DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LZ91

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00348

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245114**

2.STATE VENDOR OR MEDICAID NO.
(L2) **927400000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HARMONY RIVER LIVING CENTER**
(L4) **1555 SHERWOOD STREET SOUTHEAST**
(L5) **HUTCHINSON, MN** (L6) **55350**

4. TYPE OF ACTION: 7 (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2008**

6. DATE OF SURVEY 10/23/2013 (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective October 2, 2013, the facility is certified for120 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Timothy Rhonemus, HFE NEII 12/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 12/27/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/15/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/15/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5114 December 27, 2013

Ms. Linda Krentz, Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, Minnesota 55350

Dear Ms. Krentz:

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 October 2, 2013, the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 11, 2013

Ms. Linda Krentz, Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, Minnesota 55350

RE: Project Number S5114023

Dear Ms. Krentz:

On September 18, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 12, 2013. 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 October 23, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 2, 2013 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 September 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 2, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 12, 2013, effective October 2, 2013 and therefore remedies outlined in our letter to you dated September 18, 2013, will not be imposed.

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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245114	A. Building B. Wing	10/23/2013

Name of Facility	Street Address, City, State, Zip Code
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0315 Reg. # 483.25(d) LSC	10/02/2013	ID Prefix F0371 Reg. # 483.35(i) LSC	10/02/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** BF/AK	**Date:** 12/11/2013	**Signature of Surveyor:** 20794	**Date:** 10/23/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/12/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245114	A. Building 02 - NEW BLDG B. Wing	11/2/2013

Name of Facility	Street Address, City, State, Zip Code
HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	10/02/2013	ID Prefix Reg. # NFPA 101 LSC K0052	10/02/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 12/11/2013	Signature of Surveyor: 22373	Date: 11/02/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/10/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LZ91

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00348

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245114**

2.STATE VENDOR OR MEDICAID NO.
(L2) **927400000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HARMONY RIVER LIVING CENTER**
(L4) **1555 SHERWOOD STREET SOUTHEAST**
(L5) **HUTCHINSON, MN** (L6) **55350**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2008**

6. DATE OF SURVEY **09/12/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Karlyn Pogatchnik, HPR Social Work Specialist — 10/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/12/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/15/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed September 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 3085

September 18, 2013

Ms. Linda Krentz, Administrator
Harmony River Living Center
1555 Sherwood Street Southeast
Hutchinson, Minnesota 55350

RE: Project Number S5114023

Dear Ms. Krentz:

On September 12, 2013, 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>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;

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

Informal Dispute Resolution - 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

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 October 22, 2013, 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 October 22, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 December 12, 2013 (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 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 March 12, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245114	A. BUILDING _____ B. WING _____	09/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation 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.	F 000	RECEIVED OCT 02 2013 MN Dept of Health St.Cloud	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the continued need for the use of an indwelling Foley catheter for 2 of 2 residents (R45 & R84) with an indwelling catheter. Findings include:	F 315	F-315 R45 – In conjunction with resident physician orders on file, catheter was removed on 9/24/13 as resident skin condition improved and skin intact. Comprehensive skin assessment and Bladder and Bowel re-assessment occurred. Care plan was updated with interventions for R45. Continued on next page 10/1/13 accepted	10-02-2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda K Kreuk | TITLE: Administrator | (X6) DATE: 10-1-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245114	A. BUILDING _____ B. WING _____	09/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 1 R45 had a indwelling catheter without clinical indication for use. R45's diagnoses included urinary retention and mild intellectual dysfunction. The annual minimum data set (MDS) dated 7/8/13, indicated R45 had severe cognitive impairment and needed extensive assistance with toileting. The MDS also indicated she was frequently incontinent of urine and is at risk for skin breakdown. R45's Care Area Assessment (CAA) dated 7/8/13 indicated she had urinary urgency and need for assistance in toileitng. The CAA further indicated she was frequently incontinent of bladder and was checked and changed prior to rising, between meal, evening and at night every two to three hours. R45's plan of care dated 1/23/13 indicated she was incontinent of urine and was to be toileted checked and changed between meals, in evening and at night every two to three hours. R45's bowel and bladder assessment dated 7/24/13 indicated she had a catheter for retention. R45's fax communication to the physician on 8/23/13 indicated R45's buttocks and peri area was red and raw, they have tried various treatments with little improvement. "Do you feel cranberry pills would be effective and could we possibly order her to have a 16 F [french] 5cc [cubic centimeters] cath til peri area healed and then discontinue." The fax communication under doctors orders indicated "ok for catheter as above, do not think cranberry pills will help." The physician visit note dated 9/5/13 indicated R45 had a Foley catheter replaced a few weeks ago due to a lot of skin breakdown from her bowel	F 315	F-315 Continued R84 – On 9/26/13 bladder retraining interventions implemented with catheter removal plan. Bladder and Bowel Assessments completed. Resident R84 was comprehensively reassessed for pain. Care plan updated with new interventions for R84. All residents who have an indwelling catheter were reviewed and assessed and care plans were updated as appropriate. The facility reviewed the comprehensive bladder policy and procedure and it remains current. Education was completed with nursing staff on 9/27/13 in regards to catheter use and bowel and bladder assessments. Urinary catheter audits were completed on all current residents with indwelling catheter. Audits of catheter use will be completed weekly for six weeks and results of audits will be analyzed for Continued on next page	

