitive impairmeneurogenic bladde catheter into bladde. Review of the cliniexperienced a UTI but had not experiemenths. Physician orders discontinuous propersional anneurogenic bladde identified the trimerantibiotic for UTIs. for June 18, 2014 to R23 had a suprapuretention. The uroclinical rationale for antibiotics.	ce with toileting, experienced cress) incontinence, but did not ment of R32's risk to develop and 1/14/15 identified ed to use mechanical lift to et. The care plan listed a that include renal insufficiency, eventions to help minimize the recurrent UTIs. hylactic antibiotics but lacked risk of UTIs and lacked a r the continued use of the otic use. to the facility in 6/14/14 as ent admission record which es as chronic stage IV kidney act infection, diabetes, r. 6 dated 1/23/15 indicated no ent, no UTIs past 30 days, a r, and an ostomy (Suprapubic	F3	15			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245528	B. WING			02/	20/2015	
	PROVIDER OR SUPPLIER	RE CENTER		815 N	ET ADDRESS, CITY, STATE, ZIP CODE MAIN AVENUE SOUTH MONY, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 315	the use of an indwe extensive assist for identification of use risk for developing. The care plan date care plan listed a p and supra pubic callisted the use of prointervention to charmonthly, and to rep. During an interview stated R23 had not months and was the prophylactic antibio. R33's admission readmitted on 7/12/20 included but were readmitted but were readmitted on the case III chronic kid. R33's quarterly Min. 11/26/14 indicated incontinent (this waws not on a toiletine extensive assistance previous admission. R33 was always contileting program and assistance to toilet. R33's medical reconfailed to complete a assessment for R3 dated 11/26/14 sho incontinence.	bladder dated 5/6/14 indicated elling catheter, required to toileting, but lacked of prophylactic antibiotics and UTIs.  d 1/26/15 was reviewed. The roblem of urinary incontinence theter. The interventions ophylactic antibiotic, age indwelling catheter out signs of UTI. on 2/19/15 at 2:30 p.m. RN-C had a UTI during past 6 only resident still receiving a tic in the facility. cord noted R33 had been 0.13 with diagnoses that not limited to congestive heart thronic respiratory failure and liney disease.  Jimum Data Set (MDS) dated R33 was occasionally a decline for R33) of urine, and program and required to toilet. However, the MDS dated 8/26/14, included ntinent of urine, was not on a nod required extensive	F3	315				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		245528	B. WING		02/	/20/2015	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 815 MAIN AVENUE SOUTH HARMONY, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 315	contact the provide incontinence if she The care plan goal continent of bladde not include specific normal bladder function from the control.  On 2/19/15 at 12:48 verified R33 display according to most reference RN-B stated R33 let to go to the bathroop program. RN-B ver assess R33's toiletidecline in incontine function or to maint On 2/19/15 at 2:58 (DON) stated when assessment identification incontinence for R3 completed an asser reason for the charcare plan should have change in incontine DON verified a compassessment should to help restore and	pladder, and directed staff to r to review possible causes of experienced any incontinence. was for R33 to remain r and bowel. However it did interventions to promote ction or further loss of bladder as p.m. registered nurse (RN)-B red a decline in incontinence ecent MDS assessment. It staff know when she needed and mand was not on a toileting ified the facility did not fully ng plan to prevent further nce, to restore optimal bladder ain optimal bladder function.	F 31	5			
F 318 SS=D	not provided by the	EASE/PREVENT DECREASE	F 31	В		3/31/15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245528	B. WING		02/2	0/2015
	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 115 MAIN AVENUE SOUTH HARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 318	Based on the com resident, the facilit with a limited rang appropriate treatm range of motion ar decrease in range	prehensive assessment of a y must ensure that a resident e of motion receives ent and services to increase nd/or to prevent further of motion.	F 318			
	by: Based on observareview, the facility (R21) received rar and ambulation as therapy.  Findings include: R21 was identified change Minimum assessment dated intact, transfers, w self-performance v support was one proom support was corridor support whelp from staff; no balance during traunsteady but able assistance, no impin range of motion and received phys 1/5/15.  Document review dated 1/20/15, rev recent falls without	ation, interview, and document failed to ensure 1 of 1 resident age of motion (ROM) exercises recommended by physical  by the facility on the significant Data Set (MDS), an 1/7/15, to have cognition alk in room and walk in corridor was supervision; transfer erson physical assist, walk in set up help only, and walk in as no set up help or physical falls since last assessment, estions and walking was to stabilize without human pairment in functional limitation of upper and lower extremity, ical therapy with start date of the falls care area assessment ealed falls triggered due to a injury and some balance as hard of hearing, had poor		" (R21) Care plan will be update Nurse Manager to show intervention be taken should the resident refuse recommended restorative program March 20, 2015  o Nurse Manager will further evan R21 is acceptance and participation her program by April 3, 2015 and position continue, change or discontinue the program based on the resident is and response to the program.  "Persons working with the Restand Inition Quality Assessment Performance Improvement project for the program include better definition of the program include better definition of the program include persons responsible for review and evaluation of the program, including resident response, on a weekly to biweekly basis. The first meeting wheld by March 31, 2015	luate on in lan to e choice orative ate a m to ram fication and g	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245528	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER	E CENTER		STREET ADDRESS, CITY, STATE, 815 MAIN AVENUE SOUTH HARMONY, MN 55939	ZIP CODE	<b>V</b> _/-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD I	BE	(X5) COMPLETION DATE
F 318	vision, walks with a  Document review of 1/19-2/19/15, reveal ambulate independ wheel walker, and fonce a day Monday.  During observations R21 sat in room rectime, R21 transferred wheeled out of the R21's care plan dat problem of at risk for Approaches dated with R21 to and from walker, lower extremexercises-marches 15 times each once standing exercises-heel raises 15 times.  Approaches dated and balance program orning and goal was week; restorative quarterly and as ne R21's care plan dat problem of at risk for sight and variable be 8/1/14, included: ac walker with ambula in falls and balancir reach, and keep roof	f physician orders dated aled the following orders: may ently in room and halls with 4 alls and balance program through Friday.  s on 2/17/15, at 2:00 p.m., cliner with feet up. At that ed by self to wheelchair and room to church service.  ed 6/27/12 identified a per losing strength in legs. 2/10/15, included: ambulate m all meals with 4 wheel mity seated, kicks, knee bends, toe taps a day; lower extremity marches, squats, sidekicks, is each once a day.  8/1/14, included: invite to falls m led by activity staff once a vas R21 to attend three times or recumbent bike 10-15 a program will be reviewed eded.  ed 5/31/12 identified a per falling related to poor eye calance. Approaches dated liminister medication, use tion, encourage participating and program, keep items within	F3	118			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVE COMPLETED				
		245528	B. WING			02/	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, 815 MAIN AVENUE HARMONY, MN		1 02/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 318	revealed no falls in 1/2015. The follow 2/2015: Document review of 2/14/15, revealed Fand got up on her of was within reach. The seen by a provider symptoms and counce R21 to use call light Investigation identified unsteady on feet are walk in hallways.  Document review of revealed R 21 was sight charter that the second hand weakner R21 was reeducated was alert and orient to see the flu. R2 approximately 2 were sulted in the paties more assistance for and ambulation. The requires skilled phystrengthening, bala in order to regain putherapy to discharg with long term plants.	12/2014, and no falls in ing two falls occurred in  If the event report dated the stated had fall in bathroom own, c/o back pain, and call lite the report identified R21 was on 2/13/15 for respiratory gh. Interventions were to ask	F3	18			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 815 MAIN AVENUE SOUTH HARMONY, MN 55939	)DE		
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F 318	Goal: will ambulate walker on even surto regain prior function will be able to safely wheeled walker thromodified independent prior level of function physician for 1/5/15 for 4 weeks.  Document review of treatment notes review	iring contact guard assistance.  100 feet safely with 4 wheeled faces with supervision in order tional level. Long term goal: y ambulate with use of her 4 bughout the facility with ence in order to return to her on. Plan of care was signed by to 2/1/15, for 3 times a week of physical therapy daily realed the following: would of her ambulation today in tell she is getting stronger. lated 320 feet with 4 wheeled guard assistance. R21 oved ambulation distance and mobility. Sted to discharge from e to legs hurt after therapy. Orative therapy and ambulating ion and restorative program of physical therapy visits for the program of the progress mary dated 1/30/15, revealed all outcome included R21 ogress towards physical will continue to address the a functional maintenance.	F3	18			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZII 815 MAIN AVENUE SOUTH HARMONY, MN 55939	<sup>2</sup> CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 318	2# 15 times, kicks with blue band 15 ti squeezes 30 times. Lower extremity state active range of motion 15 of motion 15 times, motion 15 times, motion 15 times; with R21 to/from all and contact guard wheelchair due to contact guard assis hallway. Please has 5-7 days per week participate. Please department with an Document review of sheet dated 2/1/15 following: Falls and balance, attend three times as session out of 19 d Restorator or recurring and balance of Friday, R21 attended. The restorative nurring of the physical exercises dated 1/3 During interview on registered nurse (R	ated exercises: marches with with 2# 15 times, knee bends imes, toe taps 30 times, ball imes, sidekicks: marches ition 15 times, squats active range heel raises active range of Ambulation: Please ambulate Imeals with 4 wheel walker assistance and follow with dizziness. R21 is to have stance with all ambulation in the R21 perform all exercises as tolerates and is willing to contact physical therapy y questions or concerns.  If restorative nursing flow to 2/19/15, revealed the invite once a morning, will a week, R21 attended 1 ays; inbent bike 10-15 minutes a ph Saturday, goal to pedal 15 and the diays; once a day Monday through and one session out of 19 days.  Sing flow sheet did not identify therapy recommended	F3	318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING _		02	/20/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939		20/2010
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F 318	were not part of the sheet. RN-B verific directed restorative provided. RN-B s program was on the actually the same purposed whenever they can the falls and balance exercise one sessions. She verified R21 herapy exercises therapy on 1/30/15 recommendations restorative flow should also two restorative exercises. During interview or physical therapy evaluations had not completed month and would continuously exercises. NA-C sextremity exercises R21 would go to the verified not aware recommended restorative or not get done.	e restorative nursing flow ed, although the care plan enursing exercises, none were tated the falls and balance e flow sheet two times but was program offered by activity staff and the program and the bike on out of 19 possible sessions, and not received restorative as recommended by physical and the been added to the eat. RN-B stated the facility exaides who assisted with es.  1 2/19/15, at 10:54 a.m., assistant (PTA)-C stated she complete monthly physical son residents. PTA-C stated an evaluation for R 21 this	F 31	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245528	B. WING _		02/	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939	•	
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F 318	and talked with nur verified the evaluat or ambulation. PTA help to get dressed worse with most re dizziness and unstalight, and was self-to use call light. PT evaluation, R21 ha from therapy on 1/3 PTA-C attempt to a During interview or director of nursing short staffed and the restorative aides to nursing verified the provide restorative	age 38 I a review of nurse 's notes sing assistants. PTA-C ion did not include exercises a-C stated R21 needed more which was progressively cent illness, increased eadiness, refused to use call transferring despite education A-C stated, based on the declined since discharge 80/15. Surveyor requested ambulate R 21 that day.  1 2/19/15, at 12:50 p.m., stated the facility had been ney have rescheduled work on the floor. Director of a facility had no plan in place to therapy exercises when ere rescheduled to work the	F 31	8		
F 329 SS=E	stated R21 had ded 12/2015 and worse R21 requested to continuate to continuate declined as she not 483.25(I) DRUG RIUNNECESSARY DE Each resident's druunnecessary drugs drug when used in duplicate therapy); without adequate not 12/2015 and worse R21 had been stated and some stated and s	a 2/19/15, at 3:10 p.m., RN-B clined due to influenza in ening eye sight. RN-B stated lischarge from physical therapy he did not like therapy and did e. RN-B verified R21 had longer walked to meals. EGIMEN IS FREE FROM PRUGS  ag regimen must be free from an an unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of	F 32	9		3/31/15

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245528	B. WING			02/2	20/2015
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F 329	should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessary as diagnosed and record; and reside drugs receive grade behavioral interventions.	nces which indicate the dose I or discontinued; or any	F3	329			
	by: Based on intervier facility failed to obte continued use of padministered for u of 2 residents (R2: for prophylactic and failed to ensure the were monitored for clear parameters a medication is to be (R24, R21) review medications.  Findings include:  Lack of physician is	w and document review, the rain clinical rationale for prophylactic medication rinary tract infection (UTI) for 2 and the facility at psychoactive medications reffectiveness and/or identified as to when antianxiety a used for 2 of 5 residents and for unnecessary			" Prophylactic medications are conot in use within the facility; (R23) was discontinued and (R16) has executed the further individual actions are near this time.  " Director of Nursing will meet well Medical Director to clarify use of prophylactic antibiotics in order to put their inappropriate use within the fact the future by March 31, 2015  " Regular meetings with our Compart of the future by March 31, 2015  " Regular meetings with our Compart of the future of the facility. Should any be received in the future for prophy antibiotics the Consulting Pharmac make monthly notes to ask medical providers for on-going assessment.	s order spired. eded at ith orevent acility in asulting orders plactic ist will I	

