Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 4, 2025

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

RE: CCN: 245114
Cycle Start Date: February 20, 2025

Dear Administrator:

On February 20, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by May 20, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 20, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 02/20/2025

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
E 000	Initial Comments On 2/18/25 to 2/20/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/18/25 to 2/20/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H51147502C (MN00108145) H51147503C (MN00108352) H51147504C (MN00108954) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

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

Electronically Signed | 03/12/2025

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

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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		3/12/25

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F 656	Continued From page 2 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to create a comprehensive care plan for a resident with a history of respiratory conditions for 1 of 1 residents (R102) reviewed for care plans. Findings include: R102's Medicare 5-day Minimum Data Set (MDS) dated 1/22/25, indicated R102 cognitive impairment could not be decided. Diagnoses included pneumonia and respiratory failure. R102's comprehensive care plan undated, lacked a patient specific care plan or interventions related to R102's history of pneumonia and respiratory failure. During an interview on 2/20/25 at 1:16 p.m., registered nurse (RN)-B stated the care plan was updated either when there was a change in the resident's condition or when a new MDS assessment performed. RN-B reviewed R102's MDS and 5-day care plan. She acknowledged the respiratory conditions listed in the MDS but were not found on the care plan. RN-B stated the care	F 656	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F656. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. On 2/20/2025, resident (R102) plan of care was reviewed and updated with a respiratory care plan that included pneumonia and history of respiratory failure. Immediate education was initiated to the Licensed staff on the expectation that all residents plan of care will be updated when a new diagnosis is confirmed. The care plan will reflect the diagnosis within a focus, a goal and interventions to help maintain the quality and independence for the resident. The resident was under skilled respiratory monitoring post hospitalization and showed resolution of hospital pneumonia diagnosis. Care plan now reflects respiratory history.	

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F 656	Continued From page 3 plan should have been updated with a respiratory care plan, goals, and interventions when the MDS was updated on 1/22/25. During an interview on 2/20/25 at 1:43 p.m. the director of nursing (DON) stated an expectation the care plan would be filled out as appropriate based on resident needs. Facility policy Care Plan Policy and Procedure last modified 11/22, indicated the care plan would be reviewed at least with each MDS assessment period and with any significant change. The care plan would be changed and updated as the care changes for the resident and as the resident changes occurred. The care plan was to be current at all times.	F 656	By 3/4/2025, a facility-wide audit was completed to ensure resident care plans reflected new diagnoses within the last 30-days. Education was provided to the licensed staff on their responsibility to ensure that all new diagnoses post resident physician rounding, appointments, verbal, telephone or faxed orders are alerted to Health Information and Clinical Coordinators to update the resident plan of care. Clinical Coordinators are responsible for any hospital readmission diagnoses. Education for new licensed staff has been added to the licensed staff orientation packet and will occur within their orientation. Information on new diagnoses is reviewed daily during Interdisciplinary Team meeting comprised of Clinical, Social Services, Administration, Dietary, and RAI to ensure that all residents comprehensive plans of care are current and up to date. On-going audits will be completed on new diagnosis securements on residents to ensure that their care plans are up to date and in compliance with regulation. The audits will be completed twice weekly x2 weeks in random neighborhoods and random shifts to ensure compliance. The cadence will then continue weekly x2 weeks, then monthly with audit results analyzed for trends and reported to QAA committee in April 2025 for further	

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F 656	Continued From page 4	F 656	recommendations. If any outliers are identified immediate update of plan of care and re-education to occur. The Clinical Administrator/Clinical Coordinators will be responsible for compliance. Date certain: 3/14/2025.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to provide activities of daily living (ADL) assistance for 1 of 1 resident (R38) who required assistance with eating. Findings include: R38's quarterly Minimum Data Set (MDS) dated 12/10/24, identified R38 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R38's diagnoses included progressive neurological conditions, seizure disorder/epilepsy, bipolar disorder and other drug induced secondary parkinsonism. MDS did not indicate R38 exhibited any behaviors. R38's care plan dated 12/16/23, identified R.8 required assistance of 1 for eating due to extensive tremors. During observation on 2/18/25, at 5:19 p.m., R38	F 677	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F677. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. On 2/20/2025, staff education was initiated which consisted of facility-wide messaging on ensuring residents who require assistance with eating are served at the same time as their table mate. The identified resident (R38) received all further meals at the same time as his table mate. Education to nursing and culinary staff on the facility process for providing a pleasurable and dignified meal experience was completed by 3/12/2025. On-going,	3/12/25