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F 315	Continued From page 2 and bladder incontinence. The visit note also indicated the Foley has really helped keep the skin more dry and it is beginning to heal. During observation on 9/11/13 at 10:21 a.m., R45 was observed to be lying in bed with catheter bag attached to the side of her bed. During interview on 9/11/13 at 1:00 p.m., nursing assistant (NA)-A stated that R45 has a Foley catheter because she has skin breakdown from her urine and that her urine constantly flows out of her. During interview 9/12/13 at 8:43 a.m., with Registered Nurse (RN)-A stated that R45 has excoriation in her frontal peri area and her bottom. The RN-A further stated she just leaks urine and it makes her skin breakdown and they have tried barrier creams, barrier wipes, barrier spray and duoderm and hyrocolloid dressings and her skin would just not heal. The RN-A stated since those did not help on 8/23/13 they requested an order from her doctor to receive a Foley catheter. The CC also stated she frequently has skin breakdown but it just got worse in August 2013 and they were unsure why. On 9/12/13 at 9:22a.m., during observation with licensed practical nurse (LPN)-A, R45 frontal and rectal peri area was reddened. LPN-A stated R45's skin had been improving and it had been more red in the past. On 9/12/13 at 1:00 p.m., during interview with the Director of Nursing (DON) stated that R45 has chronic skin breakdown and the physician ordered the Foley catheter due to her leaking of urine that was causing her skin to breakdown.	F 315	F-315 Continued trends and reported to facility Quality Assurance Committee for follow up and direction. All residents with indwelling catheters will be reviewed and assessed as needed and in conjunction with the RAI process. Future residents admitted with a catheter will have a comprehensive bowel and bladder assessment completed per policy and procedure. The Director of Nursing is responsible for ongoing compliance.	

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F 315	Continued From page 3 The DON further stated the physician plans to discontinue the Foley catheter once her skin has healed. Although R45 had excoriation of the skin the facility did not assess what caused the increase in skin breakdown and did not attempt different incontinent products, creams or other alternative measures to prevent further skin breakdown prior to the insertion of a Foley catheter. R85 had a Foley catheter without clinical indication for use. R85 was admitted 7/2012 with diagnoses of osteoporosis and arthritis. R85's annual MDS dated 7/24/13, indicated she was cognitively intact and needed extensive assistance with transfers, toileting and had an indwelling catheter. The MDS also indicated she receives scheduled pain medication and does not receive PRN (as needed) pain medications. R85's plan of care dated 8/1/13 indicated she had a catheter that was placed in the hospital prior to admission. The family and resident were educated on risk versus the benefit of placing the catheter such as increased infections, sepsis and bladder incontinence. The plan of care also indicated family and resident understood and continued "to want the catheter," because of the resident's mobility deficit and did not feel she could make it to the bathroom in time. Medical Doctor (MD) to continue to assess need for catheter on (MD) rounds and to note reason for use, end of life diagnosis with last rounds. The plan of care also indicated she had pain related to osteoporosis and decreased mobility.	F 315		

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F 315	Continued From page 4	F 315		

R85's bowel and bladder evaluation dated 7/18/13 indicated she has a Foley catheter for end of life stage and comfort per resident, family and MD. R85's Bowel and Bladder CAA dated 7/25/13 indicated she had a Foley catheter related to end of life comfort and per family and resident request. R85's Pain Evaluation and Management Plan dated 7/17/13, indicated that she has not had pain in the last five days and she has scheduled pain medication and was able to communicate needs to pain relief.

