DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 5, 2025

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

RE: CCN: 245528
Cycle Start Date: April 10, 2025

Dear Administrator:

On June 2, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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May 5, 2025

Administrator
Gundersen Harmony Care Center
815 Main Avenue South
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RE: CCN: 245528
Cycle Start Date: April 10, 2025

Dear Administrator:

On April 10, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 July 10, 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 October 10, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	C 04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/7/25 to 4/10/25, 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 4/7/25 to 4/10/25, 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: H55282301C (MN00111809 and MN00111831).	F 000		
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:	F 689		5/26/25

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

Electronically Signed | 05/12/2025

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 689	Continued From page 1 Based on observation, interview, and record review, the facility failed to comprehensively reassess, implement appropriate person-centered interventions and analyze falls to help prevent future falls and potential injury for 2 of 2 residents (R22, R7). In addition, the facility failed to assess for proper use of a heating pad for 1 of 1 residents (R28) reviewed for accidents. Findings include: R22's Minimum Data Set (MDS) assessment dated 1/9/25 indicated no cognitive impairment. R22's function status showed she requires a walker for mobility, substantial assistance for toileting, partial assistance for dressing, and is dependent on facility staff to put on or take off footwear. R22's bladder status showed occasional incontinence. R22's special treatments include oxygen therapy. R22's diagnosis included: chronic respiratory failure with hypoxia, urinary incontinence, cognitive loss/dementia, and heart failure. R22's care plan dated 2/18/25 indicated R22 had mild cognitive impairment and problems with memory/recall, has impaired balance, and risk for falls related to impaired mobility, oxygen use, and self-transferring. R22's care plan dated 7/25/24 indicated staff interventions include assure glasses are nearby, assure floor is free of objects, encourage resident to use hand grips and handrail, provide proper footwear, give verbal reminders not to ambulate or transfer without assistance, provide environment free of clutter, and give medications	F 689	F689: Gundersen Harmony Care Center will continue to ensure that the residents environment remains as free of accident as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Falls: R22 and R 7s care plans were reviewed and updated to reflect current fall interventions. All residents care plans were reviewed to ensure that any fall interventions needed were up to date. Falls will be reviewed by IDT the same day as fall or next business day depending on time of fall. Event will be reviewed for completeness and review interventions. Care plan will be updated at that time. Reeducation for licensed nurses will include filling out the fall event and implementing interventions at the next nursing staff meeting on May 15. Policy will be reviewed and updated as needed. The IDT will audit care plans for fall interventions for residents that are at risk for falls quarterly at care conferences. Heating Pad: Heating pad was removed from resident 28s room after explaining why she could not use it here and what her options were. All residents were checked to make sure there were no other heating pads that have not been inspected in use. Types of devices that can be brought in will be reviewed with resident/resident representative at admission. When a device is brought in it will be inspected by maintenance for compliance and will be labeled with colored tape that is initialed and dated by maintenance on the cord that it has been inspected and approved to use in the	

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F 689	Continued From page 2 as ordered. R22's Fall even report dated 8/12/24 indicated R22 had an unwitnessed fall with no noted injury. R22 stated at the time she was getting up to move her blanket. Interventions at the time of fall included call light within reach, frequently used items within reach, and appropriate footwear. No new person-centered interventions updated after fall. R22's fall event report dated 8/14/24 indicated R22 had an unwitnessed fall requiring an emergency room visit and two staples for a head laceration. R22 stated at the time she was unsure of what she was trying to do when she fell. Interventions in place at time of fall included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. No new person-centered interventions updated after fall. R22's fall event report dated 2/25/25 indicated R22 had an unwitnessed fall with minor injuries. R22 stated at the time she was trying to use the restroom, and her feet got tangled in her oxygen tubing. Interventions in place at the time of fall included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. No new person-centered interventions updated after fall. R22's fall event report dated 3/10/25 indicated R22 had an unwitnessed fall with minor injuries, due to dizziness required a visit to the emergency room to rule out a head blead. Resident was sent back to facility with no injuries. Resident stated at the time she was getting up to use the restroom and her feet got entangled in her oxygen tubing.	F 689	nursing home. A provider order will be obtained and care plan will be updated. Staff will be educated to look for sticker if they see a heating pad being used by a resident. Policy will be reviewed and updated as needed. Maintenance or designee will audit with quarterly safety walk though for uninspected devices. Results of audits will be reported to the QAPI committee monthly. Completion Date: May 26,2025	