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F 677	Continued From page 5 was seated at dining room table with two other residents. Staff served the other two residents their plates, who started eating, R38 sat there watching the other residents eat. At 5:25 p.m., R38 continued watching other two resident eat. At 5:28 p.m., staff brought R38's plate to table and sat down and started to assist R38 with eating. R38 ate food when staff assisted. During observation on 2/19/25, at 5:21 p.m., R38 was seated at dining room table with two other residents. Staff served the other two residents their plates, who started eating, R38 sat watching the other residents eat. At 5:33 p.m., staff brought a bowl of soup and a plate of food and set it down in front of R28. At 5:34 p.m., staff sat down and started to assist R38 with eating. R38 ate food when staff assisted. During interview on 2/20/24 at 2:54 p.m. nursing assistant (NA)-C stated R38 needed staff assistance with eating. NA-C stated they would serve the independent residents first and then would serve the residents who needed assistance eating. During interview on 2/20/25 at 3:01 p.m., director of nursing (DON) and administrator stated residents who require assistance with eating are served last as they need staff to assist them with eating. DON stated it would be important for all residents who are seated at the same table to eat at the same time for a more pleasurable dining experience and also for the resident's dignity. During interview on 2/20/25 at 3:22 p.m., director of nursing (DON) and administrator stated they spoke with dietary who confirmed R38 was served at the end due to him needing assistance	F 677	all new employees in nursing and culinary have this education added to their orientation packet and will be educated during the orientation process. Audits were started immediately and will be completed on meal service for residents who require assistance with eating twice weekly x2 weeks in random neighborhoods and random shifts to ensure compliance. The cadence will continue weekly x2 weeks, then monthly with audit results analyzed for trends and reported to QAA committee in April 2025 for further recommendations. If any outliers are identified immediate intervention and re-education to occur. The Campus Administrator/Household Coordinators will be responsible for compliance. Date certain: 3/14/2025.	

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F 677	Continued From page 6 with eating. The facility Dining Room Protocol policy, dated 1/13, indicated staff will participate in the delivery of meal service. Staff to provide dignified, prompt meal service. After all residents are served, proceed to assigned tables to provide eating assistance, as indicated or as appropriate.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow provider orders for a resident on mild thickened liquids for 1 of 2 residents (R102) reviewed for diet changes. Findings include: R102's Medicare 5-day Minimum Data Set (MDS) dated 1/22/25, indicated R102 cognitive impairment could not be decided. Diagnoses included pneumonia and respiratory failure. R102's Order Summary Report dated 1/16/25 indicated R102 had an active diet order for level 6 soft and bite sized texture with mild thick consistency liquids.	F 689	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F689. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. On 2/19/2025 a facility-wide audit was completed on all residents with an altered thickened liquid consistency to verify that they had the correct fluid consistency available in their room for hydration purposes. No outliers were identified. Staff education was initiated, which consisted of facility-wide messaging on	3/12/25

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F 689	Continued From page 7 R102's care plan revised on 12/29/24, indicated R102 had a nutritional problem and diet was to be served as ordered. R102's therapy interdepartmental team (IDT) communication dated 2/3/25, indicated nursing and dietary was notified by speech therapy (ST) R102 was on mild thick liquids. Facility care sheets undated, indicated R102 was suppose to have mild thickened liquids. On 2/19/25 at 2:47 p.m., R102 was observed with a plastic glass half full of non-thickened water that was drank from and then placed on the over table cart. Next to the plastic cup was a large gray mug with a lid on it. During an interview on 2/19/25 at 2:52 p.m. nurse assistant (NA)-D stated floor staff were aware of resident specific diets based on the facility care sheets that are reviewed every shift. The facility care sheet was reviewed and confirmed R102 needed mild thickened liquids. NA-D entered R102's room and confirmed the water in the plastic cup and in the large gray mug was unthickened water and should have been thickened prior to it being given to resident. NA-D then removed the glass and mug of water. NA-D had also been notified that R102 had been observed taking a drink out of the plastic cup. During an interview on 2/19/25 at 2:58 p.m., the speech language pathologist (ST) stated R102 had been placed on mild thickened liquids as of 2/3/25 because R102 showed increased high risk signs of aspiration when R102 drank thin liquids. During an interview on 2/20/25 at 1:16 p.m.	F 689	ensuring residents receive the correct liquid consistency thickness during hydration water pass. The identified affected resident (R102) was immediately assessed by RN for any respiratory concerns and clinical monitoring implemented. The resident's responsible party and primary physician were notified of findings. Occurrence report completed. The resident encountered no adverse reactions. On 2/20/2025, the staff member identified as providing the improper liquid consistency was provided education, retraining, and received corrective actions. On 2/20/2025, a new process change for hydration water pass was implemented for residents on thickened liquids, with education subsequently occurring for all nursing and culinary staff. Ongoing staff 1:1 education with auditing of understanding continued. Education to nursing and culinary staff on proper liquid thickness consistency and facility processes for hydration pass completed by 3/12/2025. Education for all new employees added to the orientation packets for nursing and culinary and will be completed during the orientation process. Audits will be completed on residents who require thickened liquids twice weekly x2 weeks in random neighborhoods and	

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HARMONY RIVER LIVING CENTER	1555 SHERWOOD STREET SOUTHEAST HUTCHINSON, MN 55350

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F 689	Continued From page 8 registered nurse (RN)-B stated the care plan and the facility care sheets that the NA's use every day to guide resident care are updated when changes occurred. During an interview on 02/20/25 at 1:43 p.m., the director of nursing (DON) stated staff should follow the prescribed diet orders from the provider or ST to protect the resident from adverse effects. The facility policy Diet Policy last revised 3/23 indicated thickened liquids may be recommended for residents with swallowing difficulty to decrease the risk of chocking or coughing on liquids. All liquids would be thickened to appropriate consistency before served.	F 689	random shifts to ensure compliance. The cadence will continue weekly x2 weeks, then monthly with audit results analyzed for trends and reported to QAA committee in April 2025 for further recommendations. If any outliers are identified, immediate intervention and re-education to occur. The Clinical Administrator/Designee will be responsible for compliance. Date certain: 3/14/2025.	