Facility ID: 00125

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	15 MAIN AVENUE SOUTH		
GUNDEF	ISEN HARMONY CAF	RE CENTER		Н	IARMONY, MN 55939		
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F 329	a clinical rationale in medication. R23 was admitted resident admission chronic stage IV kie infection, diabetes, The quarterly Minim 1/23/15 indicated in UTIs past 30 days, ostomy (suprapublic report/evaluation for bladder dated 5/6/1 indwelling catheter toileting, but lacked prophylactic antibiod. The care plan listed a pand supra pubic care plan listed a pand supra pubic callisted the use of processive of the clinic experienced a UTI 2014, but had not emonths. Physician orders dawas reviewed. The trimethoprim an anneurogenic bladder this antibiotic. How justification for the antibiotic was required the infection control provide physician or control provide physician or control provide physician or chronic days and provide physician or control provide physician or chronic days and provide physician or chronic provide physician provide physic	phylactic antibiotic but lacked for the continued use of the to the facility in 6/14/14 and the record listed diagnoses as dney disease, urinary tract neurogenic bladder, num Data Set (MDS) dated o cognitive impairment, no a neurogenic bladder, and an exatheter). The observation or significant change bowel and 4 indicated the use of an required extensive assist for didentification of use of otics.  Id 1/26/15 was reviewed. The roblem of urinary incontinence theter. The interventions ophylactic antibiotic. Cal records indicated R23 had in April 2014 and in May of experienced a UTI in the past 6 experienced a UTI in the past 6 experienced a UTI in the past 6 experienced and none was provided. RN) -C who was designated as all director was asking to locumentation related to the	F 3	229	documentation of the medical necesuch medications. The Pharmacist advised of this immediately and our meeting will be held April 9, 2015.  "Nurse Managers will clarify the parameters for (R24) and (R21)s anti-anxiety medications by March 2015  "A plan for monitoring the use or psychoactive medication has alread been initiated within the facility. The Consulting Pharmacist will continue meet with designated members of nursing staff to review each resider medication regime monthly. The pharmacist and nursing team will medicate for administration beyonedical diagnosis and will request medical providers assist with identification for parameter to be included in these orders. The next meeting will be held to parameter to be included in the sorders. The next meeting will be held to parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be held to meet a parameter to be included in the sorders. The next meeting will be nearly to meet a parameter to be included in the sorders. The next meeting to meet a parameter to be included in the sorders and the necessity of clarity in the sorders. The next meeting to meet a parameter to be included	will be r next  31, f any dy e to the nt s nonitor nd the fication e ld April tion otics  e r by birector effect ed to ear. In	
	Review of the three	e prophylactic antibiotic. e urology notes for June 18,			clarified over the next six month to correlate with the plan being develo		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		COMPLETED	
		245528	B. WING _		02/	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939		
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F 329	The urology notes of rationale for the use During an interview stated R23 had not months and was the prophylactic antibio R16 lacked clinical prophylactic antibio R16 was admitted clisted on the admissipacychosis, anxiety, proteinuria, and pal The quarterly MDS had a BIMS score of impairment, had not extensive assistant living (ADL/s), had during the previous Observation Report dated 6/21/14 was the use of prophyla The plan of care dalisted a problem of infection related to an intervention to a antibiotics.  The Infection Contra Reports for March of the physician orde were reviewed for Findicated R16 receitwice a day starting discontinue date of physician's order for the physician's order for physician's order for the physician's order for the physician's order for physician's order for the physician order for the physician's order for the physician's order for the physician or	r related to urinary retention. did not identify a clinical e of prophylactic antibiotics. on 2/19/15 at 2:30 p.m. RN-C had a UTI during past 6 e only resident still receiving a tic in the facility. rationale for use of a tic to prevent UTIs. 3/17/13 and had diagnoses sion sheet of diabetes, urinary incontinence, liative care. dated 12/10/14 noted R16 of 8 or moderate cognitive of UTI past 30 days, required the with all activities of daily not received an antibiotic 7 days. The facility thowel/bladder observation reviewed and did not identify citic antibiotics. Ated 12/12/14 indicated R16 "At risk for urinary tract past history of UTI" and had dminister prophylactic fol Reports and Infection Event 2014 through November 2014 and 5 UTIs during this period. In Received an antibiotic a for all UTIs. In R16 received an antibiotic a for all UTIs. In R16 The physician orders and Bactrim DS (antibiotic)	F 32	the nursing team. Policies rela medications will be submitted to medical director for approval in September 30, 2015.	to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245528	B. WING			02/2	20/2015
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1	Cephalexin daily and 12/30/13 the physic Bactrim while on Control of the infection report 2014 through Janus prophylactic antibidas Bactrim DS with Log indicated the adiscontinued in Manfection control logorophylactic antibidation of 10/27/14. The Janus prophylactic antibidation of 1/16/15 dentified as received RN-C stated R16 work and on hoping instated she did not a self-transfer she was on hospice at the use of the propowhen requested. Lack of identifying anxiety and depressant and appropriatenessant and appropriateness	ol/14 the physician order and stop until Cipro complete. Cian noted Cipro daily, hold ipro then resume. Its were reviewed for January ary 2015. The log identified offices for R16 on January 2014 an order date of 6/18/13 The intibiotic had been rich 2014, The October 2014 gidentified R16 as receiving a offic of cephalexin starting uary 2015 log noted R16. During the time period ing the prophylactic antibiotics on a prophylactic antibiotic twould stop the UTIs. RN-C know the cause of the didentify that if R16 started to could have an infection. R16 this time and had since died. Cion or physician justification for hylactic antibiotic was received and evaluate symptoms of sision to ensure effectiveness	F3	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245528	B. WING		02	/20/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939				
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F 329	also indicated a Pl 7 indicating minim the revealed no be the time of assess R24's medication of visit dated 2/16/15 (mg) (anti-anxiety (anti-depressant in Lorazepam 0.5 mg for anxiety and Lor day. R24's care plan in anxiety and depres interventions to as symptoms howeve identify the anxiety symptoms in order Lorazepam. There when to administe individualized non- R24's medication in February 2015 ind was administered that included: "Abo with uneasiness, of with uneasiness, of something in throat and repetitive use During an interview licensed practical were not any spect Lorazepam. During an interview registered nurse (I administered after tried. Ongoing symptom depression was not	BIMS) score of 6. The MDS HQ9 (monitors mood) score of al depression symptoms, and ehaviors had been present at ment. orders identified on physician included: Buspar 7.5 milligram medication) daily, Paxil nedication) 40 mg daily, g three times a day as needed razepam 1 mg three times a  dicated R24 had a diagnosis of esion. The care plan identified sist with alleviating associated er, the care plan failed to and depression target and de	F 329					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION  NG		MPLETED
		245528	B. WING		0:	2/20/2015
	PROVIDER OR SUPPLIER	E CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 815 MAIN AVENUE SOUTH HARMONY, MN 55939		
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F 329	Nurse's progress no reviewed since 11/2 reflect symptoms of been quantified and behaviors and/or symonitor were not id interventions (included non-pharmacologic effectiveness.  During an interview RN-B stated target and signs to indicate behavior monitoring anti-depressant meanti-psychotic mediconcern then the reshort time period. Fevaluation of behavior been completed.  During an interview consulting pharmacomissed issuing a relaboratory monitoring needed Lorazepam pharmacist indicate frequency of sympty yet as evidenced or pharmacist said the initially started on 6 Lacked evidence of of target behaviors use of antianxiety analysis of data to cand interventions we R21 had diagnosis	tes and assessments were 26/14 to 2/19/15; notes did not a depression or anxiety had not and and individualized ding both pharmacological and and were not evaluated for an 2/18/15, at 5:30 p.m. (resident specific symptoms a need of antidepressant) and was not done for dications only for a cations unless there is a sident would be monitored for an effectiveness, and a sident would be monitored for an effectiveness, and a dicated he may have commendation for medication and for R24. In relation to as parameters; consulting and target symptoms and target symptoms and as needed Lorazepam was a depression and monitoring and target symptoms for the not antidepressant and lacked determine if the medications	F 3.	29		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245528	B. WING _	<del> </del>	02/	/20/2015	
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 329	Minimum Data Set 1/7/15, to have cog 15 including mood depressed, trouble feel bad about self, antianxiety medicated. Document review of for mood dated 1/2 some mood indicated change anything at improving. Mood is (due to) mood issumedication dated 1 med (medication) use for longstandinidentified R21 start medication. CAA id medication use was due to antianxiety at Document review of 1/19/15 to 2/19/15, 0.5 milligrams daily start date of 6/13/14 times a day for anx of 6/13/14; and lora day as needed for a date of 10/20/14. Treport had physicial milligrams once an start date of 1/16/1.	on the significant change (MDS), an assessment dated nition intact, moods score of s of little interest, feeling sleeping, tired, poor appetite, no behaviors, and received tion.  of care area assessment (CAA) 0/15, stated R21"endorses ors but voices a desire not to this time as she feels mood is addressed in care plan d/t es." CAA for psychotropic /20/15, read, "Psychotropic ise triggered d/t (due to) ativan g anxiety problems." CAA ed on antidepressant dentified psychotropic is addressed in the care plan and antidepressant use.  of physician orders report dated revealed orders for lorazepam of physician order, with a start date agitation or anxiety, with a start of the same physician order norders for Zoloft 50 evening for anxiety, with a start of facility medication		9			
	administration reco	rd dated 1/1/15 to 1/30/15, ved lorazepam (Ativan) and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245528	B. WING		02	/20/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939	,		
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F 329	and 2/18/15, at 12 in room. No mood that time.  R21's care plan day of psychotropic melorazepam for diagidentified included medications. Care problem of mood/behistory of chronic and charge nurse of anxiety, report to sand charge nurse of the facility target moods or restated the facility of charting on the ME monitoring of mood the facility did not on summary note of endity. Betated she result in the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of mood the facility did not on the monitoring of monitoring of mood the facility did not on the monitoring of moni	age 46 as on 2/17/15, at 10:30 a.m. as on 2/17/15, at 10:30 a.m. as or behaviors were noted at ated 3/5/14 identified a problem edication use due to received mosis of anxiety. Approaches monitor mood and response to plan dated 1/10/12, identified a behavior, has a longstanding anxiety and insomnia. and Ativan as scheduled and as or side effects and worsening ocial worker, case manager, changes in mood or behavior.  and 2/19/15, at 10:45 a.m., RN-B did not identify or monitor sponse to medications. RN-B new the medication was g with the nurses." RN-B uarterly mood and behavior as assessment was the facility do and behaviors. RN-B stated document an analysis or affectiveness of the medication. Eviewed moods and behaviors reses" and the summary was "However, it was not aluate content for accuracy.	F 32	9			
	related policies.	ne facility had no medication meters to use of antianxiety					

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according 12/25/10  R21 was MDS, an cognition moods or sleeping, no behave medication behave medication medication medication medication medication med [medication medication medication med [medication medication medicat	diagnosis g to facilitic diagnosis g to facilitic diagnosis g to facilitic diagnosis g to facilitic assessmintact, m f little interestived, poor dated on an expending anxion dated dication ding anxion dated dication ding anxion dated on an expectation of the control of the co	s of anxiety and depression by admission record dated  If on the significant change then dated 1/7/15, to have the cods score of 15 including the crest, feeling depressed, trouble for appetite, feel bad about self, received antianxiety  of care area assessment (CAA) 20/15, stated R21 "endorses at the code to the code the code	1	29		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 329	Continued From pa	ge 48	F 32	9			
	and 2/18/15, at 12:5	s on 2/17/15, at 10:30 a.m. 55 p.m., R21 sat in a recliner s or behaviors were noted at					
	of psychotropic melorazepam for diagridentified included medications. Care problem of mood/behistory of chronic at Approaches include scheduled and as reffects and worsen	red 3/5/14 identified a problem dication use due to received nosis of anxiety. Approaches monitor mood and response to plan dated 1/10/12, identified a phavior, has a longstanding enxiety and insomnia. The defendance of the determinant of th					
	stated staff administration for anxiety, after attribute interventions, or ad R21 requested as required the facility land.	2/19/15, at 2:30 p.m., RN-B stered as needed lorazepam empting non-pharmacological ministered lorazepam when needed lorazepam. RN-B acked specific identification of ty in order to administer as					
F 428 SS=D	of nursing stated th related policies.	2/19/15, at 4:15 p.m., director e facility had no medication EGIMEN REVIEW, REPORT ON	F 42	28		3/31/15	
		of each resident must be nce a month by a licensed					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
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-	NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939	
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F 428	The pharmacist muthe attending physi	age 49 ust report any irregularities to cian, and the director of reports must be acted upon.	F 428	3	
	by: The facility failed to pharmacist identific irregularities for 2 or reviewed for unnects. Findings included: R24 had last been 5/28/13 according to Admission Record. R24's quarterly Min 11/26/14 which includent anxiety disorder, he hyperlipidemia. The cognitive impairme Mental Status (BIM R24's medication of visit dated 2/16/15 medication) 10 mill 0.5 mg three times and 1 mg schedule (diuretic) 2.5 mg da (anti-hypertensive in Torsemide (diuretic) Record review of mare revealed no labs halast year to ensure	simum Data Set (MDS) dated uded diagnoses of dementia, eart failure, hypertension, and a assessment indicated severe nt with a Brief Interview of S) score of 6. rders identified on physician included: Lisinopril (lipid lower igrams (mg) daily, Lorazepam a day as needed for anxiety d three times a day, Zaroxolyn ally, Lopressor medication) 50 mg daily, and medication) 10 mg daily. Interview of the monitoring and been completed during the safe ongoing use of ions and/or continued need of		" Nurse Managers will clarify the parameters for (R24) and (R21)s anti-anxiety medications by March 3 2015  " A plan for monitoring the use of psychoactive medication has alread been initiated within the facility. The Consulting Pharmacist will continue meet with designated members of the nursing staff to review each resident medication regime monthly. The pharmacist and nursing team will medicate for administration beyond medical diagnosis and will request medical providers assist with identification of parameters for administration beyond medical providers assist with identification of parameter to be included in these orders. The next meeting will be held and clarified over the next six month to correlate with the plan being developetween the Consulting Pharmacist the nursing team. Policies related to medical director for approval no later September 30, 2015.	any y to ne t s onitor nd the cation d April ivities, oed and these

AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION  NG	` '	(X3) DATE SURVEY COMPLETED	
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F 428	nursing (DON) contaboratory monitoring the last year. R24's care plan in of anxiety and depridentified intervention associated symptor failed to identify the symptoms in order Lorazepam. No clead administer medicated non-pharmacologic R24's medication for February 2015 in Lorazepam was additionable behavioral issues the cold symptoms with home, complain of [undefined], weepy' light.  According to the February 2015 in Lorazepam was inited to be practical in were not any specific Lorazepam.  During an interview registered nurse (Radministered after between the consulting pharmacomissed issuing a relaboratory monitorine needed Lorazepam.	dicated R24 had a diagnosis ession. The care plan ons to assist with alleviating ms however, the care plan anxiety and depression target to administer as needed ar direction on when to ion or use individualized al interventions. administration record (MAR) indicated as needed ministered for varied mat included: "Abdominal pain, in uneasiness, wanting to go something in throat, anxiety and repetitive use of call estruary 2015 MAR, as needed itally started on 6/17/14 on 2/19/15, at 2:24 p.m. urse (LPN)-B verified there it parameters for the use of on 2/19/15, at 2:36 p.m. N)-B stated Lorazepam was behavioral interventions were on 2/19/15, at 2:36 p.m., sist indicated he may have commendation for medication ing for R24. In relation to as parameters; consulting ad facility had not identified haviors/mood.	F 4	about the necessity of clarity in documentation in the use of ar medication, especially psychologomedications. This training will of March 26, 2015 and further trapsychotropic medications and on geriatric residents will be present and LPN staff within the 20 staff.	ny active occur by ining on their effect ovided to	

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	NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939	•		
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F 428	R21 had diagnosis according to facility 12/25/10.  R21 was identified Minimum Data Set 1/7/15, to have cog 15 including mood depressed, trouble feel bad about self, antianxiety medicat  Document review of 1/19/15 to 2/19/15, 0.5 milligrams twice or anxiety, with a st Document review of administration histofollowing as needed -12/31/14-10 times 2/1/15 -2/18/15-1 ti identified as neede for sleep, nerves, a and resident requestion.	of anxiety and depression admission record dated on the significant change (MDS), an assessment dated nition intact, moods score of sof little interest, feeling sleeping, tired, poor appetite, no behaviors, and received ion.  If physician orders report dated revealed orders for lorazepam and aday as needed for agitation art date of 10/20/14.  If facility as needed medication may revealed R21 received the dilorazepam: 12/1/14 to 11/1/15 - 1/31/15-3 times; me. The medication record dilorazepam was administered gitation, anxiety, distressed,	F 42	28			
F 431 SS=D	p.m., facility consul expected very spec when to use as nee 483.60(b), (d), (e) I LABEL/STORE DR	•	F 43	31		3/31/15	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939			
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F 431	Continued From pa	ige 52	F 43	1			
	controlled drugs in accurate reconciliar records are in orde	ot and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordar professional princip appropriate access	als used in the facility must be note with currently accepted ples, and include the ory and cautionary e expiration date when					
	facility must store a locked compartmen	State and Federal laws, the all drugs and biologicals in the nts under proper temperature it only authorized personnel to keys.					
	permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ninimal and a missing dose can					
	by: Based on observation failed to ensure a bit testing solution) was being opened. This	NT is not met as evidenced tion and interview the facility ottle of Aplisol (tuberculin is discarded 30 days after is has the potential to effect is sions and new employees		" Facility already practices a checking medication storage for medications on a weekly basis furthermore, the Consulting Pharmacologist also checks for	or expired ;		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING			02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		81	TREET ADDRESS, CITY, STATE, ZIP CODE IS MAIN AVENUE SOUTH ARMONY, MN 55939		
(X4) ID PREFIX TAG			ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441 SS=F	storage tour with rerevealed an opened testing solution) with the medication story verified the date on should have been of date (December 1,  The Apisol package more than 30 days possible oxidation a affect potency. Fair as recommended mand inaccurate testing the story of the	0 a.m. during a medication gistered nurse (RN)-B d bottle of Aplisol (tuberculin h an open date of 11/1/14 in age room refrigerator. RN-B the bottle and stated the vial discarded 30 days after open 2014).  e insert read, "Vials in use should be discarded due to and degradation which may lure to store and handle Aplisol nay result in loss of potency	F 4		medications monthly and represent from our providing pharmacy do the same. Regardless of the triple chece method already in place, this vial of medication escaped notice because buried under other medication conto To prevent a future occurrence, the will locate and order brightly colored not use after (date)" labels that can attached to opened containers for by visualization by March 31, 2015.  "All persons responsible for medications in a meeting by March 2015 by Director of Nursing.  "Consulting Pharmacist and nur team will continue their monthly and weekly checks, monitoring for any for problems on-going.	e it was ainers. facility d'do be petter dication he use	3/31/15
	to help prevent the of disease and infe (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pushould be applied to	l Program tablish an Infection Control					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939	02/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
F 441	determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must ha	read of Infection cion Control Program esident needs isolation to of infection, the facility must . t prohibit employees with a ease or infected skin lesions with residents or their food, if eansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted	F 44			
	by: Based on observareview the facility facontrol program that and trends, to identifications and monthe spread of infections in the Findings include: Lack of analyzing in appropriate and time the spread of infection control.	nfections to determine lely interventions to prevent		" The Infection Control Nurse an Director of Nursing will initiate a pla performance improvement which winclude updating our methods of documentation to include the analy patterns and trends of infections or suspected infections. The initiation plan will occur by March 30, 2015.  The leadership team in the faci which includes all Department Hea Nurse Managers were educated at program objectives and initiation of plan by February 28, 2015.  The Safety Committee was educated of the safety Committee was educated as program objectives and initiation of plan by February 28, 2015.	an for vill sis of of this ility ds and bout the this	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245528	B. WING			02/5	20/2015
NAME OF	PROVIDER OR SUPPLIEF			S	TREET ADDRESS, CITY, STATE, ZIP CODE	UZ/Z	20/2013
					15 MAIN AVENUE SOUTH		
GUNDER	RSEN HARMONY CA	RE CENTER			IARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	reviewed. The log name, onset date, culture and x-ray of used, date resolve infection. Review cultures were not determine the cau infection/s (UTI) p X-rays were not edetermine pneumologs did not indicate facility or any time to assist the reside to minimize the sp did not indicate an completed. No furthe analysis of the requested. The facility policy 10/20/14 was revising of facility infections and the will be reviewed for Registered nurse the infection control log employee illness a indicated she wou infections during the end of the more written report or as would discuss the meetings. She wo areas of the nursir but would just keep infection would just keep infection in the second in the more written report or as would just keep indicated in the more would	age 55 g had a place to list resident site of infection, diagnosis, dates and results, antibiotic ed, and if this was a nosocomial of the logs revealed the consistently completed to se of the urinary tract rior to antibiotic use and taking onsistently completed to onia prior to treatment. The te resident location in the ly nursing/facility interventions ent to manage the infection or bread of the infection. The logs analysis or trend had been of the documentation regarding edata was provided when the documentation regarding edata was provided. The log or any patterns within the facility. (RN)-C, who was appointed as old director was interviewed on m. RN-C stated she kept the logs and would keep track of as well as resident illness. She lid keep a working log of the month and then recopy at analyze the data or trend. She infections at the morning ould look at the cultures and analyze the data or trend. She infections at the morning ould look at the cultures and the infections occur, p the information in her head. would take the information of	F 4	41	in the program objectives and initia this plan on March 11, 2015. The S committee participated in a review infection control logs for trends or p and the Infection Control nurse pro summary report of the Committee findings.  o The QA&A team will be educat participate in further review of the lany missed patterns or trends at the meeting April 9, 2015.  o All staff will be informed of the in process by March 30, 2015.	afety of the patterns vided a  ed and ogs for e next	

