



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 18, 2026

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

RE: CCN: 245114
Cycle Start Date: June 10, 2026

Dear Administrator:

On July 23, 2026, the Minnesota Department(s) 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.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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June 26, 2026

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

RE: CCN:245114

Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

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 September 10, 2026 (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 December 10, 2026 (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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

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June 26, 2026

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

Re: Event ID: 2346D4-H1

Dear Administrator:

The above facility survey was completed on June 10, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER HARMONY RIVER LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 SHERWOOD STREET SOUTHEAST , HUTCHINSON, Minnesota, 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
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/4/26 through 6/10/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey. H51142541C (3018249) H51142818C (3035651)			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			

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F0000	INITIAL COMMENTS On 6/4/26 through 6/10/26, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51142541C (3018249) with deficiencies cited at F609, F744, F757. H51142818C (3035651) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			07/03/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do			F0609	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F609. However, 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. Facility-wide education will be provided to all staff regarding the identification, reporting, and documentation of inappropriate sexual behaviors, alleged non-consensual sexual contact, resident-to-resident sexual interactions, and any observed or suspected incidents requiring immediate reporting. Education will emphasize staff responsibilities for prompt notification, protection of residents, documentation, and compliance with facility abuse prevention and reporting policies. All		07/15/2026

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 reverse for further 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.

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

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F0609 SS = D	Continued from page 1 not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report an allegation of sexual abuse to the state agency (SA) for 2 of 3 residents (R4, R5) reviewed for reporting of alleged violations when R1 displayed sexual behaviors towards R4 and R5. Findings include: R1 R1's Admission Record printed 6/11/26, indicated he was admitted to the facility 2/10/26. Diagnoses included Alzheimer's disease, dementia and psychosis. R1's significant change Minimum Data Set (MDS) dated 3/18/26, identified severe cognitive impairment and indicated he displayed verbal behaviors toward others one-to-three days during the assessment period. The MDS indicted R1 transferred independently and ambulated with supervision. R1's care plan dated 4/13/26, identified limited physical mobility and indicated he required assistance from one staff for transfers and ambulate. The care plan revised on 3/17/26 indicated a history of requiring one-to-one staff supervision due to sexual advancements toward others. Interventions included: Intervene as necessary to protect the rights and safety of others, approach in a calm manner, divert attention and move to an alternate location as needed. R1's Progress Note dated 3/7/26, indicated R1 was found naked in his doorway, exposing himself to			F0609	Continued from page 1 new employees will be through the orientation process. Leadership staff received additional education on the Vulnerable Adult Policy and Procedure and all required reporting timelines. Residents R1, R4, and R5 remain current residents of the facility. Residents R4 and R5 experienced no lasting adverse effects related to the identified occurrences, and their care plans have been reviewed and updated to reflect the events and appropriate interventions. Resident R1 has demonstrated a significant reduction in behavioral expressions following implementation of individualized interventions and ongoing monitoring. To identify other residents who may have the potential to be affected by similar concerns, the interdisciplinary team conducted a comprehensive review of residents with known sexually related behaviors, inappropriate boundary concerns, or other behaviors that could place themselves or others at risk. Care plans, behavioral interventions, supervision requirements, and monitoring practices to be further evaluated and revised as identified to ensure resident safety and promote appropriate behavioral management. To monitor ongoing compliance, the Administrator, Clinical Administrator, and Household Coordinators or designee will conduct audits four times weekly for two weeks on random shifts throughout the facility to assess staff knowledge of reporting requirements related to inappropriate sexual behaviors and sexual contact, including immediate notification expectations. Audits will continue weekly for an additional two weeks. Any identified concerns will be addressed immediately through corrective action and staff re-education. All potential vulnerable adult (VA) situations will be tracked and audited to ensure compliance with investigation and reporting requirements. Audit results, identified trends, and corrective actions will be reviewed by the Quality Assurance and Assessment (QAA) Committee in July 2026. Additional recommendations will be implemented as needed to ensure ongoing compliance with F609. Date Certain: 7/15/2026 Responsible Parties: Administrator, Clinical Administrator, and Household Coordinators.		07/15/2026

