Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 23, 2026

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

RE: CCN: 245114
Cycle Start Date: December 10, 2025

Dear Administrator:

On January 12, 2026, the Minnesota Department(s) of Health 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,

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

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December 10, 2025

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

RE: CCN:245114
Cycle Start Date: December 12, 2025

Dear Administrator:

On December 12, 2025, a survey was completed at your facility by the Minnesota Departments of Health 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:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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 March 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 June 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.

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

Email: sarah.lane@state.mn.us

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 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY RIVER LIVING CENTER	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
F0000	INITIAL COMMENTS On 10/28/25, a standard abbreviated survey was conducted at your facility. 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. H51146482C (2651983), with a deficiencies issued at F609 and F610. 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		12/19/2025
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 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	F0609	This Plan of Correction (POC) is the facility's written allegation of compliance for the deficiency cited at F609. Submission of this POC does not constitute an admission that a deficiency exists or that the citation was correctly issued. This POC is submitted in accordance with State and Federal requirements. The effected resident was discharged from the facility to his preferred facility on 11/7/2025. No incidences similar in nature have further been identified. Facility-wide education was provided to all staff on the Vulnerable Adult Abuse Prevention and Reporting Policy, including mandatory reporting requirements and required reporting timeframes. Education reinforced reporting processes, including appropriate notification, documentation, and escalation procedures. Leadership staff were re-educated on their responsibility to ensure timely reporting to the Administrator and applicable external agencies.	12/31/2025

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 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 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 allegations of abuse to the state agency, immediately, but not later than 2 hours after the allegation is made, for one of three residents (R1) reviewed. R1 reported he was abused in his room multiple times during the night. Findings include: Minimum Data Set (MDS) dated 6/24/24 indicated R1 was admitted to the facility for treatment of osteoarthritis of the right knee. R1's relevant diagnoses included chronic pain, mild intellectual disability, anxiety, unspecified psychosis, and developmental disorders. R1 required substantial to maximal assistance with repositioning in bed. R1 used a wheelchair to ambulate. R1's Brief Interview for Mental Status (BIMS) score was 10 out of 15, indicating he had mild cognitive impairment. R1's care plan indicated he had a history of behavioral disturbances. R1's care plan indicated R1 experienced delusions and paranoid about people in his room intending to harm him. R1's care plan indicated R1 was at risk for abuse and had a history of making allegations against staff. R1's care plan indicated staff were to implement the buddy care system for all care tasks and during overnight cares. R1's care plan instructed staff to report any further concerns to the campus administrator for allegations. R1's care plan indicated staff should follow the facility vulnerable adult policy. A progress note dated 7/21/25 at 8:31 p.m. indicated R1 informed staff an unknown woman hit him on the top of his head.	F0609	Continued from page 1 To monitor compliance, audits will be conducted four times weekly for two weeks on random shifts throughout the facility to assess staff knowledge and adherence to abuse reporting requirements. Audits will then continue weekly for an additional two weeks. Audit results will be reviewed for trends and reported to the Quality Assurance and Assessment (QAA) Committee in January 2026. Identified variances will result in immediate corrective action, including re-education as indicated. The Administrator and Household Coordinators are responsible for ensuring ongoing compliance. Responsible Party: Campus Administrator and Clinical Administrator	

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F0609 SS = D	Continued from page 2 A progress note dated 9/23/25 at 9:22 p.m. indicated R1 informed staff someone had struck him on the head the previous night at about 1:00 a.m. A social services note dated 9/24/25 at 3:19 p.m. indicated social services staff followed up with R1 regarding his allegations of being struck on the head. The note indicated R1 had a history of paranoia, delusions, and conflict with others. A progress note dated 10/15/25 at 10:06 p.m. indicated R1 reported to staff that someone had been touching him “down there,” and staff reassured him because they use the buddy system for his cares, this could not have happened. During an interview on 10/28/25 at 1:08 p.m., trained medication aide (TMA)-A stated if a resident tells her they had experienced any abuse in the facility, she will inform the nurse so they can document it and follow the chain of command. During an interview on 10/28/25 at 1:14 p.m., registered nurse (RN)-A stated when residents report allegations of abuse, she must report it to the on-call administrator right away. RN-A stated when R1 makes an allegation of abuse, they must document it in the chart, then leave a voice mail for the clinical coordinator. RN-A stated if what R1 claims is serious, they should then call the administrator as well. RN-A stated R1 had not made any allegations of abuse to her. During an interview on 10/28/25 at 1:22 p.m., R1 stated he did not have any concerns with the care at the facility. During an interview on 10/28/25 at 1:39 p.m., TMA-B stated if a resident alleges any type of abuse, tell the charge nurse and the administrator as soon as they mention it. TMA-B stated R1 had never mentioned any type of abuse in the facility to her, and if he did, she would tell the nurse and the administrator immediately. During an interview on 10/28/25 at 2:08 p.m., TMA-C stated if a resident alleges abuse, they will use her	F0609		