A nursing home physician note dated 7/31/13 indicated R85 was reviewed for her Foley catheter and she was using this for end of life comfort as she has significant arthritis and pain when she tries to get up and go to the bathroom. The note also indicated she was unable to walk really very much or even transfer to and from the toilet well.

Review of R85's medication record for September 2013 indicated she receives scheduled Lidoderm (analgesic) patch half patch to each shoulder topically on 12 hours and off 12 hours, Percocet 5/325 (narcotic analgesic) 1 tablet at 6:30 a.m. and Fentanyl patch 25 mcg/hr (micrograms) every 72 hours. R85 also has an as needed (PRN) Morphine 10 mg (milligrams) (narcotic) suppository every four hours and Percocet 5/325 1/2-1 tab (narcotic analgesic) every four hours as needed for pain. R85 has received one PRN dose of Percocet on 9/3/13, and has not used any PRN morphine.

During interview on 9/9/13 at 3:30 p.m., R85 stated she does not have any pain or discomfort right now and has not been having pain without

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F 315	Continued From page 5 relief. During observation on 9/11/13 at 11:01 a.m., R85 was sitting in her wheelchair with a catheter leg bag. R85 stated she has a catheter because she can not walk to the bathroom, she further stated prior to admission to the facility she was using the bathroom. R85 did not appear to be in any pain or discomfort. During interview on 9/12/13 at 8:53 a.m., with RN-A stated she admitted to the facility with the Foley catheter because she had cellulitis to her leg. The RN-A also stated she has the Foley catheter for end of life comfort and that it is painful for her to transfer, but R85 could walk but she chooses not to. During observation on 9/12/13 at 12:15 p.m., R85 was observed to be sitting in her wheelchair eating her lunch visiting with other residents and did not show any signs of pain or discomfort. During interview on 9/12/13 at 1:15p.m., with the DON stated R85 has the Foley catheter for end of life and comfort and the resident and family have been informed of the risks and benefits and they want the Foley catheter. The facility policy Prevention of Catheter-Associated Urinary Tract Infections, undated, indicated clinical conditions that may require catheterization include: Urinary retention, skin wounds, pressure sores, or irritations that are being contaminated by incontinent urine even after every attempt has been made to control incontinence and protect the wounds and care of terminally ill or severely impaired residents for whom bed-clothing changes are painful or	F 315		

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F 315	Continued From page 6 disruptive. Although R85 had an indwelling Foley catheter for end of life comfort cares, and utilized some pain medications that adequately controlled her pain. R85 did not have intractable pain to justify the use of the indwelling catheter.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. This had the potential to affect 115 of 115 residents in the facility, who were served food out of the kitchen. Findings include: During tour on 9/9/13 at 1:10 p.m. and on 9/11/13 at 1015 a.m., the following sanitation problems were observed: - Two box fans approximately 2 feet X 2 feet had a heavy buildup of hanging dust. The fans were	F 371	F-371 The two box fans were removed from the kitchen. The tilt skillet was deep cleaned. The Kitchen's Master Cleaning Checklist was updated to reflect the cleaning of the tilt skillet after every use and the deep cleaning will be completed at a minimum weekly and as needed. The facility is reviewing cooling units for use in the kitchen area. Culinary Staff was educated on October 1, 2013 that free standing fans are not used in the kitchen. All culinary staff educated on Master Cleaning Checklist and procedures for cleaning equipment. Continued on next page	10-02-2013