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 441	discuss what she "not reproducible. Recurrent Infection for July 2014 throw reviewed. In July 2 urinary tract infecti antibiotics, but org consistently identifithe log listed six (6 but no organisms. UTIs were identified. The infection contraction of R16, although on p (4) recurrent UTIs 2014. R23 although ad two (2) recurrent at two (2) UTIs identified during December 2014. Fidentified during December 2014. The Infections-Clir noted that changes physical status that infections were to nurse was to perform to notifying the directed the sympt changes in urine adysuria (frequency urinary tract infecti was advisable. The provide supportive	age 56 rality Improvement meeting and rhad in her head." Which was as: The infection control logs of December 2014 were 2014 the log identified three (3) ons (UTI) treated with anisms cultured were not ied on the log. In August 2014 of UTI treated with antibiotics, In October 2014 three (3) of In November 2014, four (4) of In November 2014, four (4) of In November 2014, four (5) of In November 2014 were reviewed. Or or phylactic antibiotic had four from March through October of In April and May. R 15 dentified in November and 251 had three (3) UTIs ecember 2014 and January ree (3) UTIs identified during ecember 2014 R32 had two (2) ing August through October sical Protocol dated 10/20/14 of in the resident's mental or the could indicate a possible of documented and the charge of the interest of the physician. The Protocol oms would include fever, ppearance, complaints of the or behavioral changes. If a on was suspected a urinalysis of the protocol stated staff would measures to assist the protocol stated staff would measures to assist the protocol of the protocol stated staff would measures to assist the protocol stated staff would measures to assist the protocol of the protocol	F 44			

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F 441	did not direct staff or need for re-assipotential reversible RN-C was intervie RN-C stated she had some resident stated she would I and symptoms of always happen. Not clinic, but not always happen. Not clinic, but not always happen. Not complete the instated that she was had recurrent UTIs back at the logs to Lack of infection in season and pneur control log for Decindicated one reside with influenza. On in December has I and one with pneur espiratory infection antibiotics or not with trends had been difficulted staff to do include fever, chair behavioral changes suspected then a completed as well Protocol directed itest as ordered by On 2/19/15 at 11:00	related to recurrent infections essments to determine e causes.  wed on 2/19/15 at 2.30 p.m. and not developed any infection he stated that she was aware its had recurrent UTIs. RN-C like nursing to document signs infection, but that did not fursing staff would contact the tys document the symptoms. The and RN-B were responsible fection event reports. She is aware that some residents is RN-C state she would look is see if any recurrent UTIs. In an agement for influenza in a symptoms of possible in a symptoms of possible in a symptoms of possible in symptoms of possible in symptoms or occumented to determine if the interespiratory illness or occumented to determine if the interespiratory illness or incresidents or staff. In a protocol dated 10/20/14 occument the symptoms that inges in urine appearance, or is. If pneumonia was oulse oximetry may be as possibly a chest x-ray. The finfluenza was suspected, then	F 44	H1			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	DATE SURVEY COMPLETED	
		245528	B. WING		2/20/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE B15 MAIN AVENUE SOUTH HARMONY, MN 55939	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 F 465 SS=B	house prophylactic The DON stated the listing of residents of during this time per 483.70(h)	had decided not to do a full treatment of other residents. at to her knowledge no line with respiratory symptoms	F 441		3/31/15
00-2	E ENVIRON  The facility must pr	ovide a safe, functional, ortable environment for			
	by: Based on observatifailed to provide a condensition by: An environmental to at 1:00 p.m. with the and the housekeep 107, 135, 124, 128, to have a buildup of windows had moist maintenance direct insulation and MD-humidifier which cat also noted the outs degrees Fahrenheir The administrator with 4:00 p.m. He stated moisture on windowneed replacing. The dining room/sc boards (had not be	ion and interview, the facility clean, comfortable and ent for several resident rooms. Our was completed on 2/19/15 e maintenance director (MD)-A ing director (HD-A. Rooms 129, 131, 137, were observed of black substance and several ure noted. During the tour the for stated this was dirt on the factor on windows. It was ide temperature was around 0 to the factor of the was at the was aware of the was at the was are getting old and larium had missing mop en replaced after painting damaged plaster. The south		Dirt accumulation (black substance) on the window calk has been removed with lacquer thinner in rooms 107,135,124,128,129,131 and 137. All windows are dry of moisture.  Maintenance will develop a schedule to remove all dirt accumulation on the insid of windows using the same method of cleaning as described above.  Person responsible: Maintenance Direct This administrator and maintenance director cannot find the missing mop board and damaged plaster in the Solarium and the missing plaster on the Solarium south wall.  The ceiling in the dining room will be cleaned with a vacuum to remove accumulated black substance (dust near the vents). The surveyor quoted the administrator as saying paint the ceiling. There is no intention to paint the ceiling. Bids are being sought to install a drop	or

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245528	B. WING		<del></del>	02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 15 MAIN AVENUE SOUTH IARMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	information provide indicated the dining recently repainted. The ceiling in the di substances over the around the vents. 2/19/15 at 1:30 p.m replace and lower that nothing had be been obtained. The interviewed on 2/19 had plans to replace room, and repaint the Bathroom floors in 124, 136, had black with debris. During an interview stated the toilets in replaced, and that the from the old toilets. gotten the spots up There was a strong room 135. Observed door two catheter be two day previously. 2/19/15 at 1:30 p.m stated the catheter procedure and store	aster and paint. Written d by MD-A on 2/19/15 room/solarium had been ining room had black e majority of the surface and MD-A was interviewed on and stated he had plans to he ceiling in the solarium, but en finalized and no bids have administrator was 1/15 at 4:00 p.m. and stated he ethe lighting in the dining he ceiling. The rooms 105, 107, 120, 121, adebris behind toilet or floor on 2/19/15 at 1:30 p.m. MD-A the bathrooms had been he black areas was probably He added they had not smell of urine in bathroom of d hanging over the bathroom ags each in a pillow case. Seen discharged to the hospital During an interview on the housekeeping director bags were washed per ed in the pillow cases. She have been thrown away when	F	465	ceiling with integrated light fixtures drop ceiling. Person responsible: Maintenance of and Administrator Bathroom floors in rooms 105,107,120,121,124,135 and 136 scheduled to be cleaned and old puremoved after replacing all stools in resident toilets with higher stools the accommodate handicapped person project is in process and was not complete when surveyed. A sched the toilet floor cleaning will be comply the housekeeping supervisor. Person responsible: Housekeeping supervisor/maintenance director. There is no resident in room 135 with need of a catheter bag.	director  are utty at as. The ule of bleted	

45528021

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING B. WING. 245528 02/17/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **815 MAIN AVENUE SOUTH GUNDERSEN HARMONY CARE CENTER** HARMONY, MN 55939 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey. **GUNDERSEN HARMONY CARE CENTER was** found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** ( K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Facility ID: 00125

**Electronically Signed** 

03/18/2015

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.

	ENTERS FOR MEDICARE & MEDICAID SERVICES		r			OND DATE OUD VEY		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION  01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED		
		245528	B. WING	-		02/	17/2015	
	PROVIDER OR SUPPLIER	RE CENTER		8	STREET ADDRESS, CITY, STATE, ZIP CODE B15 MAIN AVENUE SOUTH HARMONY, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	) BE	(X5) COMPLETIO DATE	
K 000	Continued From pa	age 1	K	000				
	Marian.Whitney@s Angela.Kappenma							
		RRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION:						
	A description of to correct the deficite	what has been, or will be, done iency.						
	2. The actual, or pr	oposed, completion date.						
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.						
	is a 1-story building building was constroriginal building wa determined to be o 1964, addition was determined to be o Because the originare of the same typ	HARMONY CARE CENTER with no basement. The ructed at 2 different times. The seconstructed in 1963 and was f Type II(111) construction. In constructed and was f Type II(111) construction. al building and the 1 addition be of construction allowed for the facility was surveyed as						
	has a fire alarm system detection, spaces of	ire sprinklered. The facility stem with full corridor smoke open to the corridor that is matic fire department						
		apacity of 43 beds and had a at the time of the survey.						

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CLIVIE	13 FOR MEDICARE	& MEDICAID SERVICES				VID IVO.	0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION I - MAIN BUILDING		E SURVEY PLETED
		245528	B. WING			02/	17/2015
	PROVIDER OR SUPPLIER	RE CENTER		815	REET ADDRESS, CITY, STATE, ZIP CODE S MAIN AVENUE SOUTH RMONY, MN 55939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 000	Continued From pa	age 2	K0	00			
K 050 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2		Κ0	50			3/31/15
	Based on docume interview, the facilit were conducted on staff under varying required by 2000 N	s not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as FPA 101, Section 19.7.1.2. ice could affect all 35			Maintenance Director has establish yearly calendar with all fire drills plater the 4th quarter 2015 and the year 2016. The plan assures a drill event each quarter Person Responsible: Maintenance Director	inned ar	
	on 02/17/2015, the for February 2014 t fire drills were miss	veen 11:00 AM and 2:30 PM review of the fire drills reports to January 2015. The following red: quarter - Night shift					

Event ID: HUFX21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OMPLETED	
		245528	B. WING	_		02/	17/2015	
	PROVIDER OR SUPPLIER	RE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  815 MAIN AVENUE SOUTH  HARMONY, MN 55939					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 050	Continued From page 3 2. 2014 - 3rd quarter - Day shift 3. 2014 - 4th quarter - Evening/Night shifts  This deficient practice was confirmed by the		ΚO	)50				
K 062 SS=D	Director of Maintenance (SL) at the time of discovery.  NFPA 101 LIFE SAFETY CODE STANDARD		K 062				3/31/15	
	Based on observation facility failed to mai in accordance with NFPA 101, Sections NFPA 25, section 2	s not met as evidenced by: tion and staff interview, the ntain the fire sprinkler system the requirements of 2000 s 19.3.5 and 9.7, and 1998 -4.1.1 (c). This deficient at all 5 out of 35 residents.			Solid sprinkler heads and a requisi installation have been ordered to re the dry fire sprinkler heads in the w cooler and freezer with a solder sprinkler head that is not affected by temperative Person Responsible: Maintenance Director	place alk-in inkler		
	Findings include:			49				
	on 02/17/2015, obs fire sprinkler heads freezer have clear f				×			
K 144 SS=F	Director of Mainten discovery.	ice was confirmed by the ance (SL) at the time of FETY CODE STANDARD	K 1	144			3/31/15	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G <b>01 - MAIN BUILDING</b>	(X3) DATE SURVEY COMPLETED	
		245528	B, WING _		02/	17/2015
	PROVIDER OR SUPPLIER	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 815 MAIN AVENUE SOUTH HARMONY, MN 55939	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
K 144		pected weekly and exercised ninutes per month in	K 14	4		
	Based on docume interview, the facilit emergency general requirements of 200 NFPA 110 Chapter practice could affect Findings include:  On facility tour betwon 02/17/2015, documentation from weekly inspection weekly inspection weekly inspection weekly inspection was a commented.  2. Review of the entrun test log sheets January 30, 2015, i	veen 11:00 AM and 2:30 PM rumentation review revealed regency generator weekly ts from February 17, 2014 to indicated that there was no in 7/14/14 to 11/6/14 that the vere completed and regency generator monthly from February 19, 2014 to indicated that there was no in 7/17/14 to 1/30/15 that the		The Maintenance Director will reveekly inspection of the emergengenerator in a log and keep the locurrent.  The monthly generator run test lowill be kept current with documenthe event by the Maintenance Director  The monthly run test will test and documented one of the following:  a. Loading maintains the minime exhaust temperatures as recommon by the manufacturer.  b. The generator under load of 3 percent or more of the nameplate for the specific generator or  c. Two (2) hour load bank test (1 minutes □ 25%, next 30 minutes and last 1 hour □ 75%).  Person Responsible: Maintenance Director	g sheets tation of ector. be um nended an rating irst 30	

		& MEDICAID SERVICES	T	TO CONSTRUCTION		U930-U38
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	IPLE CONSTRUCTION IG <b>01 - MAIN BUILDING</b>		E SURVEY PLETED
		245528	B. WING_		02/	17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 815 MAIN AVENUE SOUTH HARMONY, MN 55939	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 144	Continued From pa	age 5	K 14	.4		
	that the generator following: a. loading that mai gas temperatures a manufacturer or b. under load of 30 nameplate rating of c. 2 hour load bank	e monthly run test indicated did not meet one of the ntains the minimum exhaust as recommended by the percent or more of the figenerator or test (first 30 minutes - 25%, 50%, and last 1 hour - 75%)				
K 147 SS=D	Director of Mainter discovery. NFPA 101 LIFE SA Electrical wiring an	actices were confirmed by the nance (SL) at the time of AFETY CODE STANDARD and equipment is in accordance tional Electrical Code. 9.1.2	K 14	.7		3/31/15
	Based on observation facility failed to material accordance with the 101 - 19.5.1, 9.1.2. MSFC. The deficit of 35 residents.  Findings include:  On facility tour betwon 02/17/2015, observations.			The laundry storage and boile circuit breaker panels have be of storage that blocked access panels.  The maintenance office will be by an electrician to meet code. The power strip plugged in to a power strip has been removed. The Maintenance Director will building to prevent clutter in freelectrical panels and use of power strip has been removed. The Maintenance Director will building to prevent clutter in freelectrical panels and use of power strip has been removed.	en cleared s to the hard wired another l. monitor the ont of ower strips.	
	1. The following lo	cations have circuit breaker		Birostoi		

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	10 I OIL MEDICALLE	& MEDICAID SERVICES				CIVID IVC	. 0930-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED		
		245528	B. WING			02	/17/2015		
	PROVIDER OR SUPPLIER	RE CENTER		815 MAI	ADDRESS, CITY, STATE, ZIP C N AVENUE SOUTH DNY, MN 55939	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
K 147	panels that are block a. Laundry room b. Boiler room 2. Maintenance offit a. Extension con PVC piping b. Power strip p 3. Solarium area - the each other  These deficient pra Director of Mainten discovery.	cked: In storage Ice has the following: Ird running through wall in white Ilugged into extension cord Itwo power strips plugged into Incetices were confirmed by the Itanace (SL) at the time of	K 1	47			5		

Event ID: HUFX21



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted March 10, 2015

Mr. Timothy Samuelson, Administrator Gundersen Harmony Care Center 815 Main Avenue South Harmony, Minnesota 55939

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5528025

Dear Mr. Samuelson:

The above facility was surveyed on February 17, 2015 through February 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

Gundersen Harmony Care Center March 10, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				7. BOILDING.			
		00125		B. WING		02/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAR	RE CENTER		AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION	ORDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain	ction order has y. If, upon rein iency or deficie ected, a fine for be assessed in ines promulgat artment of Heal compliance with rule provided alle number indins several item	been issued spection, it is noies cited each violation accordance ed by rule of lth.  on has been all at the tag cated below. s, failure to				
	comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	Lack of comp ny item of mult ment of a fine of	liance upon i-part rule will even if the item				
	You may request a that may result from orders provided that the Department with notice of assessment.	n non-complian It a written requ hin 15 days of r	ce with these est is made to eceipt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm The Stat delineated on the a	participate in t nsure orders co artment of Heal in 14-01, availa tate.mn.us/divs e licensing orde	onsistent with lth able at /fpc/profinfo/inf ers are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 03/18/15

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7t. Boilebiita.			
		00125	B. WING		02/2	0/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GUNDER	SEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "correct. You must then State licensure proceompletion date, the corrected prior to elements and pepartments on February 17, 18. Department's staff, the following correction that you and identify the date. Minnesota Departments the State Licensing federal software. To assigned to Minnesota Departments of the State Licensing federal software. To assigned to Minnesota Departments and replaces the "To correction order. The findings which are in after the statement, evidence by." Follower the Suggested Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  3, 19, and 20 surveyors of this visited the above provider and ction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed.  The order of Health is documenting. Correction Orders using ag numbers have been cota state statutes/rules for the order of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  The THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 2 of 64 HUFX11

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			3/31/15
	Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.					
	by: Based on observati review, the facility f for 3 of 26 residents	ent is not met as evidenced on, interview and document ailed to follow the plan of care is (R23, R21, R56) to meet ified need and services.		corrected		
	registered dietician On 2/18/15, at 12:2 have very long fingunderneath nails ar showed broken jag R23's quarterly Min 1/23/15 included the mellitus, psychotic kidney disease and assessment indicate with a Brief Intervies score of 15. The Mirequired extensive	de nail care and follow is recommendations. 7 p.m. R23 was observed to er nails with light brown debrised at least one of ten nails ged sharp edges. imum Data Set (MDS) dated e diagnoses of diabetes disorder, and stage four open-angle glaucoma. The ed no cognitive impairment w of Mental Status (BIMS) DS also indicated R23 assist from staff to performing (ADLs) of dressing and				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 3 of 64