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F 689	Continued From page 3 Interventions in place at the time of fall included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. Resident was reminded to use call light and ask for assistance. No new person-centered interventions updated after fall. During observation and interview on 4/7/25 at 4:30 p.m., R22 stated she had fallen a few times, she has gone to the emergency room a couple of times because she became dizzy after her falls. R22 stated her last two falls were because her oxygen tubing got caught in her feet and she lost balance. R22 stated she would like shorter oxygen tubing to help prevent another fall. R22 stated staff will tell her she has to use her call light more and ask for assistance. Oxygen tubing observed extending from resident feet towards oxygen concentrator with tubing coiled in behind oxygen concentrator. Resident had call light on side table, side table was positioned in front of resident. Walker was across the room below the television. During observation on 4/8/25 at 2:04 p.m., oxygen tubing was stretched out across room, beneath walker, extending towards resident with the remaining tubing coiled beneath concentrator. During interview on 4/9/25 at 9:03 a.m., nursing assistant (NA)-C stated R22 has a history of falling; most always due to getting her feet caught in her oxygen tubing. NA-C stated the interventions in place for R22 included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. NA-C stated she didn't think these interventions were enough because R22 kept falling for the same reason.	F 689		

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F 689	Continued From page 4 During observation on 4/9/25 at 9:07 a.m., resident attempting to get up on her own, did not use call light. Staff walking with another resident asked resident if she would sit back down and they would be in to help her in a few minutes. Resident stated she wanted to get dressed now. Staff continued to assist another resident. Oxygen tubing was beneath resident feet, stretching towards oxygen tubing. During observation on 4/9/25 at 11:06 a.m., resident attempting to get up on her own, she did not use call light. Oxygen tubing was beneath walker extending towards oxygen concentrator. During interview on 4/9/25 at 1:40 p.m., DON and registered nurse (RN)-A stated the process after a fall happens is to make sure the resident is assessed and treated immediately, notify appropriate staff and family, follow up per provider orders. Post falls assessments are completed based on provider orders. Post fall evaluation is completed during next stand-up meeting and/or interdisciplinary meeting if falls are repeated. RN-A confirmed interventions in place at time of all falls was call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. RN-A confirmed only verbal reminders to ask for assistance were used to prevent future falls. DON and RN-A confirmed the current care plan does not reflect additional interventions to prevent future falls. DON and RN-A confirmed the resident does need an updated care plan to address her falls. R7	F 689		

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F 689	Continued From page 5 R7's significant change Minimum Data Set (MDS) assessment dated 1/22/25, indicated R7 was severely cognitively impaired with disorganized thinking and inattention. R7 had a history of wandering, no limitation of functional range of motion, supervision for bed mobility, partial/moderate assist for transfers and activities of daily living (ADLs). R7 had bowel and bladder incontinence. R7's diagnoses list included: Alzheimer's disease, major depression, anxiety, restlessness with agitation, osteoporosis, high blood pressure, and cerebral infarction (stroke). During an observation on 4/8/25 at 11:02 a.m., R7 sleeping at the table, staff offered to lay R7 down or wait for lunch. R7 laid down. During an observation on 4/8/25 at 12:17 p.m., R7 laying in bed hands under head, bed in normal position, wheelchair pushed against the wall, floor alarm in place, call light on lap. R7's provider orders included: furosemide (used to reduce extra fluid in the body (edema) caused by conditions such as heart failure), carvedilol for high blood pressure, lorazepam for anxiety as needed, and venlafaxine for depression. R7's provider orders included check motion detector in room and at the desk for proper function daily. Replace batteries if not working correctly. R7's care plan included altered communication evidenced by difficulty with word find and speaking in sentences that do not make sense, assistance with ADLs and mobility requiring assist	F 689		