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F0609 SS = D	Continued from page 2 another resident (R4). The other resident was able to walk away. R1 was redirected. Resident Occurrence Report dated 3/31/26, indicated R1 grabbed another resident's breast (R5) in a common area of the unit. Analysis of cause of incident indicated sexual disinhibition. Staff intervened and separated the residents and 15-minute checks were implemented. R1's Progress Note dated 3/31/26, indicated R1 had been seen "showing affection toward another resident" and indicated the other residents was not affected by it. R1 was removed from the area and brought back to his room. During interview on 6/5/26 at 7:31 a.m., licensed practical nurse (LPN)-A stated when R1 first moved to the unit, he was seated in the common area and had exposed himself to R4. LPN-A said R4 told staff and other residents about the incident and continued telling staff about it the next day. R4 R4's Admission Record printed 6/11/26, indicated she was admitted to the facility 9/23/25. R4's diagnoses included altered mental status, mild cognitive impairment and anxiety. R4's significant change MDS signed 4/23/26, indicated R4's vision was adequate with corrective lenses, had severe cognitive impairment and had no behaviors. R4 required supervision with transfers but was independent with ambulation with use of walker. R4's care plan dated 4/22/26, identified an alteration in mood and behaviors and indicated she self-transferred, wandered into other residents' rooms and enjoyed being able to navigate her way around the unit. R4 was not able to be interviewed. R4's record failed to include information regarding the incident with R1. R5 R5's Admission Record printed 6/11/26, indicated she was admitted to the facility 7/30/19. R5's diagnoses included vascular dementia and anxiety. R5's quarterly MDS signed 3/23/26, indicated R5			F0609			07/15/2026