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00125	B. WING		02/2	0/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 02/2	0/2010	
		815 MAIN	AVENUE SC				
GUNDER	RSEN HARMONY CAF	RE CENTER	Y, MN 55939				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	R23's care plan prorelated to groomingas needed for dre transfers and toileti as able-but needs sthoroughness." Cwere on Tuesday a did not address how often, or by who na During an interview registered nurse (Rwas performed by a During an interview director of nursing (was not specifically was the person that finger nails. DON a care planned. R23's care plan p 2/19/15 related to n fluid intake was bet centimeters (cc's)	ovided by the facility on 2/19/15 and hygiene read, "Assist essing, personal hygiene, ang. Encourage independence supervision and checks for are plan indicated bath days and Thursday. R23's care plan of nail care was provided, how all care should be provided by. on 2/18/15, at 5:54 p.m.  N)-B stated diabetic nail care a nurse on bath days. on 2/19/15, at 10:38 a.m., (DON) explained if nail care care planned the expectation to gave the bath would check less stated nail care should be rovided by the facility on autrition indicated R23's ideal ween 1800-2000 cubic and directed staff to record	2 565				
	centimeters (cc ' s) and directed staff to record meal and fluid intake at all meals. R23's fluid intake record from 1/19/15 through 2/19/15 was reviewed. The record revealed twelve meal fluid intakes had not been recorded. During an interview on 2/19/15, at 10:38 a.m., DON confirmed missing fluid intake entries and explained strict intake monitoring was performed only if the registered dietician had made that recommendation. During an interview on 2/19/15, at 1:29 p.m., certified dietary manager (CDM) stated R23's fluid intake had been recommended because R23 was on diuretics and had a urinary catheter. R24 on 2/17/15, at 10:15 a.m. and on 2/18/15, at 12:46 p.m. and at 6:39 p.m. R24 was observed to have long facial hair on her upper lip. R24 's quarterly MDS dated 11/26/14 included diagnoses of dementia and anxiety disorder. The						

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 4 of 64

Minnesota Department of Health				•			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUF		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION	N NUMBER:	A. BUILDING:		COMP	LETED
		00125		B. WING		02/2	0/2015
		00125				02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
01WID==			815 MAIN	<b>AVENUE SC</b>	DUTH		
GUNDER	RSEN HARMONY CAR	RE CENTER	HARMON	Y, MN 55939	9		
(V4) ID	SHMMARV STA	TEMENT OF DEFICIEN		ID	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		MUST BE PRECEDE		PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFO	RMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
					DEFICIENCY)		
2 565	Continued From pa	ne 1		2 565			
2 303	Continued From pa	96 4		2 303			
	assessment indicat						
	impairment with a E	Brief Interview of I	Mental Status				
	(BIMS) score of 6.	The MDS also inc	dicated R24				
	required extensive	assist of one staf	f member to				
	perform activities of	f daily living (ADL	's) of				
	dressing and hygier	ne.					
	R24's care plan pro	vided by the facil	ity on 2/19/15				
	read, "ADL: dressin						
	requires set up and	moderate-max a	ssist/check				
	for thoroughness tw						
	[R24] with personal						
	be offered assist wi						
	bath day. Family ha	is been notified th	nat they need				
	to bring in an electr	ic razor." The car	e plan				
	indicated bath day v	was Wednesday.					
	During an interview						
	RN-B confirmed R2	24 did have bath a	and R24 's				
	facial hair should ha	ave been remove	d.				
	During an interview	on 2/18/15, at 6:	39 p.m., R24				
	stated she had not	been aware of th	e facial hair,				
	did not wish for it to	be there, and wa	anted it				
	removed.						
	During an interview						
	nursing assistant (N	IA)-A confirmed I	R24 had				
	facial hair.						
	A policy on shaving						
	was requested and						
	facility. On 2/18/15,						
	the facility did not h	ave a policy relat	ed to female				
	facial hair.						
	DE0705 47" /5 : "	IDOINIO					
	RESTORATIVE NU		e: 1				
	R21's care plan dat						
	problem of at risk for						
	Approaches dated						
	with R21 to and from		1 wheel				
	walker, lower extre						
	exercises-marches						
	15 times each once						
	standing exercises-	marches, squate	s, sidekicks,				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 5 of 64 HUFX11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE  COMP			SURVEY LETED	
		00125	B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 5	2 565			
	approaches dated and balance programorning and goal vaweek; restorator	s each once a day. Care plan 8/1/14, included: invite to falls am led by activity staff once a was R21 to attend three times or recumbent bike 10-15 e program will be reviewed reded.				
	problem of at risk for sight and variable to 8/1/14, included: act walker with ambula	ted 5/31/12 identified a or falling related to poor eye balance. Approaches dated dminister medication, use tion, encourage participating approgram, keep items within om free of clutter.				
	R21 received 12 ph	aily treatment notes revealed nysical therapy visits for ulation between 1/5/15 and				
	and discharge sum analysis of function significant progress goals. "Will continu	of physical therapy progress mary dated 1/30/15, revealed al outcome read, "Made is towards" physical therapy e to address ongoing deficits aintenance program directed				
	Program dated 1/30 exercise program for Lower extremity se 2 pounds (#) 15 times, ball squeeze Lower extremity states active range of motion 15	ated exercises: marches with nes, kicks with 2# 15 times, ue band 15 times, toe taps 30				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 6 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE :  A. BUILDING: COMPI			SURVEY LETED	
			BOILDING.			
		00125	B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	motion 15 times; with R21 to/from al and contact guard wheelchair due to contact guard assis hallway. Please has 5-7 days per week participate. Please department with an Document review of sheet dated 2/1/15 following: Falls and balance, attend three times as session out of 19 d Restorator or recur day, Sunday throug minutes, R21 refus 1 session out of 19 Falls and balance of Friday, R21 attended. The restorative nur any of the physical exercises dated 1/3 During interview on verified the physical restorative nursing nursing flow sheet. care plan directed in none were provided balance program who but was actually the activity staff whene verified R21 receive program and the bi 19 days. She verified 19 days. She verified 19 days. She verified 19 days.	Ambulation: Please ambulate I meals with 4 wheel walker assistance and follow with dizziness. R21 is to have stance with all ambulation in the R21 perform all exercises as tolerates and is willing to contact physical therapy by questions or concerns.  If restorative nursing flow to 2/19/15, revealed the invite once a morning, will a week, R21 attended 1 ays; anbent bike 10-15 minutes a ph Saturday, goal to pedal 15 ed two sessions and attended days; once a day Monday through ed one session out of 19 days.  Sing flow sheet did not identify therapy recommended	2 565			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 7 of 64

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 7		2 565			
	by physical therapy	on 1/30/15.				
	director of nursing short staffed and the restorative aides to nursing verified the provide restorative	n 2/19/15, at 12:50 p.m., stated the facility had been ney have rescheduled work on the floor. Director of facility had no plan in place to therapy exercises when ere rescheduled to work the				
	UNNECESSARY MEDICATIONS: R21 's care plan dated 3/5/14 identified a problem of psychotropic medication use due to received lorazepam for diagnosis of anxiety. Approaches identified included monitor mood and response to medications.					
	Minimum Data Set 1/7/15, to have cog 15 including mood depressed, trouble	on the significant change (MDS), an assessment dated inition intact, moods score of s of little interest, feeling sleeping, tired, poor appetite, no behaviors, and received tion.				
	for mood dated 1/2 some mood indicat change anything at improving, " and " plan d/t (due to) more psychotropic medic Psychotropic medic (due to) ativan (lora anxiety problems."	of care area assessment (CAA) 0/15, stated R21 "endorses ors but voices a desire not to this time as she feels mood is Mood is addressed in care ood issues." CAA for cation dated 1/20/15, stated, "(medication) use triggered d/t azepam) use for longstanding CAA identified R21 started medication. CAA identified cation use was addressed in capatianxiety and				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 8 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X3) DATE SURVEY COMPLETED
00125	B. WING	02/20/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FI TAG REGULATORY OR LSC IDENTIFYING INFORMATI	ULL PREFIX (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
2 565 Continued From page 8 antidepressant use.  Document review of physician orders reprince 1/19/15 to 2/19/15, revealed orders for low 0.5 milligrams daily for anxiety disorder, with a start date of 6/13/14; lorazepam 1 milligratimes a day for anxiety disorder, with a start of 6/13/14; and lorazepam 0.5 milligrams day as needed for agitation or anxiety, with date of 10/20/14. The same physician or report had physician orders for Zoloft 50 milligrams once an evening for anxiety, with start date of 1/16/15.  Document review of facility medication administration record dated 1/1/15 to 1/30 revealed R21 received lorazepam and Zoordered.  During interview on 2/19/15, at 10:45 a.m verified the facility did not identify or monitarget moods or response to medications stated the facility knew the medication was effective by just talking with the nurses. stated the facility quarterly mood and behariting on the MDS assessment was the monitoring of moods and behaviors.  During interview on 2/19/15, at 4:15 p.m., of nursing stated the facility had no medicine related policies.  FACIAL HAIR:  R56 was identified by the facility as deperone staff for activities of daily living, according to review of facility progress notes 2/7/15, 2/12/15, and 2/17/15.  R56 was admitted to the facility on 2/4/15 according to review of R56's medical recording to review of R56's medical r	razepam vith a am two art date twice a th a start der ith a a start der ith a	

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 9 of 64

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00125	B. WING		02/2	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	sheet.					
	2/18/15, at 6:00 p.n	s on 2/17/15, at 3:19 p.m., n., and 2/18/15, at 7:40 p.m., with long chin hairs.				
	not dated, directed	of R56's interim plan of care, staff to check for chin hairs, y staff, oral care assist as				
	start date of 2/9/15,	of facility resident profile with the directed staff to assist R56 hygiene as needed.				
	During interview on 2/18/15, at 7:40 p.m., RN-A verified R56 has long chin hairs. RN-A stated female resident's facial hair was shaved on the day shift. RN-A verified R56 did not shave own facial hair.					
		2/18/15, at 7:45 p.m., nursing ated female residents 'facial the mornings.				
	of nursing stated sh was shaved on bath	2/18/15, at 7:50 p.m., director ne expected female facial hair n day and offered as needed. ity did not have a policy for				
	The director of nurs a system to educate monitoring system	THOD OF CORRECTION: sing or designee could develop e staff and develop a to ensure staff are providing the written plan of care.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 10 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED		
		00125	B. WING	B. WING		02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 55939				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ge 10	2 570				
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision		2 570			3/31/15	
	care must be review interdisciplinary teal physician, a register for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,	,					
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise and update the care plan for 4 of 7 residents (R15, R32, R37, and R43) reviewed who had facility urinary tract infection (UTI).			Corrected			
	Findings include:						
	revision of an indiviprovide directions to management and in risk of recurrent UT R15 was admitted to the admission recoincluded neurogeni infection, urine rete The quarterly Minin 1/7/15 indicated R1	o the facility on 1/15/13 and rd listed diagnoses that c bladder, urinary tract ntion, urinary frequency. num Data Set (MDS) dated					

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		A. BOILDING.			
	00125	B. WING		02/2	20/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDERSEN HARMONY CARE C	:FNIFR	AVENUE SC Y, MN 55939			
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
UTIs past 30 days. Ho indicated R15 had experienced as facility The care plan dated 12 care plan noted R15 restoileting and hygiene. To indwelling Foley cathetridentify UTIs, but did not minimize the risk of UTIs and minimize the risk of UTIs and minimize the risk of UTIs and manato minimize the risk of UTIs and minimize the risk of UTIs and minimize the risk of UTIs between July that were identified as in The care plan dated 1/1	ving, had an indwelling lenic bladder and had no ovever of the clinical record erienced three UTIs and December 2014 that ity acquired. 2/15/14 was reviewed. The equired total assistance for The care plan identified an er and interventions to ot include interventions to ot include interventions to Tis.  Trent UTIs but lacked alized plan of care to be staff regarding UTI agement and interventions recurrent UTIs. The facility in 2013 and the facility acquired and had experienced a UTI days. Review of the drass had experienced a UTI days. Review of the drass had experienced a UTI days. Review of the drass had experienced a UTI days. Review of the drass had experienced a UTI days and November 2014 facility acquired.				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 12 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00125		B. WING		02/	20/2015
	GUNDERSEN HARMONY CARE CENTER 815 MAII			DRESS, CITY, S AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 570	R37 experienced revision of an indiviprovide directions to identification and more to minimize the risk R37 was admitted a listed on the admissionary infection. The significant chain indicated memory in assistance, was free and experienced three of the December 2014 the acquired. The care plan identified bladder. The care assist with toileting revised to include in the composition of an indiviprovide directions to identification and more interventions to minute the plan identification and more interventions to more identification and mor	ecurrent UTIs budualized plan of othe staff regardanagement and sease, malaise management, requestly incontinuously between July betwee	care to ding UTI I interventions Is. ad diagnoses iabetes, stage and fatigue,  10/24/14 vired extensive ent of urine, s 30 days. red R37 had une and das facility eviewed. The inent of 87 needed t was not interventions at lacked care to ding UTI I to f recurrent sician orders d diagnoses ary tract in) vas reviewed. gnitive all activities of and had not ous 30 days. ed R43 had	2 570			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 13 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00125	B. WING		02/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUNDER	SEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 570	Continued From page 13		2 570			
	of bladder and inder not direct staff related management. The related to a diagnost interventions did not UTIs.  During an interview registered nurse (Remporary care planaresidents that had busing it. At 5:10 p.m (RN)-C stated the comost current for R1 SUGGESTED MET The director of nurs staff related to the most director to the most staff related to the most director.	3/15 noted R43 was continent pendent with toileting but did				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 895	MN Rule 4658.0529 Motion	5 Subp. 2.B Rehab - Range of	2 895			3/31/15
	that is directed towathrough positioning implemented and momented and momented and momented and momented are services of nursing services development of a moment	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which  h a limited range of motion e treatment and services to				
		notion and to prevent further				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 14 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DA CO			
		00125	B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAR	RE CENTER	N AVENUE SONY, MN 5593			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 895	Continued From pa	ge 14	2 895			
	by: Based on observati review, the facility fa (R21) received range	ent is not met as evidenced on, interview, and document ailed to ensure 1 of 1 resident ge of motion (ROM) exercises recommended by physical		Corrected		
	Findings include:					
	change Minimum D assessment dated intact, transfers, wa self-performance w support was one per room support was se corridor support was help from staff; no fi balance during tran unsteady but able to assistance, no impain in range of motion of	by the facility on the significan lata Set (MDS), an 1/7/15, to have cognition alk in room and walk in corrido as supervision; transfer erson physical assist, walk in set up help only, and walk in s no set up help or physical falls since last assessment, sitions and walking was to stabilize without human airment in functional limitation of upper and lower extremity, cal therapy with start date of				
	dated 1/20/15, reverecent falls without problems. R21 was vision, walks with a Document review o 1/19-2/19/15, revea ambulate independ	f falls care area assessment aled falls triggered due to injury and some balance is hard of hearing, had poor ssist of staff, used wheelchair of physician orders dated aled the following orders: may ently in room and halls with 4 falls and balance program of through Friday.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From page 15		2 895			
	R21 sat in room red time, R21 transferro wheeled out of the	s on 2/17/15, at 2:00 p.m., cliner with feet up. At that ed by self to wheelchair and room to church service.				
	problem of at risk for Approaches dated with R21 to and frow alker, lower extremexercises-marches 15 times each once	, kicks, knee bends, toe taps e a day; lower extremity marches, squats, sidekicks,				
	Approaches dated 8/1/14, included: invite to falls and balance program led by activity staff once a morning and goal was R21 to attend three times a week; restorator or recumbent bike 10-15 minutes; restorative program will be reviewed quarterly and as needed.					
	problem of at risk for sight and variable to 8/1/14, included: ac walker with ambula	ted 5/31/12 identified a por falling related to poor eye palance. Approaches dated diminister medication, use tion, encourage participating approgram, keep items within the free of clutter.				
	revealed no falls in 1/2015. The follow 2/2015: Document review of 2/14/15, revealed Fand got up on her of was within reach. The seen by a provider	f past three months of falls 12/2014, and no falls in ing two falls occurred in f the event report dated 821 stated had fall in bathroom own, c/o back pain, and call lite he report identified R21 was on 2/13/15 for respiratory on. Interventions were to ask				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 16 of 64

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00125		B. WING		02/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAR	E CENTER		AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	R21 to use call light Investigation identifunsteady on feet ar walk in hallways.  Document review or revealed R 21 was schair, trying to mostated was just weater. R212 had a for cough, was seed cough and weakner. R21 was reeducated was alert and orient.  Document review of dated 1/5/15, identifunstead in ambulation onset of the flu. R2 approximately 2 were sulted in the patien more assistance for and ambulation. The requires skilled phystrengthening, bala in order to regain putherapy to discharg with long term plan ambulates 40 feet weven surfaces required Goal: will ambulate walker on even surfaces required	tor wait for assist. ied R21 had been mad was to have assist fevent report dated on floor in front of rowe her bedside table k, denied pain, lung cough, was seen on after fall on 2/18/18 is and started on and to use the call lighted and made own deferral: R21 presents on and transfers due and transfers due at started noticing a eks ago which has sent now requiring sign the completion of	tance to  2/18/15, ommate ' 2/18/15, ommate ' 2/13/15 5 for tibiotic. t. R21 ecisions.  an of care e of s with a to recent decline ince inficantly ransfers 21 time for d transfer Physical a potential goal: ers on ssistance. 4 wheeled on in order m goal: of her 4 with n to her	2 895	DEFICIENCY)		
		n. Plan of care was to 2/1/15, for 3 time					