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F 689	Continued From page 6 of 1 with walker for ambulation and transfers and extensive assist for ADLs. A fall care plan indicated R7 was at risk for falling related to impaired balance during transitions, use of antidepressant medications, history of falls resulting in fractured wrist, and frequent self-transferring. Interventions included: "dicem (sticky material used to prevent slipping) between the seat of wheelchair and cushion at all times to help it from sliding out" started 4/7/25." "check motion detector in room and at the desk for proper function daily" edited 10/21/24 "observe frequently and place in supervised area when out of bed" edited 9/25/24 "provide toilet assistance every 2-3 hours" edited 9/25/24 "ensure auto-lock brakes on wheelchair remain in good , working order. If any issues or concerns arise with them, contact maintenance to assess or fix them" dated 7/2/2024. "Assure that resident is wearing proper, well-maintained footwear" dated 5/23/24. "encourage resident to participate restorative exercise as recommended by therapies. Encourage participation in group exercises when available that are led by activity staff" edited 5/23/24. "Encourage resident to use environmental devises such as hand grips, hand rails, etc. Remind resident to use assistive devices" edited 5/23/24 "Give resident verbal reminders not to ambulate/transfer without assistance. Follow physical and occupational therapy (PT/OT) recommendations for transfers and ambulation edited 5/23/24" "Monitor overall condition for underlying infection that could contribute to altered mental status,	F 689		

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F 689	Continued From page 7 weakness, and overall increased risk for falling" edited 5/23/24, "Provide an environment free of clutter. Always keep call light or pendant within reach. Keep personal items and frequently used items within reach" edited 5/34/24. R7's cognitive loss/dementia care plan indicated R7 is unable to make daily decisions without cues/supervision related to her dementia, Alzheimer's, and anxiety diagnoses. Interventions include to monitor resident for exit seeking behaviors, wandering into unsafe areas, and entering other resident rooms uninvited, redirect when potential for injury is evident. Fall progress notes indicated the following: -On 9/8/24, resident found sitting on toilet with laceration to her head, sent to ER for sutures. Interventions included "cold/ice, direct pressure to the wound" Section titled "Evaluation notes" indicated "Her careplan has been reviewed/revised, as necessary." -On 10/17/24 resident was observed reaching for floor alarm on floor and slid out of bed. Immediate intervention: put bed in lowest position. Careplan lacked documentation of intervention put in place. -On 11/14/24 resident found crawling on the floor. Motion detector was turned around so not alarming, bed in lowest position. Immediate interventions indicated "none of the above". Evaluation notes indicated "Her careplan has been reviewed/revised, as necessary." -On 12/27/24, resident observed sitting on the	F 689		

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F 689	Continued From page 8 floor scooting into the hallway from her room. Resident was assisted to toilet, provided ADLs and assisted into bed. Resident was on Covid restrictions and had to use the restroom. Immediate interventions indicated "none of the above". Summary of investigation indicated resident was assisted off the floor, toileting, received ADL's, and into bed for the night. "Her careplan has been reviewed/revised, as necessary. -On 1/1/25, staff responded to motion sensor and found resident sitting on the floor of her room. Wheelchair and walker were not near her and resident was wearing 1 gripper sock. Sent to ER for evaluation of left leg. No fracture noted. Careplan has been reviewed/revised as necessary. Immediate intervention: "rest". -On 3/19/25, resident had just been changed. Alarm was not put back in place. Immediate interventions, "Got up in wheelchair to move around, rest" -On 4/1/25, resident was found on floor by dietary staff. Immediate intervention: "rest". Summary of investigation was left blank. During interview on 4/9/25 at 1:36 p.m., registered nurse (RN)-B stated R7 is "very busy" often responds with "gibberish" when asked questions. R7 tends to have days and nights mixed up and wanders throughout the unit going into other resident's rooms. R7 can be hard to redirect and has gotten aggressive. Falls are usually stemming from falling out of bed. Staff implemented rounding program every hour. Staff anticipate resident's needs for bathroom and eating. Motion sensor in resident's room. If	F 689		