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F0609 SS = D	Continued from page 3 had severe cognitive impairment and had no behaviors. R5 required supervision with transfers and ambulation. R5's care plan dated 5/31/26, identified limited physical ability and indicated she required staff assistance to and from all destinations. R5 was not able to be interviewed. R5's progress note dated 4/1/26, indicated on 3/31/26, staff observed a male resident (R1) touch her on the breast, over her clothing. Staff intervened and redirected the male resident without incident. R5 appeared unaffected and had been holding the male resident's hand at the time of the incident. During interview on 6/5/26 at 7:31 a.m., licensed practical nurse (LPN)-A stated at one-point R1 had been placed on 15-minute checks, "Maybe for being more sexual. I truly don't know." LPN-A stated when R1 first moved to the unit, he had exposed himself to R4, indicating he had his pants down and was facing R4. LPN-A stated R4 told staff about the incident the next day. During an interview on 6/8/25 at 12:51 p.m., with the administrator and director of nursing (DON), the administrator stated he was aware of the incident between R1 and R5 and said staff had intervened and separated the residents. The administrator stated R5 had been unaffected by the incident but R5's family member (FM)-A, had been very upset about the incident. The administrator stated the incident between R1 and R5 had not been reported to the SA because R5 had not been affected by it. The administrator and DON stated they had no knowledge of the incident between R1 and R4. During interview on 6/9/26 at 5:44 p.m., FM-A stated if R5 had been able to understand what happened when R1 touched her breast she would have been extremely uncomfortable. FM-A stated R5 was a very private and quiet person and would not have been okay with the situation. FM-A said R5 would have felt sexually harassed. Facility policy Vulnerable Adult Abuse Prevention Plan dated October 2025, identified sexual assault as sexual contact that resulted from force, threats or the inability of the person to give consent and included any sexual activity that occurred when and individual could not give consent. The policy indicated allegations of abuse			F0609			07/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245114		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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F0609 SS = D	Continued from page 4 will be reported immediately within state and federal guidelines and indicated if the allegation involved abuse the report must be made no later than two hours after the allegation was made.			F0609			07/15/2026
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop and implement resident specific approaches to behavior for 1 of 3 residents (R1) diagnosed with dementia who displayed negative behaviors affecting himself and other residents in the facility. Findings include: R1's Admission Record printed 6/11/26, indicated he was admitted to the facility 2/10/26. Diagnoses included Alzheimer's disease, dementia and psychosis. R1's significant change Minimum Data Set (MDS) dated 3/18/26, identified severe cognitive impairment and indicated he displayed verbal behaviors toward others one-to-three days during the assessment period. The MDS indicted R1 transferred independently and ambulated with supervision. R1's care plan: Revised on 3/17/26, identified an alteration in mood or behavioral expression due to Alzheimer's and dementia. Targeted behaviors included exit seeking, wandering into other residents' rooms, sexual behaviors toward staff, delusions and hallucinations. Revised on 3/1/26, see behavior intervention care plan: Revised on 3/17/26, encourage activities of interest.			F0744	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F744. However, 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 6/10/2026, Resident 1's medical record, behavioral interventions, and care plan were updated by the interdisciplinary team (IDT). Additional individualized interventions were implemented to address dementia-related behavioral expressions, including resident-specific approaches, communication techniques, environmental modifications, diversion activities, and other non-pharmacological interventions. Input was obtained from nursing, activities, social services, direct caregivers, and family to ensure interventions reflected the resident's current needs. To prevent recurrence, the facility will audit all residents with dementia diagnoses exhibiting behavioral expressions affecting themselves or others to ensure interventions, monitoring, and care plans accurately reflect resident needs and will make updates as identified. Moving forward, monthly interdisciplinary reviews of residents in memory care, who exhibit dementia-related behavioral expressions directed toward themselves or others, and as needed following significant behavioral changes. Care plans will be updated to reflect current interventions and resident response. The Memory Care IDT Quality Improvement meeting agenda has been revised to include a standing review of behavioral interventions, effectiveness of approaches, identified trends, and recommendations for additional individualized interventions. Additionally, the organization's Memory Care Services Director provides support and consultation to help ensure appropriate care, services, and interventions for residents living with dementia. Dementia Orientation Validation Education (DOVE) Captains provide additional guidance related to resident safety and abuse prevention. To monitor ongoing compliance, the Administrator, Clinical Administrator, or designee will conduct a weekly audit for two weeks, every two weeks, and monthly to verify interventions are implemented and		07/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245114		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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F0744 SS = D	Continued from page 5 Revised on 3/24/26, Therapeutic fibbing (bending the truth or telling small white lies to someone with dementia), redirection, reassurance, explain procedures, conversation, food, drink and toileting. Intervene as needed to protect the rights and safety of others. Approach and speak in calm manner. Revised on 4/17/26, had required 1:1 care due to sexual advancements toward others. Revised on 5/20/26, Utilize my favorite activities as opportunities for my behaviors: listening to personal music, going for walks, going outside, talking about hunting/fishing, ice cream, looking through picture books, watching television, calling family. The care plan identified potential to demonstrate verbally abusive behaviors related to cognitive impairment, dementia and poor impulse control. The care plan directed staff to observe for and document side effects of medication. When agitated, staff were directed offer photo album, busy board, and/or white noise machine. R1's care plan lacked evidence of comprehensive assessment of behaviors or resident specific interventions between 3/24/26 and 5/20/26 and lacked evidence of recommendations for non-pharmacological behavior interventions. R1's Progress Notes indicated the following: 3/4/26, R1 walked around the neighborhood several times during the shift. Pleasant with staff. Confused at times but was able to make needs known. 3/7/26, R1 was found naked in the doorway of his room exposing himself to another resident. The other resident was able to walk away from him. Staff intervened. 3/9/26. R1's family member expressed concerns for his demeanor and mood and said she had noticed R1 had been less cooperative and irritable since he moved to the secured unit. R1 had been refusing care from staff over the weekend.			F0744	Continued from page 5 documented, care plans are current, behavioral monitoring is completed, and interdisciplinary reviews are conducted. Audit results, education compliance, and Quality Improvement findings will be reported to the QAA Committee in July and October 2026 for review and additional recommendations to ensure ongoing compliance with F744. Date certain: 7/15/2026 Responsible Parties: Administrator and Household Coordinator		07/15/2026

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F0744 SS = D	Continued from page 6 3/11/26, Interdisciplinary team met to discuss R1's current status. R1 showed improvement in activities of daily living and mobility. 3/17/26, R1 had severe cognitive impairment, alert and oriented to self and family. Exhibits confusion, memory loss, impaired safety awareness and disorientation. Presented with minimal symptoms of depression. Targeted behaviors included exit seeking, wandering into other rooms, sexual behaviors toward staff. Behaviors often redirected by conversation, offer food/drink, escort to different location and allowing him to express feelings. R1 was generally pleasant and cooperative on a daily basis. 3/17/26, During assessments, R1 made sexual comments toward staff. 3/18/26. R1 admitted to hospice care. Medication changes implemented. 3/19/26, R1 awake at night, intermittently coming out of room and walking around common area. Staff assisted back to room several times. Offered snack and accepted. Sexual comments made to staff. 3/19/26, R1 was noted to have an increase in sexual behaviors and comments over the last week. 3/23/26, R1 stated he had to be somewhere tomorrow. Staff told him it was 1:00 a.m., R1 told staff they did not know how to read time and said staff knew nothing. Wandering in unit throughout shift. Assisted back to bed/room several times. Staff had been shutting R1's door to hear him exit due to wandering at night. R1 stated if door did not get opened, he would smash the window out. Staff opened door slightly to appease R1. 3/23/26, R1was agitated and asking to leave. Writer tried therapeutic fibbing and explained needed a few days to complete paperwork. R1 stated he was livid and would burn the place down then went back to his room. 3/23/26, R1 talked about enlisting in the Navy and			F0744			07/15/2026