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 17 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		00125	B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	Continued From pa	age 17	2 895			
	treatment notes revi 1/16/15, R21 was pand reports she can 1/23/15, R21 ambuwalker and contact demonstrated imprindependence with 1/30/15, R21 requesting physical therapy during R21 agreed to rest with staff. Ambulat completed.	of physical therapy daily vealed the following: broud of her ambulation today in tell she is getting stronger. Illated 320 feet with 4 wheeled guard assistance. R21 roved ambulation distance and mobility. Ested to discharge from the to legs hurt after therapy. For orative therapy and ambulating tion and restorative program in the strong strong with the strong therapy visits for				
		oulation between 1/5/15 and				
	Document review of physical therapy progress and discharge summary dated 1/30/15, revealed analysis of functional outcome included R21 made significant progress towards physical therapy goals. R21 will continue to address ongoing deficits with a functional maintenance program directed by facility staff.					
	Program dated 1/3 exercise program f Lower extremity se 2# 15 times, kicks with blue band 15 t squeezes 30 times Lower extremity state active range of motion 15 of motion 15 times; motion 15 times;	ated exercises: marches with with 2# 15 times, knee bends imes, toe taps 30 times, ball				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 18 of 64 Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				
		00125	B. WING		02/20/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 5593				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 895	and contact guard wheelchair due to contact guard assis hallway. Please ha 5-7 days per week participate. Please department with an Document review of sheet dated 2/1/15 following: Falls and balance, attend three times assisted as the session out of 19 diagrams. Sunday through minutes, R21 refus 1 session out of 19 Falls and balance of Friday, R21 attended. The restorative nurrany of the physical exercises dated 1/3 During interview or registered nurse (Figure 1)	assistance and follow with dizziness. R21 is to have stance with all ambulation in the R21 perform all exercises as tolerates and is willing to contact physical therapy by questions or concerns.  If restorative nursing flow to 2/19/15, revealed the invite once a morning, will a week, R21 attended 1 ays; anbent bike 10-15 minutes a ph Saturday, goal to pedal 15 ed two sessions and attended days; once a day Monday through ed one session out of 19 days.  Ising flow sheet did not identify therapy recommended 30/15.	2 895				
	were not part of the sheet. RN-B verified directed restorative provided. RN-B st program was on the actually the same public whenever they can the falls and balance exercise one sessions.	dations for restorative nursing a restorative nursing flow ed, although the care plan and the falls and balance at flow sheet two times but was program offered by activity staff. RN-B verified R21 received be program and the bike on out of 19 possible sessions. ad not received restorative as recommended by physical RN-B verified the					

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 19 of 64 HUFX11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
00125			B. WING			02/20/2015	
	NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER  815 MAIN HARMON				<del>-</del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pare recommendations in restorative flow she had two restorative restorative exercises. During interview on physical therapy as was responsible to therapy evaluations had not completed month and would concern the provex of th	nad not been added et. RN-B stated the aides who assisted es.  2/19/15, at 10:54 a sistant (PTA)-C stated monthly on residents. PT an evaluation for Romplete that day.  2/19/15, at 10:56 a NA)-C verified she wide facility restorationated she provided bike for 10 minutes are exercise room. Not the physical thereforative program exactive aides frequented the restorative exercise room. And the restorative exercise room at the restorative exercise room. And the restorative exercise room are review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse and the restoration of the physical that time. She shall be a review of nurse are review of nurse are review of nurse are review of nurse are review.	e facility d with  a.m., ted she chysical A-C stated 21 this  a.m., was ve nursing lower whenever IA-C apy ercises. tly have to xercises do  c.m., PTA-C sical tated the s notes TA-C exercises ded more ssively sed o use call e education on the scharge quested	2 895			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	00125		B. WING			02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAR	E CENTER		AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG		TEMENT OF DEFICII ' MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 895	During interview on director of nursing short staffed and the restorative aides to nursing verified the provide restorative aides we floor.  During interview on stated R21 had decensed R21 had decensed R21 requested to decensed as she not want to continue declined as she not SUGGESTED MET The DON, director could review and reand procedures regmaintaining proper DON, director of the provide an in-service providing treatment	2/19/15, at 12:5 stated the facility ey have resched work on the floor facility had no putherapy exercises are rescheduled 2/19/15, at 3:10 slined due to influing eye sight. Sischarge from putherapy or designating implementation of the signature of motion erapy or designate for all appropries.	y had been duled or. Director of plan in place to les when to work the op.m., RN-B uenza in RN-B stated hysical therapy nerapy and did d R21 had o meals.  RRECTION: signee(s) ary the policies enting and a care. The lee(s) could riate staff on	2 895			
	care. The DON, director could monitor to as range of motion treatment.  TIME PERIOD FOR Twenty-One (21) D	ector of therapy sure residents r atment.	or designee(s) eceive proper				
2 910	MN Rule 4658.0528 Incontinence  Subp. 5. Incontiner have a continuous property management to recurrence of the state of th	5 Subp. 5 A.B R nce. A nursing h program of bow luce incontinence	nome must el and bladder ce and the	2 910			3/31/15

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 21 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	PLE CONSTRUCTION  G:		(X3) DATE SURVEY COMPLETED	
00125			B. WING	B. WING 02		
	PROVIDER OR SUPPLIER	RE CENTER 815	EET ADDRESS, CITY MAIN AVENUE S RMONY, MN 559	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident whreceives appropriat prevent urinary trace	ident assessment, a nursi	zed es r			
	by: Based on interview failed to assess uring then develop interview from developing for R43, R16, R15, R3 or history of having a resident following	ent is not met as evidence and record review, the factoriary tract infections (UTIs) entions to prevent further 7 of 7 residents (R51, R3 2, R23) identified with hav a UTI, Also failed to reass a decline in urinary 3 residents (R33) reviewe e.	cility I, UTIS I, I, III III III III III III III III	Corrected		
	Findings include: UTIs:					
	consistent identification, lacked an lacked a care plant UTIs. R51 was admitted to diagnoses that includingly frequency. The 60-day Minimu	ecurrent UTIs and lacked ation of symptoms of an assessment of UTI risk, a for the management of the to the facility 10/31/14 and uded urinary tract infection m Data Set (MDS) dated R51 was cognitively intact	had ,			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 22 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
	00125	B. WING		02/2	0/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GUNDERSEN HARMONY CAI	RE CENTER	AVENUE SC Y, MN 55939				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
daily living (ADLs), of bladder and had previous 30 days. The observation rewas reviewed. The resident was alway extensive assistant (urge and stress) in assess/evaluate the UTIs. The care plan date urinary incontinent interventions include encourage fluid, erprovide incontinent assist staff to ident UTIs. Registered nurse (2/19/15 at 2:36 p.m. culture was done of UTIs and 3 were the UTIs were treated but not a culture.  R37 experienced remonths) but lacked develop UTIs, lack prior to treatment, plan to include main UTIs. R37 was admitted listed on the admis III chronic kidney durinary infection. The significant chaindicated memory assistance, was freand experienced in	assistance with activities of was occasionally incontinent l'experienced a UTI during the port/evaluation dated 11/07/14 e observation report noted is incontinent of urine, required ce with toileting, had mixed incontinence, but did not e residents risk to develop ed 1/7/15 had a problem or se and a history of UTI. The ded: administer antibiotics, incourage emptying of bladder, if the resident 's symptoms of RN)-C was interviewed on in. RN-C stated only one even though R23 had three eated with antibiotics. The based on the dip stick result, ecurrent UTIs (3 UTIs in 6 d an assessment of the risk to ed identification of symptoms and lacked revision of care nagement and prevention of on 6/6/14 and had diagnoses is sion record as diabetes, stage lisease, malaise and fatigue, ange MDS dated 10/24/14 impairment, required extensive equently incontinent of urine, o UTI is previous 30 days. report/ evaluation dated	2 910				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 23 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BOILDING.				
		00125		B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAF	RE CENTER		AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	Continued From part 10/20/14 for bowel change, identified is requiring extensive experiencing mixed incontinence, but differ factors to develop in the care plan date care plan identified hospice. The care incontinent of bladde R37 needed assist was not revised to management of UT R43 experienced a of urinary symptom determine risk to defailed to have a revinclude UTI management. The physicial through 2/19/14 list chronic diarrhea, un (pain with urination The MDS dated 11 indicated R43 had independent with a always continent, aduring the previous Care plan dated 1/1 of bladder and independent. The related to a diagnosinterventions did not UTIs.  R16 lacked consist urinary tract infection treatment and lacked to the same part of the consist urinary tract infection treatment and lacked treatment and lacked to the consist urinary tract infection treatment and lacked treatment and la	and bladder signal assistance with assistance with a (urge and stress id not assess R3 JTIs.  d 11/3/14 was recording a plan identified Fider. The care plan identification of the care ement.  5/1/14 according a plan identification of the care ement.  5/1/14 according a plan identification of the care ement.  5/1/14 was review and cognitive imparts the care ement.  5/1/14 was review and cognitive imparts the care plan identification of the prior to initiation in prior to initiation in the care initiation of the care initiation of the prior to initiation of the care initiation	y incontinent, a toileting use, as) 87's risk eviewed. The dmitted to 137 as at time an directed ted 8/1/14 but ation and identification sessment to UTIs, and plan to 15 at included tion, dysuria eved. The MDS airment, was airment, was airment as was continent leting but did ave a problem out the zing the risk of symptoms of on of				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 24 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00125		B. WING		02/:	20/2015
NAME OF	PROVIDER OR SUPPLIER	Sī	TREET ADDRESS, CITY, S	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAF	RE CENTER 8	15 MAIN AVENUE SC	DUTH		
GONDE	ISENTIANIMONT CAI	H H	ARMONY, MN 55939	9		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	prophylactic antibio R16 was admitted a listed on the admiss psychosis, anxiety, proteinuria, and pal The infection controurinary tract infectio 7/31/14 and 10/24/10 noted R16 started proteinuria. Event rep. 1) 8/14/14 for UTI behaviors, and flan 2) 10/22/14 for UT R16 's care plan darequired assistance transfer, and assist restorative nursing exercise, The care 11/7/13 which read infection related to interventions noted antibiotics, educate encourage fluids, e and provide perical The quarterly MDS had a BIMS score of impairment, had no extensive assistance received an antibiotic The facility Observation dated observation indicate condition, urinary in required extensive had mixed form of it evaluate/assess R1 reversible factors to developing UTIs or The physician orde	tic. 3/17/13 and had diagnosion sheet of diabetes, urinary incontinence, liative care. of reports listed R16 as ons on 3/11/14, 4/11/14, 14. The February 2014 prophylactic antibiotics forts included:  Symptoms of frequent pain were listed. I ated 12/12/14 indicated with toileting (E-Z stantilet with personal hygiene) for urinary incontinence plan had a problem day, "At risk for urinary trapast history of UTI." The to administer prophylactics staff on proper hygiene incourage bladder empting to staff on proper hygiene incourage bladder empting incourage incoura	having log 5/18/13 cy, R16 d for had ated ct e ctic e tired t days. wel The of bit dent t t ls or			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 25 of 64

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
	00125				02/20/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AN		STATE, ZIP CODE			
NAIVIL OI	THOUBER ON 301 TEIER		AVENUE SC				
GUNDER	RSEN HARMONY CAF	RE CENTER	Y, MN 55939				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 910	Continued From pa	ge 25	2 910				
	day with a day of 4/11/13 and discontinue date of 1/17/15. R16 had a physician 's order for ceftriaxone twice a day with a start date of 3/18/13 and a discontinue date of 1/17/15. On 11/20/14 the physician order Cephalexin daily and stop until Cipro complete. 12/30/13 the physician noted Cipro daily, hold Bactrim while on Cipro then resume.  During an interview on 2/19/15 at 2:36 p.m. with RN-C/infection control director state R16 was on a prophylactic antibiotic off and hoping it would stop the UTIs. RN-C stated she did not know the cause of the infections but would identify that if R16 started to self-transfer she would have an infection. R16 was on hospice at this time and had since died.						
	R15 experienced recurrent UTIs (3 in 3 months) but lacked an assessment of UTI risk and revision of care plan to minimize the risk of recurrent UTIs. R15 was admitted to the facility on 1/15/13 and the admission record listed diagnoses that included neurogenic bladder, urinary tract infection, urine retention, urinary frequency. Event report dated 8/4/14 identified a UTI. The culture was completed, but no organisms identified and symptoms related to behaviors, lethargy, and urine changes were listed. Event report dated 11/9/14 indicated a UTI, that was cultured and the organisms were list, and symptoms of lethargy, decreased intake, blood in urine and cloudy urine were noted. Event report dated 12/4/14 indicated R15 had a UTI that was cultured and the organism was listed and symptoms of low grade temp, decreased appetite, and malaise were listed. The quarterly MDS dated 1/7/15 indicated R15 had impaired cognitive/memory, required extensive assistants with activities of daily living.						

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 26 of 64

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` '	E CONSTRUCTION		SURVEY PLETED
				A. BUILDING:			
		00125		B. WING		02/	20/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEI	RSEN HARMONY CAF	RE CENTER		AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	had an indwelling obladder and had not an indwelling obladder and had not a the observation recatheter and frequents are sident had an indincontinent of bowers assess the resident tract infections.  The care plan date had been admitted noted C15 required and hygiene. The condwelling Foley can identify UTIs, but dominimize the risk of minimize the risk of the condition of synthesis and incontinent admission dysuria (painful urinurinary tract infection diarrhea, neurogen kidney disease. The quarterly MDS R32 had a BIMS (bwas 9 or moderate extensive assistance incontinent, had a rexperienced a UTI Event report dated cultured, but no organd symptoms of a 8/15/14 for UTI individid not list organism.	atheter, had a neuro of UTIs past 30 days. port/evaluation for incently incontinent of bowed. The report indivelling catheter and el daily. The report dit is risk of developing to hospice. The care to hospice. The care plan identified artheter and intervention of a UTIs.  UTIs in 5 months burptoms of a UTI, lackrisk with recurrent U	dwelling owel dated cated the was do not gurinary  wed. R15 e plan toileting ons to ontions to ontions to ontions to and the ses as arge, ation, or onic reviewed. It lastatus) do days. If				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 27 of 64

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/S IDENTIFICATI	UPPLIER/CLIA ON NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125		B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAF	RE CENTER		AVENUE SC Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	Continued From pareport listed a UTI Escherichia coli (co as the organism. Ninfection control log 11/26/14 with E-col symptoms were list. The observation refor quarterly bowel was occasionally in past assessment pincontinent, was inextensive assistant mixed (urge and stinclude an assessmuTIs. The care plan date interventions of nextransfer R32 to tolk medical diagnosis but did not list interrisk of developing r R23 received proplan assessment for clinical rationale for prophylactic antibio R23 was admitted found on the reside also listed diagnosidisease, urinary traneurogenic bladder The quarterly MDS cognitive impairmeneurogenic bladder atheter into bladder Review of the clini experienced a UTI but had not experiemenths. Physician orders divas reviewed. The	for R21 on 10/2 ommonly abbrevalo symptoms were listed a UTI for it as the organisated. port/evaluation and bladder incontinent of bladeriod but currence with toileting, ress) incontinent of R32's risted to use mechal etc. The care plate that include renaventions to help ecurrent UTIs. Involved a UTIs and a the continued of the	viated E. coli) ere listed. The r R32 on m and no  dated 8/21/14 licated R32 dder during the attly frequently vel, required experienced ace, but did not sk to develop  fied anical lift to an listed a al insufficiency, minimize the cs but lacked d lacked a use of the  6/14/14 as ecord which age IV kidney betes, ndicated no t 30 days, a y (Suprapubic cated R23 had May of 2014, he past 6  ough 2/15/15	2 910			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 28 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00405	B. WING		22.5	
		00125			02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER		N AVENUE SO	STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAF	RE CENTER	IY, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	trimethoprim an anneurogenic bladder identified the trimet antibiotic for UTIs. for June 18, 2014 the R23 had a suprapuretention. The urol clinical rationale for antibiotics.  The observation rechange bowel and the use of an indwer extensive assist for identification of use risk for developing. The care plan date care plan listed a properties and supra pubic callisted the use of profintervention to charmonthly, and to repuring an interview stated R23 had not months and was the prophylactic antibiotom R33's admission readmitted on 7/12/20 included but were readmitted on the readmitt	tibiotic on 8/22/13 for r. The infection control log hoprim as a prophylactic Review of the urology notes hrough July 23, 2014, noted bic catheter related to urinary ogy notes did not identify a rithe use of prophylactic port/evaluation for significant bladder dated 5/6/14 indicated elling catheter, required ritiliting, but lacked of prophylactic antibiotics and UTIs. d 1/26/15 was reviewed. The roblem of urinary incontinence theter. The interventions ophylactic antibiotic, age indwelling catheter fort signs of UTI. If on 2/19/15 at 2:30 p.m. RN-C and a UTI during past 6 e only resident still receiving a stic in the facility.				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 29 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00125		B. WING		02/	20/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEI	RSEN HARMONY CAF	RE CENTER		AVENUE SC Y, MN 55939	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE / MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From parassistance to toilet.  R33's medical recofailed to complete a assessment for R3 dated 11/26/14 sho incontinence.  R33's care plan pro 6/27/14 indicated the continent of bowel/1 contact the provide incontinence if she The care plan goal continent of bladde not include specific normal bladder functioner of the too program bladder function or the bathroo program. RN-B stated R33 let to go to the bathroo program. RN-B ver assess R33's toiletidecline in incontine function or to maint  On 2/19/15 at 2:58 (DON) stated when assessment identification in incontine function or the charcare plan should had change in incontine DON verified a compassessment should to help restore and	rd review reveal a comprehensive 3 when the quarwed a decline in oblem for toileting at R33 was gent oladder, and directly a comprehensive decline in iteration or further lost of the quarterly Market and bowel. However, to restore a decline in iteration or further lost of the facility of the facility of the facility of the grant mand was not a staff know when and was not a staff know when a staff kn	e bladder terly MDS bladder  g dated lerally ected staff to lible causes of y incontinence. emain wever it did promote loss of bladder  d nurse (RN)-B incontinence essment. en she needed on a toileting did not fully ent further optimal bladder der function.  r of nursing DS h bladder ould have mine the ice and the d to reflect the g needs. The dder upleted for R33	2 910			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 30 of 64