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F 371	Continued From page 7 situated on either side of the food preparation area, blowing air towards the meal preparation table which included preparation of vegetables and meat. - The tilt skillet located to the side of the food preparation table had a build up of grease on and around the control panel. The right side and legs of the unit had food splatter and dust/grease buildup. A coil spring under the unit was heavily coated with dirt and dust and the underside of the unit had heavy dust buildup. Review of the Master Cleaning Checklists for July 1st thru September 12, 2013 indicated the procedure for the tilt skillet was to "clean and sanitize all spills". There was no indication of deep cleaning for the unit. When interviewed on 9/9/13 at 1:15 p.m., the nutrition/culinary director (NCD) and registered dietitian (RD) confirmed the fans were dirty and needed cleaning. The NCD stated there was no policy for cleaning the fans and they were not on any cleaning lists as they were more seasonal and should have been cleaned before using them. When interviewed on 9/11/13 at 10:15 a.m., the NCD confirmed the tilt skillet was dirty and needed cleaning. He further stated their cleaning policy is the Master Cleaning Checklist which indicates staff should clean and sanitize all spills and that the tilt skillet should have but was not designated for deep cleaning.	F 371	F-371 Continued Weekly audits of appliances for cleanliness and audits to assure free standing fans are not in use will be completed for 8 weeks with results reported to the Quarterly Quality Assurance Committee to ensure ongoing compliance and further frequency of audits. Culinary Director is responsible for ongoing compliance.	

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	245114	A. BUILDING 02 - NEW BLDG B. WING _____	09/10/2013

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K 000	INITIAL COMMENTS 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 10, 2013. At the time of this survey, Harmony River Living Center was found not to be 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) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. 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 Facsimile: 651-215-0525, or	K 000	POC ok PB 10-23-13 RECEIVED OCT - 8 2013 OCT - 8 2013 FIRE SAFETY	

DC: 10.22.2013

EXIT: 09.17.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda K Kreutz — TITLE: Administrator — (X6) DATE: 10-1-13

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

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K 000	Continued From page 1 By e-mail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Harmony River Living Center was constructed in 2012, is two-stories in height, has a partial basement, is fully sprinklered and was determined to be of Type II(111) construction. The facility has a complete automatic fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Each Resident Room is equipped with hard-wired, single-station smoke detectors. The facility has a capacity of 120 beds and had a census of 118 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in	K 025		

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K 025	Continued From page 2 accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a smoke barrier wall in accordance with the requirements at NFPA 101 (00) Chapter 18, Section 18.3.7.3 and Chapter 8, Section 8.3. In a fire emergency, this deficient practice could adversely affect 32 of 120 residents. FINDINGS INCLUDE: On 09/10/2013 at 12:18 PM, observation revealed that above the ceiling above the cross-corridor smoke barrier doors on the Agate Trail Corridor, the smoke barrier wall was penetrated by a section of conduit, and the interstitial space between the conduit and the wall was not properly sealed to prevent the migration of fire/smoke, and the required one-hour fire resistance rating of the wall was not maintained. This finding was confirmed with the chief building engineer at the time of discovery.	K 025	K 025 NFPA 101: Smoke barrier wall by Agate Trail was sealed with fire/smoke rated caulking and putty to bring this area into compliance with the code. All other smoke barrier walls were checked and in compliance with Fire Code requirements. Engineering staff will audit smoke barrier walls annually as part of our preventive maintenance program with results reported to the Quarterly Quality Committee and Safety Committee to ensure ongoing compliance and further recommendations. Responsible: Engineering Director	10/2/2013
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052 SS=F	Continued From page 3 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based upon a review of available documentation provided by facility staff, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 18, Section 18.3.4.1 and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 120 of 120 residents. FINDINGS INCLUDE: On 09/10/2013 at 10:29 AM, during a review of the facility's annual Fire Alarm Inspection and Testing Form - as completed by a contract vendor and dated 12/18/2012 - no documentation was provided verifying the outcome of functional testing for each alarm initiating device on the system. As such, it could not be verified that visual and functional testing of each device on the fire alarm system had been properly conducted. This finding was confirmed with the chief building engineer.	K 052	K 052 NFPA 70 and 72: Engineering Director contacted the facilities Fire Alarm Inspection contractor (Conway Fire) and discussed the requirement of inspecting and documenting all future annual fire alarm equipment inspections. December of 2013 all fire alarm inspection reports will specify individual fire alarm tests completed and documented as required per CMS code. Engineering staff will audit all reports associated with the annual fire alarm system requirements. Results of these audits will be reviewed at the Quarterly Safety Committee and Quarterly Quality Assurance Committee for further recommendations. Responsible: Engineering Director	10/2/2013