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	245528	A. BUILDING _____ B. WING _____	C 04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 self-transferring, staff get her up and let her wander around. Staff have also been instructed not to wake resident up in the middle of the night unless necessary. Staff also offer resident food and bring her out to the common area for distraction as resident likes to fidget. There are also photo albums and has a short attention span. Resident is on hospice and hospice has ordered morphine and lorazepam. Resident is also on scheduled Gabapentin (used to treat partial seizures, nerve pain from shingles and restless leg syndrome) to help with restlessness. Most of resident's falls occur in the evening and night. During interview on 4/10/25 at 10:22 a.m., RN-A stated unwitnessed falls require an assessment and neuros (assess an individual's neurological functions, motor and sensory response, and level of consciousness). The expectation is to paint a picture of what happened, and where they were. An email is sent out to everyone regarding the fall. RN-A mentioned to management last week they need to change how they look at falls. Currently, RN-A and the activity manager are assigned to monitor falls. Interventions are based on what type of fall. If resident's crawl out of bed, motion detectors are used. Referrals to PT/OT are made when appropriate. R7 had a couple falls when diagnosed with Covid due to being isolated to her room. When awake, R7 should be up and supervised out of her room. Current interventions include ambulation program, motions sensor, dicem under chair, toileting every 2-3 hours, autolock breaks on wheelchair, and nonstick footwear. They also increased her PRN (as needed) Ativan. RN-A confirmed the facility needs to do a better job at documenting interventions that have been put in place and	F 689		

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F 689	Continued From page 10 need to get more people involved in fall investigation to do a better review of falls and appropriateness of interventions During an interview on 4/10/25 at 11:11 a.m., the director of nursing (DON) stated R7 has a history of behaviors and falls. The DON stated there isn't always a rhyme or reason for resident's falls as she does not feel they are all related to sundowning. R7 tends to be more active in the evening and has a history of spitting out medications. Staff attempt to distract R7. R7 can be very unpredictable. Current interventions include nonstick footwear, motion detector when in bed, antiroll back brakes, dicem in wheelchair and increased supervision. R7 is also toileted every 2-3 hours because R7 cannot really communicate toileting need. Staff encourage R7 to participate in restorative programs. Reminders to ask for assistance do not work for her [due to dementia diagnosis.] Staff also keep frequently used items close and allow resident to "roam free" when she is anxious. The DON also indicated staff do hourly rounding. She confirmed they need to do a better job at looking deeper into each fall and making sure all interventions are on the care plan. Heating Pad Admission Minimum Data Set (MDS) assessment dated 3/21/25 indicated R28 was cognitively intact and had functional limitation in range of motion for both upper and lower extremities. R28's diagnoses list included displaced pelvic fracture, morbid obesity, anxiety, borderline personality disorder, bipolar II disorder, and left femur fracture.	F 689		

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F 689	Continued From page 11 During observation on 4/7/25 at 7:30 p.m., R28 was sitting in her recliner with her legs up. R28 was wearing long pants and an abd bandage (a thick rectangular bandage used to absorb fluids and protect skin) on the left shin area. R28 placed a sheet over her legs and reached for her heating pad. R28 placed heating pad on top of the sheet over her left shin area. Heating pad did not contact bare skin. R28 turned heating pad on. R28's provider orders lacked order for use of heating pad. R28's careplan lacked documentation of use of heating pad. R28's hospital discharge summary lacked documentation for use of heat/heating pad. Progress notes dated 4/8/25 at 1:28 a.m., indicated R28 reported pain to lower left leg and "did have her heating pad on the location for about 20 minutes". Progress notes dated 4/8/25 at 7:15 a.m., R28 does have a heating pad in her room. Progress notes dated 4/8/25 at 11:29 a.m., indicated R28 reported pain of 9 out of 10 to left leg with leg spasms. R28 was repositions and used heating pad. Progress notes dated 4/9/2025 at 3:42 a.m., indicated R28 "does have her heating pad" in her room. During interview on 4/8/25 at 2:59 p.m., licensed	F 689		