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00125	B. WING		02/2	20/2015
	PROVIDER OR SUPPLIER	RE CENTER 815 MAIN	DRESS, CITY, S AVENUE SC Y, MN 5593	· -		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910 2 915	function and prever incontinence.  A bladder assessm not provided by the SUGGESTED MET The director or nurs and bladder assess review identification urinary tract infection treatment, and educand revising the plat of UTI's.  TIME PERIOD FOR (21) days.	nt further decline in bladder ent policy was requested, but	2 910			3/31/15
	comprehensive res home must ensure A. a resident is treatments and sen abilities in activities deterioration is a not the resident's condipart, activities of da resident's ability to:  (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the as, and groom; d ambulate;				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICATI	UPPLIER/CLIA ON NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SU COMPLE	
		00125		B. WING		02/2	0/2015
	PROVIDER OR SUPPLIER	RE CENTER	815 MAIN	DRESS, CITY, S AVENUE SC Y, MN 5593			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 31		2 915			
	This MN Requirements: Based on observation review, the facility of care and services of maintain or improved. Findings include: R21 was identified change Minimum Dassessment dated intact, transfers, was self-performance was support was one perform support was one perform support was corridor support was corridor support was corridor support was leading to balance during transmittenacy but able to assistance, no impain range of motion of and received physical 1/5/15.	ion, interview, a ailed to provide or 1 of 1 resider or 2 ability to ambure by the facility or 2 ata Set (MDS), 1/7/15, to have alk in room and as supervision; erson physical as set up help only is no set up help falls since last a sitions and wall o stabilize without of upper and love	nd document the necessary nt (R21) to help ulate.  In the significant an cognition walk in corridor transfer assist, walk in and walk in or physical assessment, king was but human ional limitation wer extremity,		Corrected		
	Document review of dated 1/20/15, reverse recent falls without problems. R21 was vision, walks with a	ealed falls trigge injury and some s hard of hearin	red due to e balance g, had poor				
	Document review of 1/19-2/19/15, reveal ambulate independ wheel walker, and fonce a day Monday	lled the followin ently in room ar alls and balanc	g orders: may nd halls with 4 e program				
	During observation	s on 2/17/15, at	2:00 p.m.,				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 32 of 64

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	OL/L	.0/2010
	RSEN HARMONY CAF	RE CENTER 815 MAIN	AVENUE SC Y, MN 5593	DUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 32	2 915			
	time, R21 transferre wheeled out of the	cliner with feet up. At that ed by self to wheelchair and room to church service.				
	problem of at risk for Approaches dated with R21 to and frow alker, lower extremexercises-marches 15 times each once standing exercises heel raises 15 time Approaches dated and balance programorning and goal wa week; restorator of the standing exercises heel raises 15 time Approaches dated and balance programorning and goal wa week; restorator of the standing exercises.	kicks, knee bends, toe taps a day; lower extremity marches, squats, sidekicks, seach once a day.  8/1/14, included: invite to falls meled by activity staff once a vas R21 to attend three times or recumbent bike 10-15 program will be reviewed				
	problem of at risk for sight and variable to 8/1/14, included: ac walker with ambula	red 5/31/12 identified a por falling related to poor eye palance. Approaches dated diminister medication, use tion, encourage participating approgram, keep items within the pom free of clutter.				
	revealed no falls in 1/2015. The following two far Document review of 2/14/15, revealed Fand got up on her of was within reach. The seen by a provider symptoms and cours R21 to use call light.	f past three months of falls 12/2014, and no falls in alls occurred in 2/2015: If the event report dated 321 stated had fall in bathroom own, c/o back pain, and call lite the report identified R21 was on 2/13/15 for respiratory gh. Interventions were to ask tor wait for assist.				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 33 of 64

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY IPLETED
		00125		B. WING		02	/20/2015
	PROVIDER OR SUPPLIER	E CENTER	815 MAIN	DRESS, CITY, S AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG		TEMENT OF DEFICII 'MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From particles and ambulation. Threquires skilled phystrengthening, bala in order to regain potential with long t goal: ambulates 40 even surfaces requ Goal: will ambulate walker on even surfaces required for 1/5/15 for 4 weeks.	f event report do on floor in front e her bedside tak, denied pain, cough, was seen after fall on 2/ss and started of do use the calted and made of the defendent of the completion and transfers ago which hent now requiring the completion nerapy necessity sical therapy at noe training, gainer level of function e with patient at erm plan in place with patient at erm plan in place feet with 4 whe iring contact gual 100 feet safely faces with superional level. Longy ambulate with patient of care in order to an Plan of care in to 2/1/15, for 3	ated 2/18/15, of roommates able. R21 lung sounds n on 2/13/15 18/15 for on antibiotic. I light. R21 wn decisions. Py plan of care edate of sents with a due to recenting a decline has since g significantly of transfers y: R21 this time for it and transfer tion. Physical maximum se. Short term eled walker on ard assistance. with 4 wheeled rvision in order g term goal: use of her 4 lity with return to her was signed by times a week				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 34 of 64

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915	treatment notes revi 1/16/15, revealed F ambulation today a getting stronger. 1/23/15, R21 ambu walker and contact demonstrated imprindependence with 1/30/15, R21 reque physical therapy du R21 agreed to restowith staff. Ambulat completed.  R21 received 12 phexercises and amb 1/30/15.  Document review of and discharge sum analysis of function made significant program directed by the program directed by Document review of Program dated 1/30 exercises:  Lower extremity sea 2# 15 times, kicks with blue band 15 times, with R21 to/from all	realed the following: R21 was proud of her and reports she can tell she is lated 320 feet with 4 wheeled guard assistance. R21 oved ambulation distance and mobility. sted to discharge from e to legs hurt after therapy. orative therapy and ambulating ion and restorative program  rysical therapy visits for ulation between 1/5/15 and  of physical therapy progress mary dated 1/30/15, revealed al outcome included R21 ogress towards physical will continue to address h a functional maintenance y facility staff.  of Physical Therapy Restorative 0/15, revealed the following  ated exercises: marches with with 2# 15 times, knee bends imes, toe taps 30 times, ball	2 915			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 35 of 64

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
			A. BUILDING	:		
		00125	B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAF	RECENTER	MAIN AVENUE S MONY, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 915	wheelchair due to contact guard assishallway. Please ha 5-7 days per week participate. Please department with an Document review of sheet dated 2/1/15 following: Falls and balance, attend three times a session out of 19 d Restorator or recurday, Sunday through minutes, R21 refus 1 session out of 19 Falls and balance of Friday, R21 attended During interview on registered nurse (Ratherapy recomment were not part of the sheet. RN-B verified directed restorative provided. RN-B st program was on the actually the same pure whenever they can received the falls at bike exercise one so verified R21 had not been adder RN-B stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective to the same pure stated the fact who assisted with respective the same pure stated the fact who assisted with respective to the same pure stated the same p	dizziness. R21 is to have stance with all ambulation in the R21 perform all exercise as tolerates and is willing to contact physical therapy y questions or concerns. If restorative nursing flow to 2/19/15, revealed the invite once a morning, will a week, R21 attended 1 ays; inbent bike 10-15 minutes and Saturday, goal to pedal and the set two sessions and attended the stance of two sessions and attended the stance of two sessions and attended the stance of the	es o o o o o o o o o o o o o o o o o o o			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 36 of 64

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
00125 B. WING		
00123		02/20/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST  815 MAIN AVENUE SOL	•	
GUNDERSEN HARMONY CARE CENTER HARMONY, MN 55939		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE COMPLETE
2 915  Continued From page 36  nursing assistant (NA)-C (NA-C) stated she provided lower extremity exercise bike for 10 minutes whenever R21 would go to the exercise room. NA-C verified not aware of the physical therapy recommended restorative program exercises. NA-C stated restorative aides frequently have to work on the floor and the restorative exercises do not get done.  During interview on 2/19/15, at 12:35 p.m., PTA-C stated had completed the monthly physical therapy evaluation at that time. She stated the evaluation included a review of nurse 's notes and talked with nursing assistants. PTA-C verified the evaluation did not include exercises or ambulation. PTA-C stated R21 needed more help to get dressed which was progressively worse with most recent illness, increased dizziness and unsteadiness, refused to use call light, and was self- transferring despite education to use call light. PTA-C stated, based on the evaluation, R21 had declined since discharge from therapy on 1/30/15. Surveyor requested PTA-C attempt to ambulate R 21 that day.  During interview on 2/19/15, at 12:50 p.m., director of nursing stated the facility had been short staffed and they have rescheduled restorative aides to work on the floor. Director of nursing verified the facility had no plan in place to provide restorative herapy exercises when restorative aides were rescheduled to work the floor.  During interview on 2/19/15, at 3:10 p.m., RN-B stated R21 had declined due to influenza in 12/2015 and worsening eye sight. RN-B stated R21 requested to discharge from physical therapy 1/30/15, because she did not like therapy and did not want to continue. RN-B verified R21 had		

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 37 of 64

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00125		B. WING		02/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAR	RE CENTER		AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 915	declined as she no SUGGESTED MET The DON or design as necessary the peregarding the need rehabilitative service could provide training these policies and peregarding to assure a adequate and approximately the period of the per	Ionger walked a longer walked	RRECTION: riew and revise redures with restorative or designee (s) priate staff on importance of nee (s) could receiving  N: Twenty-one	2 915			0/04/45
2 920	MN Rule 4658.0528 Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liviservices to maintain and personal and of this MN Requirements.  This MN Requirements with the facility for 3 residents (R24 dependent of staff the living (ADL).  Findings included: R24 on 2/17/15, at 12:46 p.m. and at 6 have long facial hai	of daily living. Ident assessment is unable to caing receives the good nutrition ral hygiene.  ent is not met a con, interview, a cailed to provide, R23 and R56) to meet their accomment is a	Based on the ent, a nursing arry out enecessary, grooming, as evidenced and document services for 3 who were tivities of daily  on 2/18/15, at bserved to	2 920	Corrected		3/31/15

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 38 of 64

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	0/2015
NAME OF I	PROVIDER OR SUPPLIER		ORESS CITY S	STATE, ZIP CODE		
		815 MAIN	AVENUE SC			
GUNDER	RSEN HARMONY CAF	RE CENTER	Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 38	2 920			
	R24's quarterly MD diagnoses of deme assessment indicatimpairment with a E (BIMS) score of 6. required extensive perform ADLs inclu R24's care plan proread, "ADL: dressin requires set up and for thoroughness to R24 with personal I offered assist with shath day. Family hat to bring in an electrindicated bath day During an interview registered nurse (R bath and R24's faciremoved.	S dated 11/26/14 included ntia and anxiety disorder. The ed severe cognitive Brief Interview of Mental Status The MDS also indicated R24 assist of one staff member to ding hygiene. Evided by the facility on 2/19/15 ag, sponge bath, grooming: moderate-max assist/check vice a day AM and PM. Assist hygiene. R24 would like to be shaving chin hair weekly on as been notified that they need ic razor." The care plan				
	stated she had not did not wish for it to removed. During an interview nursing assistant (Nacial hair. A policy on shaving was requested and facility. On 2/18/15,	been aware of the facial hair, be there, and wanted it on 2/18/15, at 6:40 p.m., NA)-A confirmed R24 had female resident's facial hair was not provided by the at 7:50 p.m. the DON stated ave a policy related to female				
	facial hair. R23 on 2/18/15, at have very long fingunderneath nails ar showed broken jag R23's quarterly MD diagnoses of periph mellitus, and open-	12:27 p.m. was observed to er nails with light brown debris and at least one of ten nails				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 39 of 64

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA ION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00125		B. WING		02/	20/2015
	PROVIDER OR SUPPLIER	RE CENTER	815 MAIN	DRESS, CITY, S AVENUE SC Y, MN 5593			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	with a Brief Intervie score of 15. The Mirequired extensive ADLs including hyg R23's care plan prorelated to groomingas needed for dretransfers and toileti as able-but needs sthoroughness. " Cawere on Tuesday a did not address how often, or by who na During an interview RN-B stated diabet a nurse on bath day During an interview director of nursing (was not specifically was the person that finger nails. DON a care planned.  R56 was identified one staff for activitic document review of 2/7/15, 2/12/15, and R56 was admitted the according to review sheet.  During observations 2/18/15, at 6:00 p.n. R56 was observed.  Document review of not dated, directed hair and nail care beneded.	w of Mental Sta DS also indicat assist from sta- iene. ovided by the fa- and hygiene re- essing, persona- ng. Encourage supervision and are plan indicat nd Thursday. If w nail care was il care should be on 2/18/15, at ic nail care was ys. on 2/19/15, at (DON) explained to gave the bath lso stated nail of the facility are es of daily living facility progresed 2/17/15. To the facility or of R56's medi	red R23 ff to perform  acility on 2/19/15 ead, "Assist al hygiene, independence d checks for ed bath days R23's care plan provided, how be provided by. 5:54 p.m. s performed by  10:38 a.m., ed if nail care the expectation would check care should be  s dependent on g, according to ss notes dated  12/4/15, cal record face  t 3:19 p.m., , at 7:40 p.m., hairs.  In plan of care, for chin hairs,	2 920			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 40 of 64

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUNDER	SEN HARMONY CAR	RE CENTER	AVENUE SO Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRES (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 920	Continued From page 40		2 920			
	start date of 2/9/15, with grooming and During interview on verified R56 long chresident's facial hai	f facility resident profile with directed staff to assist R56 hygiene as needed.  2/18/15, at 7:40 p.m., RN-A nin hairs. RN-A stated female r was shaved on the day shift. did not shave own facial hair.				
		2/18/15, at 7:45 p.m., NA-A ents' facial hair was shaved in				
	During interview on 2/18/15, at 7:50 p.m., director of nursing stated she expected female facial hair was shaved on bath day and offered as needed. She stated the facility did not have a policy for shaving facial hair.					
	director of nursing of policies and proced receive assistance determined necess of care. The director could educate all appolicies and proced or her designee could educate could educate all appolicies and procede or her designee could educate all appolicies and procede or her designee could educate all appolicies and procede or her designee could educate all appolicies and procede or her designee could educate all appolicies and procede or her designee could educate all appolicies and procede or her designee could educate all appolicies and procede or her designee could educate all appolicies and procede or her designees and procede or her design	THOD OF CORRECTION: The or her designee could develop lures to ensure residents with activities of daily living as ary by their individualized plan or of nursing or her designee opropriate staff on these lures. The director of nursing all develop monitoring ongoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			3/31/15
		on control program. A nursing sh and maintain an infection				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 41 of 64

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7 IVD I EXIIV	OF COTTLECTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
		00125	B. WING	****	02/2	0/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE
21375	This MN Requirements: Based on observation review the facility facontrol program that and trends, to identifications and monithe spread of infect all residents in the life Findings include: Lack of analyzing in appropriate and time the spread of infect The infection control through January 20 reviewed. The log name, onset date, so culture and x-ray daused, date resolved infection. Review of cultures were not condetermine the causinfection/s (UTI) pri X-rays were not condetermine pneumon logs did not indicate facility or any timely to assist the resident of minimize the spread of not indicate and appropriate and appropriate and timely to assist the resident of the prediction of the spread of the prediction of the spread o	signed to provide a safe and nt.  ent is not met as evidenced on, interview and record alled to maintain an infection at analyzed infection patterns ifying recurrent urinary tract attoring of symptoms to prevent ion. This practice could affect nome.	21375	Corrected		
	the analysis of the orequested. The facility policy In	data was provided when  fection-Clinical Protocol dated wed. The policy directed: A				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 42 of 64

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	log of facility infection and reported at quaretings. This log infections and the towill be reviewed for Registered nurse (If the infection control log employee illness as indicated she would infections during the the end of the monwritten report or an would discuss the imeetings. She would areas of the nursing but would just keep RN-C stated she wnumbers to the Quadiscuss what she "Inot reproducible. Recurrent Infection for July 2014 throug reviewed. In July 2 urinary tract infection for July 2014 throug reviewed. In July 2 urinary tract infection antibiotics, but orgation consistently identified antibiotics, and in Decentidentified. The infection control R16, although on p (4) recurrent UTIs for 2014. R23 although and two (2) recurrent at two (2) UTIs id	ge 42 ons being treated will be kept arterly Quality Improvement will include the type of reatment provided. The log any patterns within the facility. RN)-C, who was appointed as I director was interviewed on an RN-C stated she kept the is and would keep track of swell as resident illness. She is keep a working log of the month and then recopy at the RN-C said she did not do a alyze the data or trend. She infections at the morning and look at the cultures and ghome that infections occur, the information in her head. The information of ality Improvement meeting and had in her head. Which was seen the log identified three (3) ons (UTI) treated with anisms cultured were not ead on the log. In August 2014 and UTI treated with antibiotics, In October 2014 three (3) d. In November 2014, four (4) on the recommendation of the logs for 2014 were reviewed.	21375			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 43 of 64