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F0744 SS = D	Continued from page 7 that he had been told to wait and it had been days of waiting. 3/25/26, R1 self-transferred and stood in his doorway a couple times without a shirt on. Assisted back to wheelchair and refused food. Inappropriate remarks and gestures made to staff. 3/26/26, Nursing staff denied any new or worsening behaviors. 3/27/26, R1 continued to ambulate out of room, a few times without pants on. Mid-morning, R1 came out and reported to staff that staff in facility were drinking on the job and stated he needed to wake up staff laying on the floor. Also talked about enlisting in the Navy. 3/28/26, R1 continued to refuse care and declined to wear incontinent brief. 3/31/26, R1 was wandering on the unit looking for his wife and his car. R1 was seen showing affection toward another resident. Writer firmly told R1 to stop and separated the residents. 4/1/26, R1 awake throughout shift. Came out to common area looking for his wife and indicated he needed to get to work. Staff re-oriented him to time of day. Was offered a drink and snack which he declined. 15-minute checks performed per administrator. 4/1/26, R1 picked up phone and stated he was calling security because people were trying to break into his space. 4/1/26, R1 wandered around the unit looking for a way out. 4/1/26, Interdisciplinary team (IDT) discussion held regarding R1's escalating behavior and need for additional management strategies. Family member (FM)-C expressed hesitancy about using antipsychotic medications and questioned if behavior was related to new medication. It was explained that R1 was currently receiving			F0744			07/15/2026

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F0744 SS = D	Continued from page 8 one-on-one supervision which was not sustainable long term and if behavior continued or escalated without adequate symptom control through medication, a higher level of care may be necessary including potential hospital evaluation or alternate placement. 4/2/26, Staff had conversation with R1's FM-C regarding his care plan after recent "incident." Facility staff requested family provide additional presence in the building by family or friends to manage R1 during periods of increased behaviors. Team would also be calling FM-A to request additional assistance. 4/3/26, Family meeting was held to discuss R1's care needs and ongoing challenges with care coordination. Family was informed that if hospice recommendations continued to be declined or over-ridden the facility may proceed with a 30-day discharge notice and assist with alternate placement. Family was also told if R1 were to reach out physically toward staff or other residents, the facility had been instructed to send him the emergency department. Agreement was reached to continue one-on-one supervision for seven days with the understanding that it was a temporary measure. 4/4/26, R1 was seen naked and urinating in the sink in his room. 4/5/26, FM-A arrived and took over the one-on-one staff assigned to R1. 4/6/26. R1 noted to be hallucinating. Thought FM-A was in his bed and reported seeing two dogs. 4/7/26, Care meeting held. Physician scheduled Buspirone and provided education to family about Seroquel. Plan in place to discontinue the one-on-one if medications start to work. 4/9/26, R1 agitated and wandering. Became upset when staff was following him in hallways and day room and commented, "you better stop following me or else." Later talked about the woman who was following him.			F0744			07/15/2026

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F0744 SS = D	Continued from page 9 4/10/26, IDT reviewed R1’s overall mood and behaviors over the past several days. While there appeared to be a decrease in behaviors it did not mean behaviors had been resolved. The apparent reduction was largely due to the staff provision of one-on-one supervision which limited his ability to seek out or escalate behaviors. However, the behaviors were still present. 4/10/26, Hospice recommended the use of antipsychotic medications to address ongoing behaviors which family had declined. The IDT determined continued one-on-one supervision was required to maintain the safety of residents and staff. Family was provided with information on private long-term one-on-one staff that they would need to secure by Monday. Administrator advised family that if recommendations were not followed and behaviors continued, the facility would seek alternate placement. 4/10/26, Following ongoing discussion and IDT review a comprehensive evaluation of R1's clinical presentation, care needs and safety considerations was completed. Based on this review it was determined that the current care setting was no longer able to meet R1’s long-term care needs. Conclusion was primarily due to progression and persistence of behavioral concerns that pose an increased risk to other residents and staff. 4/13/26, R1 left his room and walked to a recliner and sat down. Staff followed him and asked if he needed something to which he stated, what he wanted was to get away from staff. R1 went back to his room. Irritated that staff kept following him. Resident Occurrence Report dated 3/31/26, indicated R1 grabbed another resident’s breast in a common area of the unit. Analysis of cause of incident indicated sexual disinhibition. Staff intervened and separated residents, and 15-minute checks were implemented. Facility document provided to family dated 4/10/26, indicated: Notice of discharge and indicated the facility was unable to meet R1’s needs and required 1:1 supervision to meet R1’s needs and ensure the health and safety of other residents and staff, and the facility was unable to provide the level of supervision R1 required. The documented indicated R1 would be discharged 5/10/26. The discharge			F0744			07/15/2026