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F 689	Continued From page 12 practical nurse (LPN)-C stated R28 takes muscle relaxer and narcotic pain medications every 4 hours for pain. R28 refuses ice and repositioning to help with pain control. LPN-C reported seeing the heating pad for the first time on 4/7/25 and thought R28's mother brought it in. LPN-C stated the heating pad should have been reported to the director of nursing (DON), however it "slipped my mind". During interview on 4/9/25 at 9:35 a.m., registered nurse (RN)-C stated R28 will ask for pain medications routinely as soon as she is allowed to take them. RN-C reported seeing the heating pad in R28's room but assumed it had already been "checked out" by maintenance and approved. RN-C stated R28 does not usually use heating pad. RN-C confirmed electric items brought in from home have to be checked out by maintenance or policy has to be verified. During interview on 4/9/25 at 1:18 p.m., RN-B stated resident has struggled with pain control. Provider has evaluated and adjusted medications. RN-B stated she was not aware R28 had a heating pad in her room. RN-B stated R28 did ask about using a heating pad when she was first admitted. Staff informed R28 a heating pad "has to have an automatic shut-off" to be used in the facility. RN-B stated social services director (SS)-A told R28 if a heating pad was brought in, it needs to be "checked out". RN-B stated R28's husband brought in the heating pad. During interview on 4/10/25 at 9:20 a.m., SS-A stated R28 asked about using a heating pad upon admission. R28 was informed she could bring one in but it would have to be evaluated to ensure it had the correct connection, indicate accurate temperature, and had an automatic shut off.	F 689		

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F 689	Continued From page 13 SS-A stated R28's husband "must have brought it in without telling anyone." SS-A was not made aware of heating pad until 4/8/25. During interview on 4/10/25 at 9:55 a.m., maintenance director (M)-A stated heating pads are required to have a grounded (3-prong) plug to be approved. M-A stated he was not aware R28 had a heating pad. During interview on 4/10/25 at 11:04 a.m., R28 stated her husband brought in the heating pad however, could not recall what date. During interview and observation on 4/10/25 at 11:27 a.m., the director of nursing (DON) stated she was not aware R28 had a heating pad. The director of nursing provided the heating pad which was observed to have an ungrounded 2-prong cord and temperature indicator of "low, medium, high". The director of nursing stated using an ungrounded heating pad can increase the risk of an electrical short. There is also an increased risk of burns if resident were to fall asleep with the heating pad on due to the inability to determine exact temperature. A policy titled "Portable Space Heaters/ Electric Blankets, HAREM-" dated 4/2025 indicated "With a doctor's order, electric blankets may be used provided they are new (dedicated to that resident only), UL listed, and are plugged directly into an electrical outlet (extension cords are not permitted). Facility fall prevention policy revised 4/2025 titled "Fall Prevention" indicated "After an observed or probable fall, the staff will clarify the details of the fall, such as the staff will clarify the details of the	F 689		

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F 689	Continued From page 14 fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. This will be done by calling a Fall Huddle (see attached algorithm). -Nursing supervisor at the time will have all staff, working in the area of the fall, meet together to determine root cause analysis -Huddle will be called immediately after resident is stabilized -Staff will evaluate chain of events or circumstances preceding the fall (see attached fall huddle form) including: Time of day Whether fall was witnessed or not What the resident was doing What type of footwear did the resident have on What was the resident doing prior to the fall Distance of fall from starting location Location of fall ie. Bedside, between bed and bathroom, etc Last time resident had been to the bathroom and whether he/she was incontinent or not Mental status Gait assist devices -Staff will address any immediate interventions needed to prevent resident from falling again and communicate this to staff If fall is related to defective equipment, nursing supervisor will be responsible for taking this equipment out of service and notify the maintenance of need to examine and improvements can occur -Nursing supervisor will enter information gathered from huddle and interventions taken into the event form -Nursing supervisor will then place completed	F 689		