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER    SIMMARY STATEMENT OF DEFICIENCIES   15 MAIN AVENUE SOUTH HARMONY, MN 55939	-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPI IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
MAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  TAG  21375  Continued From page 43  identified during December 2014 and January 2015. R37 had three (3) UTIs identified during January through December 2014 R32 had two (2) UTIs identified during August through October 2014.  The Infections-Clinical Protocol dated 10/20/14 noted that changes in the resident's mental or physical status that could indicate a possible infections were to be documented and the charge nurse was to perform an additional assessment prior to notifying the physician. The Protocol directed the symptoms would include fever, changes in urine appearance, complaints of dysuria (frequency) or behavioral changes. If a urinary tract infection was suspected a urinarylsis was advisable. The Protocol stated staff would provide supportive measures to assist the resident in managing the infection. The Protocol did not direct staff related to recurrent infections or need for re-assessments to determine potential reversible causes. RN-C was interviewed on 2/19/15 at 2.30 p.m. RN-C stated she had not developed any infection control policies. She stated that she was aware that some residents had recurrent UTIs. RN-C stated she would like nursing to document signs and symptoms of infection, but that did not always happen. Nursing staff would contact the clinic, but not always document the symptoms. RN-C stated that she and RN-B were responsible to complete the infection event reports. She stated that she was aware that some residents had recurrent UTIs. RN-C state she would look back at the logs to see if any recurrent UTIs.			00125		B. WING		02/	20/2015
CANDERSEN HARMONY CARE CENTER   S15 MAIN AVENUE SOUTH HARMONY, NN 55939	NAME OF		00.20	0.7.0.5.7.4.0		7175 710 0005		20,2010
X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PRIOVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERBNCED TO THE APPROPRIATE DATE DEFICIENCY MUST BE PRECEDED BY PULL FROULATORY OR LSC (DENTEYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REPERBNCED TO THE APPROPRIATE DATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REPERBNCED TO THE APPROPRIATE DATE DATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REPERBNCED TO THE APPROPRIATE DATE DATE DATE DATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REPERBNCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D	NAME OF	PROVIDER OR SUPPLIER						
IXA-ID   SUMMARY STATEMENT OF DEFICIENCIES   PRETX   DECOMPORT OF LOCATION SHOULD BE   CROWN DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PRETX   TAG   TAG CHOOPAGE ACTION SHOULD BE   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY)   COMPLETE   DATE	GUNDER	RSEN HARMONY CAF	RE CENTER					
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  21375  Continued From page 43  identified during December 2014 and January 2015. R37 had three (3) UTIs identified during January through December 2014 R32 had two (2) UTIs identified during Aguat through December 2014 R32 had two (2) UTIs identified during Aguat through December 2014. The Infections-Clinical Protocol dated 10/20/14 noted that changes in the resident's mental or physical status that could indicate a possible infections were to be documented and the charge nurse was to perform an additional assessment prior to notifying the physician. The Protocol directed the symptoms would include fever, changes in urine appearance, complaints of dysuria (frequency) or behavioral changes. If a urinary tract infection was suspected a urinalysis was advisable. The Protocol stated staff would provide supportive measures to assist the resident in managing the infection. The Protocol did not direct staff related to recurrent infections or need for re-assessments to determine potential reversible causes. RN-C was interviewed on 2/19/15 at 2.30 p.m. RN-C stated she had not developed any infection control policies. She stated that she was aware that some residents had recurrent UTIs. RN-C stated she would like nursing to document signs and symptoms of infection, but that did not always happen. Nursing staff would contact the clinic, but not always document the symptoms. RN-C stated that she was aware that some residents had recurrent UTIs. RN-C stated that she was aware that some residents had recurrent UTIs. RN-C stated that she was aware that some residents had recurrent UTIs. RN-C state the infection event reports. She stated that she was aware that some residents had recurrent UTIs.		T			Y, WIN 5593			
identified during December 2014 and January 2015. R37 had three (3) UTIs identified during January through December 2014 R32 had two (2) UTIs identified during August through October 2014.  The Infections-Clinical Protocol dated 10/20/14 noted that changes in the resident's mental or physical status that could indicate a possible infections were to be documented and the charge nurse was to perform an additional assessment prior to notifying the physician. The Protocol directed the symptoms would include fever, changes in urine appearance, complaints of dysuria (frequency) or behavioral changes. If a urinary tract infection was suspected a urinalysis was advisable. The Protocol stated staff would provide supportive measures to assist the resident in managing the infection. The Protocol did not direct staff related to recurrent infections or need for re-assessments to determine potential reversible causes.  RN-C stated she had not developed any infection control policies. She stated that she was aware that some residents had recurrent UTIs. RN-C stated she would like nursing to document signs and symptoms of infection, but that did not always happen. Nursing staff would contact the clinic, but not always document the symptoms.  RN-C stated that she and RN-B were responsible to complete the infection event reports. She stated that she was aware that some residents had recurrent UTIs. RN-C stated she would look back at the logs to see if any recurrent UTIs.	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED	BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE
2015. R37 had three (3) UTIs identified during January through December 2014 R32 had two (2) UTIs identified during August through October 2014.  The Infections-Clinical Protocol dated 10/20/14 noted that changes in the resident's mental or physical status that could indicate a possible infections were to be documented and the charge nurse was to perform an additional assessment prior to notifying the physician. The Protocol directed the symptoms would include fever, changes in urine appearance, complaints of dysuria (frequency) or behavioral changes. If a urinary tract infection was suspected a urinalysis was advisable. The Protocol stated staff would provide supportive measures to assist the resident in managing the infection. The Protocol did not direct staff related to recurrent infections or need for re-assessments to determine potential reversible causes. RN-C was interviewed on 2/19/15 at 2.30 p.m. RN-C stated she had not developed any infection control policies. She stated that she was aware that some residents had recurrent UTIs. RN-C stated she would like nursing to document signs and symptoms of infection, but that did not always happen. Nursing staff would contact the clinic, but not always document the symptoms. RN-C stated that she and RN-B were responsible to complete the infection event reports. She stated that she was aware that some residents had recurrent UTIs. RN-C states she would look back at the logs to see if any recurrent UTIs.	21375	Continued From pa	ge 43		21375			
Lack of infection management for influenza season and pneumonia: Review of the infection control log for December 2014 and January 2015 indicated one resident R18 had been diagnosed with influenza. One other resident was identified		identified during De 2015. R37 had through De UTIs identified during 2014.  The Infections-Clininoted that changes physical status that infections were to be nurse was to perforprior to notifying the directed the symptochanges in urine and dysuria (frequency) urinary tract infection was advisable. The provide supportive resident in managing did not direct staff or need for re-asse potential reversible RN-C was interview RN-C stated she had control policies. So that some residents stated she would like and symptoms of in always happen. Not clinic, but not alway RN-C stated that she was had recurrent UTIs back at the logs to Lack of infection meason and pneum control log for Deceindicated one residence.	ecember 2014 and see (3) UTIs identified and August through it in the resident's recould indicate a property of the could include the protocol stated on was suspected to protocol stated measures to assist the infection. The lated to recurrent saments to determine the course of th	ied during 2 had two (2) 3 October d 10/20/14 mental or cossible d the charge ssessment Protocol efever, aints of inges. If a a urinalysis staff would at the The Protocol t infections nine 2.30 p.m. any infection was aware FIS. RN-C ment signs id not contact the ymptoms. e responsible ts. She residents would look at UTIs. luenza the infection anuary 2015 diagnosed				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 44 of 64

STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
1		00125	B. WING		n2/2	0/2015
NAME OF F				DIATE ZID CODE	02/2	.0/2013
NAIVIE OF F	PROVIDER OR SUPPLIER		AVENUE SC	STATE, ZIP CODE		
GUNDER	SEN HARMONY CAF	RE CENTER	Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	respiratory infection respiratory infection antibiotics or not we trends had been do facility had any other influenza among the influenza among the Infections-Clinic directed staff to do include fever, changed suspected then a protocol directed if test as ordered by the On 2/19/15 at 11:00 (DON) verified the fit that the physicians house prophylactic The DON stated the listing of residents and during this time per SUGGESTED MET The director of nursemployees responsing program to include interventions to pre Also the administration policies to ensure a resident equipment.	nonia. No other residents with as or symptoms of possible as whether treated with are identified. No analysis or cumented to determine if the er respiratory illness or eresidents or staff. cal Protocol dated 10/20/14 cument the symptoms that ges in urine appearance, or as. If pneumonia was ulse oximetry may be as possibly a chest x-ray. The influenza was suspected, then he physician, a.m. the director of nursing facility had had influenza, but had decided not to do a full treatment of other residents. At to her knowledge no line with respiratory symptoms iod had been kept. THOD OF CORRECTION: sing could in-service sible for infection control tracking, evaluating, vent the spread of infection. tor or designee could develop clean environment and	21375			
21530	A. The drug regim reviewed at least m	O A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist y the Board of Pharmacy.	21530			3/31/15

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 45 of 64

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00125		B. WING	····	02/	20/2015
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CHNDE	RSEN HARMONY CAR	PE CENTER	815 MAIN	AVENUE SO	DUTH		
GUNDER	SENTIANWONT CAN	IE GENTEN	HARMON	Y, MN 5593	9		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is incavailable through the system. It is not sure B. The pharma irregularities to the and the attending properties of the and the attending properties. For purpon means the acreport and the signification of nursing services. C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely affer fer the matter to the attending physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070, the medical direct must refer the matter assessment and as sessment and a	e done in accordance at the Operations Makes for Pharmaceutical ang-Term Care, publicated by reference Minitex interlibrary bject to frequent character and these in by the time of the report, if indicated by proses of this part, occeptance or rejection or initialing by the and the attending plant in the pharmacist in the resident's qualities the resident's qualities the medical director for is not the attending plant in the attending edical director determined and the attending plant in the attending edical director determined and the attending edical director determined and the attending edical director determined and if the attending the order, the review to the qualities are committeed in the attending physic, the consulting pharmace committeed as a committeed as a committeed and in the attending physic, the consulting pharmace committeed as a com	nual, al Service lished by Services, April 1992. nce. It is y loan ange. ervices reports next of the elacted on of the e	21530			
	by:	ent is not met as ev ensure the consulta			Corrected		

Minnesota Department of Health STATE FORM

TATE FORM 6899 HUFX11 If continuation sheet 46 of 64

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SU			E CONSTRUCTION	(X3) DATE COMP	SURVEY
				A. BUILDING.			
		00125		B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAF	RE CENTER		AVENUE SO Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICION Y MUST BE PRECEDION SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21530	Continued From participations of the last year to ensure prescribed medicat prescribed medicat prescribed medicat prescribed medication of the last year.  R24's care plan incanative yamptoms in order Lorazepam. No cle administer medication of the continue of the last year to ensure prescribed medication of the last year.  R24's care plan incanative yamptoms to assist yamptoms in order Lorazepam. No cleadminister medicatifications are prescribed medicated and the last year.	ed and reported of 7 residents (Riessary medication admitted to the fit of acility's "Resimum Data Set uded diagnoses eart failure, hypere assessment in the with a Brief In (IS) score of 6. (Indersidentified a day as needed three times a faily, Lopressor medication) 50 medication lab medication lab medication lab medication lab medication lab medication lab medication and/or contitions.  If on 2/19/15, directions and been correlated R24 had sion. The care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and depression to administer as ar direction on warding the care plant and the care plant a	24 and R21) ons.  facility on ident  (MDS) dated of dementia, extension, and dicated severe atterview of on physician pril (lipid lower ly, Lorazepam d for anxiety day, Zaroxolyn mg daily, and mg daily, and mg daily, onitoring ted during these of tinued need of extern of extension mpleted during a diagnosis of plan identified mg associated failed to target is needed when to	21530			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 47 of 64

Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	R24's medication a February 2015 indice was administered for that included: "Abdowith uneasiness, was something in throat and repetitive use of According to the February 2016 and repetitive use of According to the February and interview licensed practical in were not any specific Lorazepam.  During an interview registered nurse (Radministered after litried.  During an interview consulting pharmac missed issuing a relaboratory monitorin needed Lorazepam pharmacist indicates specific resident be parameters for use  R21 had diagnosis according to facility 12/25/10.  R21 was identified Minimum Data Set 1/7/15, to have cog 15 including mood depressed, trouble feel bad about self, antianxiety medicated Document review of the self-parameters for use for the self-	dministration record (MAR) for cated as needed Lorazepam or varied behavioral issues ominal pain, cold symptoms anting to go home, complain of anxiety [undefined], weepy" of call light.  Sebruary 2015 MAR, as needed cially started on 6/17/14  on 2/19/15, at 2:24 p.m.  urse (LPN)-B verified there ic parameters for the use of an 2/19/15, at 2:36 p.m.  N)-B stated Lorazepam was behavioral interventions were an accommendation for medication ong for R24. In relation to as a parameters; consulting and facility had not identified chaviors/mood. Lack of of Ativan:  of anxiety and depression admission record dated  on the significant change (MDS), an assessment dated nition intact, moods score of so of little interest, feeling sleeping, tired, poor appetite, no behaviors, and received	21530			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 48 of 64

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00125	B. WING		02/2	02/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21530	Continued From pa	ge 48	21530				
	0.5 milligrams twice a day as needed for agitation or anxiety, with a start date of 10/20/14.						
	administration histor following as needed -12/31/14-10 times; 2/1/15 -2/18/15-1 til identified as needed	of facility as needed medication by revealed R21 received the d lorazepam: 12/1/14 to g 1/1/15 - 1/31/15-3 times; me. The medication record d lorazepam was administered gitation, anxiety, distressed, st.					
	The facility lacked identification of specific parameters to administer as needed lorazepam.						
	During telephone interview on 2/19/15, at 3:20 p.m., facility consultant pharmacist stated he expected very specific parameters identified for when to use as needed lorazepam.						
	The administrator, of consulting pharmacon policies and procedured medication usage reporting irregularities designee could mo	THOD OF CORRECTION: director of nursing and sist could review and revise lures for proper monitoring of elated to identifying and ies. The director of nursing or nitor medications on a regular mpliance with state and federal					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One					
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			3/31/15	
	must be free from ι	al. A resident's drug regimen unnecessary drugs. An s any drug when used:					

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 49 of 64

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00125	B. WING		02/20/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAR	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the odiscontinued. In addition to the d part 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is included available through the system and the State subject to frequent  This MN Requirement of the American Standard is included use of prediction of the American Standard is included as a subject to frequent of the American Standard is included as a subject to frequent of the American Standard is included as a subject to frequent of the American Standard is included as a subject to frequent of the American Standard Included American I	dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State guidance to Surveyors for licilities, published by the lith and Human Services, ing Administration, April 1992. corporated by reference. It is le Minitex interlibrary loan te Law Library. It is not	21535	Corrected		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 50 of 64 HUFX11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE S	
	00125	B. WING		02/20	0/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
GUNDERSEN HARMONY CARE	CENTER	AVENUE SO Y, MN 55939			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DESIGNATION (CONTROL OF THE PROPERTY OF THE PRO	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
urinary tract infections  R23 received a proph a clinical rationale for medication.  R23 was admitted to resident admission rechronic stage IV kidnominfection, diabetes, not the quarterly Minimu 1/23/15 indicated not UTIs past 30 days, a ostomy (suprapubic oreport/evaluation for subladder dated 5/6/14 indwelling catheter, retoileting, but lacked in prophylactic antibiotic The care plan dated care plan listed a prophylactic antibiotic The care plan dated care plan listed a prophylactic antibiotic The care plan dated care plan listed a prophylactic antibiotic The care plan dated care plan listed a prophylactic antibiotic The care plan dated care plan listed a prophylactic antibiotic The care plan dated care plan listed a prophylactic antibiotic at the clinical experienced a UTI in 2014, but had not expendently bu	actic therapy to prevent s:  hylactic antibiotic but lacked the continued use of the the facility in 6/14/14 and the ecord listed diagnoses as ey disease, urinary tract eurogenic bladder, am Data Set (MDS) dated cognitive impairment, no neurogenic bladder, and an eatheter). The observation significant change bowel and indicated the use of an equired extensive assist for dentification of use of cs.  1/26/15 was reviewed. The blem of urinary incontinence eter. The interventions hylactic antibiotic.  records indicated R23 had April 2014 and in May of perienced a UTI in the past 6 and 1/19/15 through 2/15/15 obysician ordered physician ordered inotic on 8/22/13 for and has continued to receive ever, a physician 's agoing use of a prophylactic ted and none was provided. N) -C who was designated as				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 51 of 64

Minnesota Department of Health

AND PLAN OF CORRECTION    DENTIFICATION NUMBER:   A. BUILDING:   COMPLETED		IT OF DEFICIENCIES		(VO) MULTIPL	F CONSTRUCTION	(VO) DATE	CLIDVEV
NAME OF PROVIDER OR SUPPLIER  GUNDERSEN HARMONY CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  815 MAIN AVENUE SOUTH HARMONY, MN 55939  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY)  21535  Continued From page 51  suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic in the facility. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care. The quarterly MDS dated 12/10/14 noted R16			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  815 MAIN AVENUE SOUTH HARMONY, MN 55939   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21535  Continued From page 51 suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility.  R16 lacked clinical rationale for use of a prophylactic antibiotic to prevent UTIs. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care.  The quarterly MDS dated 12/10/14 noted R16				A. BUILDING:		]	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  815 MAIN AVENUE SOUTH HARMONY, MN 55939   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21535  Continued From page 51 suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility.  R16 lacked clinical rationale for use of a prophylactic antibiotic to prevent UTIs. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care.  The quarterly MDS dated 12/10/14 noted R16							
GUNDERSEN HARMONY CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE    21535   Continued From page 51   21535			00125	B. WING		02/2	0/2015
GUNDERSEN HARMONY CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETE DATE	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21535  Continued From page 51  suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic to prevent UTIs. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care.  The quarterly MDS dated 12/10/14 noted R16	10 10 1	THOUBER ON OUT LIER			•		
SUMMARY STATEMENT OF DEFICIENCIES   ID PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETE DEFICIENCY)    21535   Continued From page 51   Suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic to prevent UTIs. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care. The quarterly MDS dated 12/10/14 noted R16	GUNDEF	RSEN HARMONY CAF	RE CENTER				
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  21535  Continued From page 51  suprapubic catheter related to urinary retention. The urology notes did not identify a clinical rationale for the use of prophylactic antibiotics. During an interview on 2/19/15 at 2:30 p.m. RN-C stated R23 had not had a UTI during past 6 months and was the only resident still receiving a prophylactic antibiotic in the facility. R16 lacked clinical rationale for use of a prophylactic antibiotic to prevent UTIs. R16 was admitted 3/17/13 and had diagnoses listed on the admission sheet of diabetes, psychosis, anxiety, urinary incontinence, proteinuria, and palliative care. The quarterly MDS dated 12/10/14 noted R16							
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proteinuria, and palliative care. The quarterly MDS dated 12/10/14 noted R16							
The quarterly MDS dated 12/10/14 noted R16		psychosis, anxiety,	urinary incontinence,				
		proteinuria, and pal	liative care.				
had a BIMS score of 8 or moderate cognitive		had a BIMS score of	of 8 or moderate cognitive				
impairment, had no UTI past 30 days, required							
extensive assistance with all activities of daily			•				
living (ADL/s), had not received an antibiotic							
during the previous 7 days. The facility							
Observation Report/bowel/bladder observation							
dated 6/21/14 was reviewed and did not identify			,				
the use of prophylactic antibiotics.							
The plan of care dated 12/12/14 indicated R16							
listed a problem of "At risk for urinary tract							
infection related to past history of UTI " and had							
an intervention to administer prophylactic			dminister prophylactic				
antibiotics.							
The Infection Control Reports and Infection Event							
Reports for March 2014 through November 2014							
revealed that R16 had 5 UTIs during this period.							
During these 5 UTIs R16 received an antibiotic a							
few times and not for all UTIs.							
The physician orders dated 11/19/14 to 2/19/15	ļ						
were reviewed for R16. The physician orders							
indicated R16 received Bactrim DS (antibiotic)							
twice a day starting 4/11/13 and had a							
discontinue date of 1/17/15. R16 had a							
physician's order for ceftriaxone twice a day with							