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F0609 SS = D	Continued from page 3 walkie talkie device to notify the charge nurse right away. TMA-C stated this information would then go to the supervisor. During an interview on 10/28/25 at 3:00 p.m., RN-B stated if a resident reported abuse to her, she would notify the administrator right away. RN-B stated R1 told her on 10/15/25 someone was “touching him down there in his private parts and abusing him.” RN-B stated she then notified the clinical coordinator about R1’s allegations. During an interview on 10/28/25 at 3:02 p.m., the household coordinator stated when she receives allegations of abuse, she tells the supervisor right away. The household coordinator stated because R1 has such a long history of making allegations against staff, they do not report all R1’s allegations to the state agency, otherwise they would be reporting quite frequently. During an interview on 10/28/25 at 3:22 p.m., the clinical coordinator stated he contacts the director of nursing as soon as there is an allegation made and will begin investigating if he is in the building. The clinical administrator stated he investigates by speaking with the resident and any other staff present during the time of the alleged incident. The clinical administrator stated he then brings the information to the administrator who makes the report to the state agency. During an interview on 10/28/25 at 3:41 p.m., the assistant clinical administrator stated if a resident alleges abuse, they use two staff to enter the room and complete assessment to determine if the abuse was physically possible. The assistant clinical coordinator stated if they believe the allegation may have occurred, they report it to the administrator of the director of nursing. During an interview on 10/28/25 at 3:53 p.m., the administrator stated if nursing staff are expected to notify the director or nursing or himself if appropriate. The administrator stated allegations of abuse that would need to be reported to him are allegations of physical abuse, residents being yelled at, or residents being sexually abused. The administrator stated he then takes these allegations	F0609		

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F0609 SS = D	Continued from page 4 and “vets” them further based on the resident’s plan of care and history making abuse allegations. The administrator stated if this is the resident’s first instance of an abuse allegation, the administrative team would complete an investigation. The administrator stated if a resident reported sexual abuse, reporting would depend on their history and if the resident could recall specific details. The administrator stated if the resident has a known history of abuse allegations, the nurse will evaluate and determine if the situation possibly occurred. The administrator stated they need to report allegations of abuse if the resident’s care plan was not followed, but if it was followed, the allegations are not reportable. The administrator stated there is a two-hour window for reporting to the state if the allegations pose risk for immediate harm to the resident. A facility policy titled "Vulnerable Adult Abuse Prevention Plan," dated October 2025, the policy indicated the facility administrator, or designee will make a report according to federal and state requirements. The policy indicated allegations of abuse must be made within two hours after the allegation is made.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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:	F0610	This Plan of Correction (POC) is the facility’s written allegation of compliance for the deficiency cited at F610. Submission of this POC does not constitute an admission that a deficiency exists or that the citation was correctly issued. This POC is submitted in accordance with State and Federal requirements. The effected resident was discharged from the facility to his preferred facility on 11/7/2025. A facility-wide review was conducted to identify other residents who may have been affected or were at risk for similar alleged violations. No incidences similar in nature have been identified. Immediately following Rapid Response survey for allegation, all facility leadership staff received verbal education on the reporting requirements per the CMS State Operation Manual. On investigating alleged violations including abuse, all need to report allegations immediately, understanding that the duty is triggered by the allegation or suspicion, not proof. Facility-wide education was provided to all staff on the Vulnerable Adult Abuse Prevention and Reporting Policy, including mandatory reporting requirements and	12/31/2025