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F 689	Continued From page 15 Safety Huddle Form in Director of Nursing's mailbox Review of falls -The interdisciplinary team reports on all falls daily at the stand-up meeting and reviews the details known about the fall. -The IDT team will review fall events in their group discussion at the next daily stand-up meeting and close the event, including: Occurrence, huddle findings' Root cause Interventions in place-Do they match RCA" Are they weak, intermediate, or strong interventions? Suggestions? Protocol adherence-Are systems and operational changes needed? Any addition interventions desired through IDT analysis Monitoring subsequent falls and fall risk: -The staff will monitor and documents each resident's response to interventions intended to reduce falling or the risks of falling -If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measure are still needed if a problem that required the interventions (e.g. dizziness or weakness) has resolved -If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue tor change current interventions. As needed, the Attending Physician will help the staff reconsider possible	F 689		

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F 689	Continued From page 16 causes that may not previously have been identified -If a resident is noted to fall twice in a 2-month time period, referral to therapy will be made. If referral to therapy is not made, reasons for not referring will be documented on the fall investigation form -If a resident is noted to fall twice in a 2-month time period, need for pharmacy consult will be evaluated. If it is determined that thee is a need for a pharmacy consult, a referral be made, If referral is not made, reasons for not referring will be documented on fall investigation event form. -The staff and/or physician will document the basis for conclusion that specific irreversible risk factors exist that continue o present a risk for falling or injury due to falls"	F 689		

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/08/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/08/2025. At the time of this survey, GUNDERSEN HARMONY CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 05/12/2025

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

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K 000	Continued From page 2 Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification. There are two occupancies in the building. The nursing home (I-2) and an outpatient clinic (B) with proper fire separation. The facility has a capacity of 43 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain means of egress	K 211	K211 Gundersen Harmony Care Center will ensure that approved means of	5/26/25

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K 211	Continued From page 3 requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2025 between 10:30 AM and 1:30 PM, it was revealed by observation that the corridor exit (# 5) used for egress and exhibited a threshold-to-slab height delta of greater than one-half inch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	egress is continuously maintained free of all obstructions to full use in case of emergency. The threshold-to-slab height at door #5 will be less than one-half inch. The threshold-to-slab height at door #5 will be fixed by installing an aluminum tread plate ramp to match elevation differences which will allow wheelchairs to negotiate the exit path. The Environmental Services Director will do monthly audits of all exit discharge walking surfaces monthly ongoing. POC will be reviewed at next Safety Committee Mtg and at the next QAPI Committee Mtg.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7. These deficient findings could have a widespread impact on the	K 712	K712 Gundersen Harmony Care Center will ensure randomness of fire drills as per NFPA. Fire Drills will be conducted randomly meeting NFPA standards and will be	5/26/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 4 residents within the facility. Findings include: 1. On 04/08/2025 between 10:30 AM and 1:30 PM, it was revealed by review of available documentation that the documentation present for review exhibited a lack of randomness in the conducting of fire drills. 2. On 04/08/2025 between 10:30 AM and 1:30 PM, it was revealed by review of available documentation that the documentation present for review identified that there was no timestamp recorded for the Q1 - 2nd shift drill conducted on Jan 31, 2025. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712	recorded on the appropriate form with time and date indicated. The last three drill as recorded were: 2.20.25, 11:00pm, 3rd Shift; 3.21.25, 10:20am, 1st Shift; 4.30.25, 4:00pm, 2nd Shift. The Environmental Services Director will inspect the record of fire drills monthly for randomness and times stamps. POC will be reviewed at the next Safety Committee Mtg. and next QAPI committee Mtg.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		5/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/08/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 5 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/08/2025 between 10:30 AM and 1:30 PM, it was revealed by observation that in RM 137 that two medical devices were connected to a relocatable power-strip (non-1363A). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K 920 Gundersen Harmony Care Center will ensure that appliances and medical equipment be plugged in according to NFPA 99 (2012 edition). The two medical devices in room #137 have been unplugged from power strip and plugged directly into a wall outlet. The Environmental Services Director will do monthly room audits to assure all appliances and medical devices are plugged in with accordance to NFPA 99 (2012 edition). POC will be reviewed at next Safety Committee Mtg and at the next QAPI Committee Mtg.	