Minnesota Department of Health

1/17/15. On 11/20/14 the physician order

STATE FORM 6899 HUFX11 If continuation sheet 52 of 64

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00125	B. WING		02/2	0/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Cephalexin daily ar 12/30/13 the physic Bactrim while on C The infection repor 2014 through January prophylactic antibio as Bactrim DS with Log indicated the a discontinued in Mainfection control log prophylactic antibio 10/27/14. The Jan expired on 1/16/15 identified as receiving R16 did have UTIs. During an interview RN-C stated R16 woff and on hoping it stated she did not be infections but would self-transfer she wow was on hospice at the US of the prophylactic antibio 10/27/14. The Jan expired on 1/16/15 identified as receiving R16 did have UTIs. During an interview RN-C stated R16 woff and on hoping it stated she did not be infections but would self-transfer she wow was on hospice at the use of the prophylactic anti-depressant and prescribed. Lack of identifying anxiety and depressant and prescribed: R24 had last been 5/28/13 according the Record.  R24's quarterly MD diagnoses of demed depressive disordes severe cognitive improved the record.	and stop until Cipro complete. Sian noted Cipro daily, hold ipro then resume. Its were reviewed for January ary 2015. The log identified stics for R16 on January 2014 an order date of 6/18/13 The ntibiotic had been rech 2014, The October 2014 identified R16 as receiving a stic of cephalexin starting uary 2015 log noted R16. During the time period ing the prophylactic antibiotics on 2/19/15 at 2:36 p.m. with was on a prophylactic antibiotic would stop the UTIs. RN-C know the cause of the didentify that if R16 started to build have an infection. R16 this time and had since died. In or physician justification for hylactic antibiotic was received and evaluate symptoms of sion to ensure effectiveness	21535			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 53 of 64

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
			D WINO			
		00125	B. WING		02/2	0/2015
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GUNDERSE	EN HARMONY CAR	RE CENTER	AVENUE SO			
		HARMON	Y, MN 5593	9		T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21535 C	ontinued From pa	ge 53	21535			
7 th th R vi (n (a Lo fo da R arin s) id s) Lo win R Fo wth w so are dri O do tri	indicating minima are revealed no behale time of assessme 24's medication of sit dated 2/16/15 ing) (anti-anxiety manti-depressant metorazepam 0.5 mg or anxiety and Lora ay.  24's care plan indinxiety and depressive terventions to assign the symptoms in order and the symptoms in the symptom of the symptoms in the symptoms in the symptoms in the symptoms in the symptoms and interview of the symptoms in the symptoms and interview	rders identified on physician ncluded: Buspar 7.5 milligram nedication) daily, Paxil edication) 40 mg daily, three times a day as needed azepam 1 mg three times a licated R24 had a diagnosis of sion. The care plan identified ist with alleviating associated to administer as needed was not a clear direction on medication or use charmacological interventions. In differential designation of the care designation of				

Minnesota Department of Health

reviewed since 11/26/14 to 2/19/15; notes did not

STATE FORM 6899 HUFX11 If continuation sheet 54 of 64

Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00125	B. WING		02/	20/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAF	RECENTER	I AVENUE SC IY, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21535	reflect symptoms of been quantified and behaviors and/or symonitor were not id interventions (included non-pharmacologic effectiveness.  During an interview RN-B stated target and signs to indicate behavior monitoring anti-depressant meanti-psychotic medic concern then the reshort time period. Fevaluation of medic evaluation of behavior monitoring an interview consulting pharmacist indicate frequency of sympty yet as evidenced or pharmacist said the initially started on 6  Lacked evidence of of target behaviors use of antianxiety and interventions were reflected.	f depression or anxiety had not dindividualized target amptoms to specifically entified and individualized ding both pharmacological and al) were not evaluated for on 2/18/15, at 5:30 p.m. (resident specific symptoms e need of antidepressant) g was not done for dications only for cations unless there is a esident would be monitored for RN-B verified no quarterly eation effectiveness, and viors and interventions had not on 2/19/15, at 2:36 p.m., cist indicated he may have ecommendation for medicationing for R24. In relation to as a parameters; consulting and target symptoms and oms had not been identified in the February 2015 MAR, and as needed Lorazepam was 1/17/14.				

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00125		B. WING		02/	20/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDE	RSEN HARMONY CAR	RE CENTER		AVENUE SC Y, MN 55939	=		
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From parameters of 6/13/14; and lora day as needed for a date of 10/20/14. Treport had physicia milligrams once an start date of 1/16/15. Document review o of 1/16/15. Document review of 1/16/15. Document review of 1/19/15 to 2/19/15, 0.5 milligrams daily start date of 6/13/14 times a day for anx of 6/13/14; and lora day as needed for a date of 10/20/14. Treport had physicia milligrams once an start date of 1/16/15. Document review of 1	(MDS), an assenition intact, mosof little interesisleeping, tired, problem of the care area assenotes. The care area assenotes area assenotes are area assenotes are area assenotes. The care area assenotes are addressed in care area, "Problem of the care area, and "Problem of the care area	ods score of t, feeling poor appetite, and received essment (CAA) "endorses desire not to e feels mood is are plan d/t sychotropic (due to) ativan ms." CAA sant tropic he care plan ant use.  The symmetric response to the care plan and the care plan d/t for lorazepam recer, with a milligram two the a start date grams twice a ety, with a start sian order oft 50 iety, with a tion to 1/30/15, Ativan) and				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 56 of 64

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ъ.	` '	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		00125		B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAR	RE CENTER		AVENUE SC 7, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21535	in room. No moods that time.  R21's care plan dat of psychotropic melorazepam for diagridentified included redications. Care problem of mood/behistory of chronic at Approaches includenceded, observe for anxiety, report to so and charge nurse of the problem of mood of the facility of target moods or resisted the facility did not disummary note of eff. BN-B stated she reby "Talking with nur" Done in my head." reproducible to evaluated policies.  Lack of clear paramedication use: R21 had diagnosis	ge 56 s or behaviors were noted and a predication use due to recensis of anxiety. Appromonitor mood and responsion dated 1/10/12, idented and the anxiety and insomnia. The arrivation as scheduled at a side effects and worse ocial worker, case manath anges in mood or behaviors at 10:45 a.m., did not identify or monitor sponse to medications are with the nurses." RN-uarterly mood and behaviors and behaviors. RN-Bocument an analysis or and the summary of the arrivation and the ses and the summary of the arrivation and the ses and the summary of the arrivation and the summary of th	roblem ived aches onse to tiffied a ding and as ening ger, avior.  RN-B or RN-B or facility stated cation. aviors was cy.  lirector tion ety	21535			

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Minnesota Department of Health STATE FORM

HUFX11 If continuation sheet 57 of 64

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00125	B. WING		02/2	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 5593			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 57	21535			
	MDS, an assessme cognition intact, mo moods of little inter sleeping, tired, poo no behaviors, and r medication.	on the significant change ent dated 1/7/15, to have ent dated 1/7/15, to have ends score of 15 including est, feeling depressed, trouble rappetite, feel bad about self, received antianxiety				
	Document review of care area assessment (CAA) for mood dated 1/20/15, stated R21 "endorses some mood indicators but voices a desire not to change anything at this time as she feels mood is improving. Mood is addressed in care plan d/t [due to] mood issues." CAA for psychotropic medication dated 1/20/15, read, "Psychotropic med [medication] use triggered d/t ativan use for long standing anxiety problems." CAA identified R21 started on antidepressant medication. CAA identified psychotropic medication use was addressed in the care plan due to antianxiety and antidepressant use.					
	1/19/15 to 2/19/15, 0.5 milligrams twice	of physician orders report dated revealed orders for lorazepam e a day as needed for agitation art date of 10/20/14.				
	administration histor following as needed -12/31/14-10 times 2/1/15 -2/18/15-1 ti identified as needed	of facility as needed medication by revealed R21 received the d lorazepam: 12/1/14 to; 1/1/15 - 1/31/15-3 times; me. The medication record d lorazepam was administered gitation, anxiety, distressed, st.				
	and 2/18/15, at 12:5	s on 2/17/15, at 10:30 a.m. 55 p.m., R21 sat in a recliner s or behaviors were noted at				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 58 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED		
		00125		B. WING		02/2	20/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDER	RSEN HARMONY CAR	RE CENTER		AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21535	Continued From page 58			21535			
	R21's care plan dat of psychotropic med lorazepam for diagridentified included reproblem of mood/be history of chronic at Approaches include scheduled and as reffects and worsen worker, case mana changes in mood of During interview on stated staff administ for anxiety, after att interventions, or ad R21 requested as reflected lorazepam.	dication use ductions of anxiety, monitor mood a colan dated 1/10, ehavior, has a lonxiety and insorted Ativan (lorazededd, observed anxiety, repeger, and charged behavior.  2/19/15, at 2:30 stered as needed empting non-pheministered lorazedacked specific in the colan acked specific in order to additional acked specific in the colan ack	e to received Approaches nd response to /12, identified a ongstanding mnia. epam) as e for side ort to social e nurse  0 p.m., RN-B d lorazepam narmacological zepam when am. RN-B dentification of				
	During interview on of nursing stated th related policies.						
	SUGGESTED MET The administrator, of consulting pharmace policies and proceded medication usage for urinary tract infection psychoactive mediceffectiveness and to needed medication. The director of nursum medications on a recompliance with states.	director of nursicist could review lures for proper or prophylactic lons, to ensure the cations are being identify parames for antianxiety sing or designed egular basis to estate the cations are some or designed egular basis.	ng and v and revise monitoring of medication for nat g monitored for neters for as v medications. e could monitor ensure				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
		00125		B. WING	<del></del>	02/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAR	RE CENTER		AVENUE SO Y, MN 5593			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 59		21535			
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.						
21620	MN Rule 4658.1345	5 Labeling of	Drugs	21620			3/31/15
	Drugs used in the n in accordance with						
	This MN Requirements: Based on observatifailed to ensure a bettesting solution) was being opened. This new resident admissioned.	on and interviottle of Apliso s discarded 3 has the pote	iew the facility I (tuberculin O days after ential to effect		Corrected		
	Findings included: On 2/19/15, at 11:50 storage tour with revealed an opened testing solution) with the medication story verified the date on should have been adate (December 1,	gistered nurs of bottle of Apli of an open da of age room refr of the bottle and of scarded 30 of	e (RN)-B isol (tuberculin te of 11/1/14 in rigerator. RN-B d stated the vial				
	The Aplisol package more than 30 days possible oxidation a affect potency. Fail as recommended n and inaccurate test	should be dis and degradation lure to store a nay result in lo	carded due to on which may and handle Aplisol				
	SUGGESTED MET The director of nurs						

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00125	B. WING		02/2	02/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GUNDER	RSEN HARMONY CAF	RE CENTER	AVENUE SO Y, MN 55939				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21620	Continued From pa	ge 60	21620				
	are dated when ope could educate nurs nursing could moni	lures to ensure medications ened. The director of nursing ing staff. The director of tor staff compliance.  R CORRECTION: Twenty-one					
21685	5 MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance		21685			3/31/15	
	Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.						
	by: Based on observatifacility failed to enshygiene assessed rigood repair and cle R42, R53, R55) whand also failed to min a state of good rewho utilized a whee Findings include: An environmental trat 1:00 p.m. with thand housekeeping Soiled commodes: R28 located in room commode set over commode was observationed.	on and interview review the ure equipment used for needs were kept in a state of an for 4 of 4 resident (R28, o used a portable commode raintain wheelchair upholstery epair for 1 of 3 residents (R24) elchairs for movement.  Our was completed on 2/19/15 e maintenance director (MD)-A director (HD)-A.  In 120 had a portable the toilet. The portable erved to have cracked plastic verely stained bucket to be		Corrected			

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 61 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00125	B. WING		02/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GUNDEF	RSEN HARMONY CAF	RE CENTER	AVENUE SC Y, MN 55939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	soiled with debris a learned that R42 in portable commode. R58 located in roor 137 used the same observed to have a areas on the legs. A R55 the grab bars on the metal. During an interview HD-A stated she fe surfaces. Wheelchair upholst R24 located in in roa.m. had a wheel c soiled with debris, a had vinyl missing e During an interview maintenance direct procedure to notify is unaware of this v SUGGESTED MET. The facility administreview and revise prelation to the facility maintenance and hadministrator or deweekly/monthly auditation.	nd rust on metal. It was room 121 used this same in 135 and R55 located in room a portable commode which was chipped plastic seat and rusty Also in bathroom of R58 and were worn and rust was noted of on 2/19/15 at 1:30 p.m. the lit these were not cleanable there is that was observed to be and the arms of wheel chair exposing the foam underneath. For on 2/19/15 at 1:30 p.m. the or stated staff have a him of wheelchair issues and wheelchair needing to be fixed. THOD OF CORRECTION:  trator or designee could colicies and procedures in the signee could could do	21685			
21695	, ,	eration, & Maintenance	21695			3/31/15
	provide housekeep	eping. A nursing home must ing and maintenance services ain a clean, orderly, and				

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 62 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
				7t. BOILDING.								
00125		B. WING		02/2	02/20/2015							
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE					
21695	Continued From page 62			21695								
	comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.											
	This MN Requirem by: Based on observat failed to provide a chomelike environmerial tat 1:00 p.m. with thand the housekeep 107, 135, 124, 128 to have a buildup owindows had moist maintenance directinsulation and MD-humidifier which cat also noted the outs degrees Fahrenheit The administrator v4:00 p.m. He stated moisture on windowneed replacing. The dining room/sc boards (had not be walls recently) and wall had missing plinformation provide indicated the dining recently repainted. The ceiling in the disubstances over tha round the vents.	ion and interviewed ent for several replaced water on was interviewed that he was awas as they are golarium had missed by MD-A on 20 groom/solarium ining room had le majority of the MD-A was interviewed in the majority of the MD-A was interviewed as they are golarium had missed by MD-A on 20 groom/solarium ining room had le majority of the MD-A was interviewed in the majority of the MD-A was interviewed as the majo	v, the facility ble and esident rooms. ted on 2/19/15 director (MD)-A l-A. Rooms were observed be and several and the tour the as dirt on the 107 had a windows. It was was around 0 on 2/19/15 at ware of the etting old and sing moper painting er. The south Written 19/15 had been black a surface and viewed on		Corrected							
	walls recently) and wall had missing pl information provide indicated the dining recently repainted. The ceiling in the d substances over the	damaged plaster aster and paint. ed by MD-A on 2. groom/solarium ining room had le majority of the MD-A was internant and stated he che ceiling in the een finalized and	er. The south Written /19/15 had been colack surface and viewed on had plans to solarium, but no bids have									

Minnesota Department of Health

STATE FORM 6899 HUFX11 If continuation sheet 63 of 64

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED								
00125			B. WING		02/2	02/20/2015							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  815 MAIN AVENUE SOUTH													
GUNDERSEN HARMONY CARE CENTER HARMONY, MN 55939													
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE							
21695	interviewed on 2/19 had plans to replace room, and repaint the Bathroom floors in 124, 136, had black with debris. During an interview stated the toilets in replaced, and that the from the old toilets. gotten the spots up There was a strong room 135. Observed door two catheter be The resident had be two day previously. 2/19/15 at 1:30 p.m. stated the catheter procedure and store stated they should be the resident left the SUGGESTED MET The facility administreview and revise p relation to the facility maintenance and h administrator or decone	of/15 at 4:00 p.m. and stated he e the lighting in the dining he ceiling.  rooms 105, 107, 120, 121, a debris behind toilet or floor  on 2/19/15 at 1:30 p.m. MD-A the bathrooms had been the black areas was probably. He added they had not a smell of urine in bathroom of a dhanging over the bathroom ags each in a pillow case. Been discharged to the hospital During an interview on a the housekeeping director bags were washed per ed in the pillow cases. She have been thrown away when building.  THOD OF CORRECTION: trator or designee could colicies and procedures in the pillow case and procedures in the pillow case and ongoing ousekeeping program. The signee could could do	21695										

Minnesota Department of Health STATE FORM