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F0610 SS = D	Continued from page 5 Based on interview and document review, the facility failed to conduct a formal investigation into the allegations of physical and sexual abuse for one of three residents reviewed (R1) for abuse. Findings include: Minimum Data Set (MDS) dated 6/24/24 indicated R1 was admitted to the facility for treatment of osteoarthritis of the right knee. R1's relevant diagnoses included chronic pain, mild intellectual disability, anxiety, unspecified psychosis, and developmental disorders. R1 required substantial to maximal assistance with repositioning in bed. R1 used a wheelchair to ambulate. R1's Brief Interview for Mental Status (BIMS) score was 10 out of 15, indicating he had mild cognitive impairment. R1's care plan indicated he had a history of behavioral disturbances. R1's care plan indicated R1 experienced delusions and paranoid about people in his room intending to harm him. R1's care plan indicated R1 was at risk for abuse and had a history of making allegations against staff. R1's care plan indicated staff were to implement the buddy care system for all care tasks and during overnight cares. R1's care plan instructed staff to report any further concerns to the campus administrator for allegations. R1's care plan indicated staff should follow the facility vulnerable adult policy. A progress note dated 7/21/25 at 8:31 p.m. indicated R1 informed staff an unknown woman hit him on the top of his head. A progress note dated 9/23/25 at 9:22 p.m. indicated R1 informed staff someone had struck him on the head the previous night at about 1:00 a.m. A social services note dated 924/25 at 3:19 p.m. indicated social services staff followed up with R1 regarding his allegations of being struck on the head. The note indicated R1 had a history of paranoia, delusions, and conflict with others.	F0610	Continued from page 5 required reporting timeframes. Education reinforced reporting processes, including appropriate notification, documentation, and escalation procedures. Leadership staff were re-educated on their responsibility to ensure timely reporting to the Administrator and Administrator or designee reporting suspicions or allegations of abuse within two hours of allegation being made. To monitor compliance, audits of leadership understanding of the requirement, review of medical records, along with Random resident and staff interviews regarding abuse reporting. Results will be reviewed in the QAPI committee, and additional corrective actions will be implemented as needed. The Administrator and Clinical Administrator are responsible for ensuring ongoing compliance. Responsible Party: Campus Administrator and Clinical Administrator	

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F0610 SS = D	Continued from page 6 A progress note dated 10/15/25 at 10:06 p.m. indicated R1 reported to staff that someone had been touching him “down there,” and staff reassured him because they use the buddy system for his cares, this could not have happened. During an interview on 10/28/25 at 1:14 p.m., registered nurse (RN)-A stated when residents report allegations of abuse, she must report it to the on-call administrator right away. RN-A stated when R1 makes an allegation of abuse, they must document it in the chart, then leave a voice mail for the clinical coordinator. RN-A stated if what R1 claims is serious, they should then call the administrator as well. During an interview on 10/28/25 at 3:00 p.m., RN-B stated if a resident reported abuse to her, she would notify the administrator right away. RN-B stated R1 told her on 10/15/25 someone was “touching him down there in his private parts and abusing him.” RN-B stated she then notified the clinical coordinator about R1’s allegations. During an interview on 10/28/25 at 3:02 p.m., the household coordinator stated when she receives allegations of abuse, she tells the supervisor right away. The household coordinator stated her investigation would depend on what the administrator tells her to do next. The household coordinator stated after the allegations, she educated R1 to tell staff about his concerns immediately, rather than waiting multiple hours or days prior to notifying staff. During an interview on 10/28/25 at 3:22 p.m., the clinical coordinator stated he contacts the director of nursing as soon as there is an allegation made and will begin investigating if he is in the building. The clinical administrator stated he investigates by making a timeline of events, looking at the psychiatric diagnoses of the residents making the allegation, and determining if they have a past history of abuse allegations. The clinical administrator stated he when he spoke with R1 following his allegations on 10/15/25, R1 was unable to give a consistent account of what the alleged perpetrators looked like. During an interview on 10/28/25 at 3:53 p.m., the administrator stated if nursing staff are expected to	F0610		

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HARMONY RIVER LIVING CENTER	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
F0610 SS = D	Continued from page 7 notify the director or nursing or himself if appropriate. The administrator stated he then takes these allegations and “vets” them further based on the resident’s plan of care and history making abuse allegations. The administrator stated if this is the resident’s first instance of an abuse allegation, the administrative team would complete an investigation. The administrator stated if the resident has a known history of abuse allegations, the nurse will evaluate and determine if the situation possibly occurred. The administrator stated investigations are mostly managed by himself or the director of nursing, however he was not available when R1 made allegations to staff on 10/15/25, and the concern would have been brought to the interdisciplinary team. The administrator stated the interdisciplinary team determined because R1 had a history of making allegations, there were no residents who would have wandered into R1's room, and they had buddy care in place on his care plan, a formal investigation was not necessary. A facility policy titled "Vulnerable Adult Abuse Prevention Plan," dated October 2025 indicated the facility must review of each allegation. The policy indicated internal investigations should contain an Investigation Form and Staff Interviews document. The policy indicated the administrator, or designee will complete a full review of investigative documentation to determine if trends exist.	F0610		