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F0744 SS = D	Continued from page 10 notice was rescinded 5/8/26, only after an appeal was filed on R1's behalf. Hospice visit note dated 5/15/26, indicated a care conference was held for R1. FM's expressed concerns related to anti-psychotic medications. "[FM]'s have been given until 5:00 p.m. today to give consent or approval of hospice recommendations before going into the weekend." R1's behaviors indicated "appropriate for situation, calm." The assessment lacked evidence of non-pharmacological behavioral interventions attempted. During observation on 6/4/26 at 1:05 p.m., R1 was lying in bed and appeared to be asleep. At 1:46 p.m., R1 was lying in bed and was snoring. During observation on 6/8/26 at 4:19 p.m., R1 was seated in a common area of the unit. R1 stood up and ambulated independently to his room. At 4:29 p.m., R1 came out of his room wearing a jacket. At 4:34 p.m., R1 went to his room to retrieve his walker, headed toward the exit doors of the unit then turned around and sat in a chair in the common area. At 4:41 p.m., staff attempted to get R1 to go to the dining room to eat, which was refused. Staff then assisted him to a recliner in the common area. R1 then got up from the chair and headed back to the exit door. At 4:50 p.m., R1 was ambulating, and staff asked him if he needed to use the bathroom. R1 replied he was trying to go outside and staff said he couldn't because everyone was eating. R1 swore quietly. During observation on 6/9/26 at approximately 7:30 a.m., staff was in R1's room talking to him. A medication cart was parked outside the door. Staff left the room and turned off the light. At 8:00 a.m., the same staff member was talking to licensed practical nurse (LPN)-A and said, "I tried 129 [R1] but he wouldn't wake up." During interview on 6/5/26 at 7:31 a.m., licensed practical nurse (LPN)-A stated at one-point R1 had been placed on 15-minute checks, "Maybe for being more sexual. I truly don't know." LPN-A stated when R1 first moved to the unit, he had exposed himself to R4, indicating he had his pants down and was facing R4. LPN-A stated R4 told staff about the incident the next day. During interview on 6/9/26 at 1:34 p.m., the household coordinator (HC) stated R1's discharge notice was given because he needed one-on-one staff supervision which was not a long-term			F0744			07/15/2026

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F0744 SS = D	Continued from page 11 solution. Essentially R1 needed more care than the facility could provide. Registered nurse (RN)-B was present and stated family had declined in-patient mental health placement. The one-on-one supervision was implemented after he had a physical touch situation with another resident. When asked about interventions for his behaviors, RN-B said staff diverted his attention with photo albums and music (not implemented until 5/20/26). When asked about psychiatric referrals, RN-B said because R1 was on hospice they would not normally reach out to psychiatry. RN-B said after the incident with the female resident, they needed some other interventions so R1 was placed on the one-on-ones. RN-B stated compared to other residents in the facility who also had dementia, R1 was impulsive and displayed sexual behaviors toward residents and staff. RN-B acknowledged no further incidents with other residents had occurred since 3/31/26. During interview on 6/9/26 at 3:23 pm., RN-A stated R1 displayed agitation and was always looking for items or family. The previous evening (6/8/26), staff was attempting to transfer another resident and R1 sat in the resident's chair and would not get up. The more staff attempted to talk to him, the more upset R1 got. RN-A said staff tried to distract R1 by offering him ice cream or toileting but said he had been refusing those things. During interview on 6/9/26 at 3:39 p.m., with the administrator and director of nursing (DON), the administrator stated the discharge was initiated due to the facility's inability to provide one-on-one staff supervision, which R1 required for the welfare of the staff and residents. R1's family declined in-patient mental health and medications. The administrator stated they asked family to help with one-on-one supervision. The family was provided with a list of organizations that could provide one-on-one care, but family did not want to pay for it. The DON stated R1's behavior was better when he was receiving one-on-one supervision. The DON acknowledged R1 had not sought out other residents since the incident on 3/31/26 and stated that it had been an isolated incident. When asked how the facility managed other residents' behaviors, the DON stated staff administered medications. Regarding non-pharmacological interventions, the DON said what worked was dependent on the day. The DON stated she had not observed staff interactions with R1, nor had she requested feedback from the staff in an effort to assess behavioral interventions.			F0744			07/15/2026

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F0744 SS = D	Continued from page 12 During interview on 6/9/26 at 4:26 p.m., nursing assistant (NA)-A stated R1 made some sexual comments and said he could be aggressive with staff. NA-A stated they had a class provided by the company regarding dementia and stated, “I have been working here a long time, so I am pretty good at dementia.” NA-A said she had not received any specific education related to R1. During interview on 6/9/26 at 4:31 p.m., NA-B said R1 would refuse toileting and would raise his voice but never touched anyone, “he’s just loud.” NA-B said R1’s behaviors were not present when he admitted to the facility and said they started when he moved to the secured unit. NA-B said when R1 was agitated or exit-seeking he had stuff in his room to distract him.			F0744			07/15/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure pharmacy recommendations were addressed to include a clinical rationale for declined			F0757	This Plan of Correction constitutes our written allegation of compliance for deficiency cited on F757. However, 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. Upon identification of the concern, the hospice physician overseeing Resident 1's care provided written clinical rationale on 6/5/2026 outlining the benefits versus risks associated with the medication regimen. To identify other residents who may be affected by a similar concern, the facility will conduct an audit of all residents receiving three or more CNS-active medications as identified by the AGS Beers Criteria and review recent pharmacy consultant recommendations. The facility will also review residents with recent falls to ensure medication-related contributing factors were considered and addressed when clinically indicated. Any recommendations that were declined without sufficient documented clinical rationale supporting that the benefits outweigh the risks will be referred to the attending physician for review and appropriate follow-up. To prevent recurrence, the facility will revise the Pharmacy Consultant Recommendation form to include a narrative section requiring the physician to document objective clinical indications supporting the benefits versus risks when declining or not implementing pharmacy consultant recommendations. Clinical Coordinators will review all physician responses to pharmacy consultant recommendations to ensure adequate clinical rationale is provided. If		07/15/2026

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F0757 SS = D	Continued from page 13 recommendations and failed to identify and address medications as a contributing factor for falls for 1 of 3 residents (R1) reviewed who sustained multiple falls following the implementation of hospice prescribed medications. Findings include: R1's Admission Record printed 6/11/26, indicated he was admitted to the facility 2/10/26. Diagnoses included Alzheimer's disease, dementia and psychosis. R1's significant change Minimum Data Set (MDS) dated 3/18/26, identified severe cognitive impairment and indicated he displayed verbal behaviors toward others one-to-three days during the assessment period. The MDS indicted R1 transferred independently and ambulated with supervision. R1 received scheduled and as needed medication to relieve pain as well as non-medication interventions. R1 denied having, "pain or hurting," during the assessment period. R1's care plan included: Revised on 3/17/26, history of requiring one-on-one staff supervision due to sexual advancements toward others. Interventions had been implemented along with extensive conversation to manage behaviors. Interventions included: Intervene as necessary to protect the rights and safety of others, approach in a calm manner, divert attention and move to an alternate location as needed. Revised on 3/18/26, R1 entered hospice care. Revised on 4/13/26, identified limited physical mobility. R1 required assistance from one staff for transfers and ambulation. The care plan Revised on 4/23/26, behavior required intervention evidenced by sexual behaviors toward staff. R1 would comment on staff's appearance and voice sexual desires toward that staff member. R1 was often redirected through conversation. R1 had a history of masturbating in private room and being observed with hands inside pants in common areas, creating potential discomfort for others and need for redirection. Refer to Hospice regarding medication adjustments for behaviors.			F0757	Continued from page 13 sufficient rationale is not documented, the recommendation will be re-addressed with the provider. The Medical Director will be consulted when necessary if required clinical justification is not provided. Physicians and applicable licensed nursing staff will be educated on the revised process and the requirement for documented clinical rationale supporting medication-related decisions when pharmacy consultant recommendations are not accepted, including consideration of medications as a potential contributing factor when residents experience falls. To monitor compliance, the Clinical Administrator or designee will audit all pharmacy consultant recommendations that are declined by the attending provider on a monthly basis for three months to ensure an appropriate clinical rationale is documented and supported in the medical record. The audit will also verify that medication-related contributing factors are considered following resident falls when appropriate. Any identified variances will be addressed through immediate follow-up and re-education as indicated. Audit results and corrective actions will be reported to the Quality Assurance and Assessment (QAA) Committee in July and October 2026 for review and additional recommendations to ensure ongoing compliance with F757. Date Certain: 7/15/2026 Responsible Parties: Clinical Administrator, Assistant Clinical Administrator, Clinical Coordinators, Medical Director, and Administrator.		07/15/2026

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F0757 SS = D	Continued from page 14 The care plan further identified a risk for falls related to weakness, Alzheimer’s and a history of falls. Interventions included alert R1 to changes in environment, call light in reach, appropriate footwear, wheelchair out of path in room and review of information on past falls to determine cause and remove any potential causes of falls. Occurrence Report dated 2/11/26, indicated at 3:30 a.m., R1 fell in his room. Analysis indicated he was confused and may have fallen when returning from using the bathroom. Reminder to use the call light. R1’s progress notes reviewed 3/16/26 through indicated: 3/18/26, indicated R1 admitted for hospice services. Hospice orders included: Start Lexapro (used to treat major depressive disorder and generalized anxiety. Typical side effects include nausea, fatigue, sexual dysfunction, and sleep changes) 5 milligram (mg) tablets. Take 5 mg daily for seven days then re-evaluate. Start Seroquel (typical antipsychotic used to treat schizophrenia, bipolar disorder, and major depressive disorder. Potential side effects included heavy sedation and dizziness) 25 mg tablet. Administer 25 mg every four hours as needed for inappropriate sexual behaviors, agitation, and delirium. Mood disorder/ Discontinue after 14 days. Start Dilaudid (opioid analgesic used to manage severe pain that does not respond to other medications. Potential side effects included dizziness and drowsiness) 1 mg tablet, administer 1 mg every hour as needed for pain or shortness of breath. 3/19/26, Seroquel placed on hold at this time. 3/24/26, No pain noted, R1 reported feeling tired and family member (FM)-B reported R1 had been sleeping all the time. Order was received to increase Lexapro.			F0757			07/15/2026

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F0757 SS = D	Continued from page 15 4/1/26, hospice orders: Start Rivastigmine (used to treat mild to moderate dementia caused by Alzheimer's or Parkinson's disease. Potential side effects included dizziness and fatigue) 1.5 mg by mouth three times daily for dementia. Buspirone (used primarily to treat generalized anxiety disorder. Potential side effects included dizziness, drowsiness, lightheadedness and excitement) 5mg tablet by mouth three times daily for anxiety. Haloperidol (antipsychotic medication used to manage sever behaviors. Typical side effects included drowsiness, dizziness and restlessness)1 mg Solu tab every four hours for agitation, hallucinations and delirium. 4/2/26, FM-C denied consent for Haloperidol. 4/4/26, R1 was seen naked and urinated in the sink in his room. Buspirone given. 4/7/26, care meeting, Buspirone scheduled twice daily and R1 could still have as needed. Education provided related to Seroquel. 4/8/26, indicated R1 fell on his right side at 4:04 p.m. Intervention indicated weakness, medication changes and hip pain. Occurrence Report dated 4/8/26, indicated at 4:04 p.m., R1 fell in the hallway. Suggestion included therapy assessment and assistance with transfers and ambulation. Occurrence Report dated 4/15/26, indicated at 7:15 p.m., R1 fell near the desk. Suggestions included when R1 displayed behaviors, avoid bringing him out where he could see other residents coming and going. Occurrence Report dated 4/19/26, indicated at 12:30 p.m., R1 was observed on the floor in his room. Suggestions included continue 15-minute checks and ensure needs were met.			F0757			07/15/2026

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NAME OF PROVIDER OR SUPPLIER HARMONY RIVER LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 SHERWOOD STREET SOUTHEAST , HUTCHINSON, Minnesota, 55350			
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F0757 SS = D	Continued from page 16 Occurrence Report dated 4/20/26, indicated at 3:40 a.m., R1 was observed crawling out of his room into the hallway. Suggestion included promote sleep, “how do we get this man to sleep.” Pharmacist’s Recommendation to Prescriber dated 4/23/26, indicated R1 had experienced multiple falls, is at high risk for falls and received the following medications known to increase falls: Buspirone 10mg three times daily. Hydromorphone 1 mg every four hours as needed. Handwritten note on form indicated “on hospice-meds [medications] effective.” Check box on form indicated benefits outweigh risk and deemed necessary for R1. No changes. The recommendation lacked a clinical rationale for continuing the medications as prescribed and was signed by the physician on 5/19/26. Occurrence Report dated 4/25/26, indicated at 6:30 a.m., R1 fell in his room. Suggestions included medication review and getting him dressed for the day. R1’s MAR dated April 2026 indicated he received the following medications: Buspirone 5 mg twice daily from 4/7/26 through 4/16/26 and as needed doses on 4/4/26, 4/5/26, 4/6/26, 4/7/26, 4/8/26, 4/9/26, 4/10/26 x 2, 4/11/26, 4/13/26, 4/15/26 and 4/16/26. Buspirone 10 mg three times daily from 4/16/26 through 4/30/26 and as needed doses received on 4/18/26, 4/19/26, 4/24/26 x 2, 4/25/26, 4/28/26 x 2 and 4/29/26 x 2. Hydromorphone (Dilaudid) 1 mg three times daily from 4/2/26 through 4/9/26. Hydromorphone 1 mg every four hours (six times daily) from 4/9/26 through 4/30/26. Hydromorphone 1 mg as needed doses administered 24 times.			F0757			07/15/2026

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F0757 SS = D	Continued from page 17 Occurrence Report dated 5/4/26, indicated at 10:20 a.m., R1 fell in the dining room. Analysis indicated R1 had not slept well over the weekend, contacted hospice and requested nurse visit. Occurrence Report dated 5/29/26, indicated at 3:12 a.m., family observed resident fall (via camera in room). R1 got himself up off the floor. Second incident at 7:57 a.m., family again observed R1 on the floor via camera. Suggestions included management of bowel status and restlessness. R1's May 2026 Mar indicated he received the following medications. Buspirone 10 mg three times daily. As needed doses were administered 19 times. Hydromorphone 1 mg every four hours (six times daily) from 5/1/26 through 5/27/26. As needed doses were administered 12 times. Hydromorphone 1 mg five times daily from 5/27/26 through 5/31/26. Occurrence Report dated 6/1/26, indicated at 6:23 p.m., R1 was observed on the floor by family via video footage. Suggestions included staff to perform one to one. Progress Note dated 6/2/26 indicated that FM called around 12:15 a.m. and reported R1 had fallen at approx. 6:23 p.m. on 6/1/26. Occurrence Report dated 6/3/26, indicated at 12:00 a.m., R1 was observed on the floor. Suggestions included an increase in dose of anti-anxiety medication and one to one care. Progress Note dated 6/4/26, indicated orders from hospice. Increase Hydromorphone to every four hours (six times daily) and may also have every hour as needed. Start Seroquel 50 mg at bedtime and 25 mg every four hours as needed. During interview on 6/8/26 at 2:38 p.m., the			F0757			07/15/2026

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F0757 SS = D	Continued from page 18 consultant pharmacist (CP) stated concern for R1’s medication included: dilaudid caused drowsiness and dizziness; seroquel caused increased hallucinations and agitation especially in the elderly and also caused dizziness and sleepiness; buspirone could also cause drowsiness. The CP said concerns with R1’s medications included falls and the recently added Seroquel dose. During interview on 6/9/26 at 11:34 a.m., medical doctor (MD)-A stated R1 was at risk for falls. The dilaudid was started for hip pain, MD-A was not sure if it was scheduled or as needed but said it was not a medication he would use for pain management. MD-A did not remember what dose R1 was receiving and said, it was just his preference, but he would have used something else. During interview on 6/10/26 at 11:38 a.m., the assistant director of nursing (ADON) stated falls were discussed with the interdisciplinary team and during weekly fall meetings. The ADON said any discussion of high-risk medications contributing to falls done through the coordination with hospice and said they collaborated with them. The ADON said hospice had access to the medical record and could read the notes. The ADON said they always talked about medications and said they discussed the whole resident but said she did not document any medication review and/or adjustments as part of R1’s falls discussions. Facility Unnecessary Medication Use policy dated March 2025, indicated residents receiving medications for an undocumented reason or without clear indication for the medication requires the facility to document if continuing the medication is justified by evaluating the condition, risks and existing medication regime. The medical record must reflect a rational for continued use of medications.			F0757			07/15/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/4/26 through 6/10/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey. H51142541C (3018249) H51142818C (3035651)			20000			07/03/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			07/03/2026