Electronically Delivered
May 15, 2025

Administrator
Harmony Gardens
1438 County Road C East
Maplewood, MN 55109

RE: CCN: 245381
Cycle Start Date: April 4, 2025

Dear Administrator:

On May 13, 2025, the Minnesota Department 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2025

Administrator
Harmony Gardens
1438 County Road C East
Maplewood, MN 55109

RE: CCN: 245381
Cycle Start Date: April 4, 2025

Dear Administrator:

On April 4, 2025, a survey was completed at your facility by the Minnesota Department 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
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 July 4, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 4, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections

488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY GARDENS	1438 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/3/25 - 4/4/25, 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 complaint was reviewed: H53812466C MN111892/MN111494 with deficiencies at F609, F610, F641, F700 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.	F 000		
F 609 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	F 609		5/6/25

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

Electronically Signed | 04/14/2025

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

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F 609	Continued From page 1 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 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 observation, interview, and record review the facility failed to immediately report allegations of abuse and injury of unknow origin to the State Agency (SA) no later than two hours after the allegation is made for 1 of 1 resident (R1) reviewed. R1's family filed a facility grievance that indicated staff was "aggressive" with R1 and a facility nurse found bruising that were similar to finger marks on R1's upper arm where a cause was not identified. Neither event was reported. Findings include: R1's admission Minimum Data Set dated 3/6/25 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair	F 609	F609 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia Harmony Gardens to comply with F609. To ensure continued compliance, the following plan has been put into place: Regarding cited resident: OHFC report submitted to MDH. Thorough investigation was conducted into injury of unknown origin.	

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F 609	Continued From page 2 transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). R1's event history dated 3/4/25 - 4/3/25 did not indicate an event for any bruising of unknown origin. R1's abuse assessment dated 3/6/25 indicated R1 had physical limitations which made her susceptible to abuse explained due to R1 was a stroke victim. R1 had cognitive deficits which made her susceptible to abuse with no explanations indicated. R1's care plan dated 3/6/25 did not indicate R1 was at risk for abuse. A facility grievance dated 3/12/25 indicated R1 expressed to FM-B that NA-A was aggressive with her. The facility investigation follow-up 3/14/25 indicated R1 continued to have "cares in pairs". The follow-up included the statement "Staff feel like this pain is continuing to make her feel like the aids are throwing her around." R1's progress note dated 3/13/25 at 7:45 a.m. indicated R1 had three circular dark purple bruises noted near R1's left elbow during the night shift. Visual inspection completed on the left side prior to medication administration as resident had complained of pain on the left side after transferring to the bed. The bruise measures were as follows (superior to inferior), 1.0 centimeters (cm) x 1.0 cm, 1.5 cm x 1 cm, and 1	F 609	Actions taken to identify other potential residents having similar occurrences: All residents are determined to be at risk. Measures put in place to ensure deficient practice does not recur: Retraining of all facility staff on facility Vulnerable Adult policy which includes requirements on reporting in regard to timing. Effective implementation of actions will be monitored by: The Administrator or Designee will audit progress notes, grievances, and wound reports weekly x 4 weeks for allegations of abuse and injury of unknown origin. Results of these audits will be reviewed by the facility's QAPI committee, which will determine if audits can be reduced or discontinued. Those responsible to maintain compliance will be: The Administrator or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 5/6/2025	

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F 609	Continued From page 3 cm. 1.2 cm. No other progress notes indicated any skin concerns. Upon interview on 4/3/25 at 12:18 p.m. family member (FM)-A was visiting. R1 had mentioned to him three- or four-times in the past few weeks how NA-A was aggressive verbally and physically with R1. He stated that same week FM-B found three small bruises on R1's upper arm that resembled fingers markings. The bruising was not reported to the family until the family asked about the bruising and was told by the director of nursing (DON) that the facility was not certain when or how the bruising occurred. Upon interview on 4/3/25 at 12:25 p.m. FM-B stated the family met with the staff on 3/10/25 and spoke of their concerns with nursing assistant (NA-A). FM-B was asked to fill out a grievance form with her concerns. She completed the form. She stated she wanted the facility to address the "aggressive" cares for R1 completed about. The family noticed a change in R1 both mentally and physically. Mentally her conversations became "dark" saying she just did not want to live anymore if care meant physical and mental pain. On 3/14/25 was when R1 showed the family the bruising on R1s left arm. FM-B witnessed when the DON assessed R1's arm. The DON stated she could not say how or when the bruising happened. "It looked like finger markings." Upon observation and interview on 4/3/25 at 1:33 p.m. R1 was able to lift her left shirt sleeve above her elbow and point to where the bruising had been. She stated it must have happened at some point when NA-A "threw her around". She stated she did not know whether someone had gripped her during a transfer or "moving her in bed." R1	F 609		

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F 609	Continued From page 4 stated she was having pain on her left side "one night." She called for the nurse and RN-B found the bruising. RN-B asked R1 a lot of questions about the bruising and brought in another nurse to look at them. R1 stated the next day she showed the bruising to her family and the family had the "head nurse" look at it, who did not know what caused it. "I told her it was the aggression." In addition, R1 stated NA-A yelled at her almost every time she worked with her and made her feel "like I would rather be dead than receive this care." She stated she would say things like telling her to how awful she was to care for and that I better not say anything about how aggressive she is. She stated she felt safe at the facility if NA-A stayed o out of her room. Upon interview on 4/3/25 at 12:50 p.m. NA-B stated he was aware there was to be two aides in R1's room with cares but was not certain why. He stated aggression was abuse as aggression was mentioned in the yearly abuse training, he had recently completed. He stated both concerns of aggression and bruising, when the root cause is not known, is reportable immediately. Upon interview on 4/3/25 registered nurse (RN)-C stated she had not noticed bruising on R1, however bruising any allegations of verbal and mental abuse must be reported immediately. Upon interview on 4/3/25 at 2:09 p.m. social worker (SW)-A stated yelling would be considered verbal and abuse should be reported within 24 hours. She stated the term "aggression" is a broad term and the facility would need to investigate that before making a report. She stated she was not aware of the grievances.	F 609		

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F 609	Continued From page 5 Upon interview on 4/3/25 at 2:25 p.m. the DON stated when she inquired with the family and R1 about the bruising she could not explain what happened. She stated maybe it was staff using her body instead of a bed sheet to lift her that could have caused bruising, "we just don't know." We moved R1 to care in pairs immediately. The DON stated in her follow-up report where other indicated other nursing assistants (unidentified) stated "throwing her around" meant yanking on and hurting R1. The DON was not aware that injury of unknown origin was reportable and did not feel R1's allegations of aggression and being thrown around was not reportable to the SA as the facility kept it inhouse and provided interventions. The facility was meeting with R1's family weekly and the family had no other concerns currently after the interventions the facility put in place. Upon interview on 4/3/25 at 3:33 p.m. NA-A stated the DON spoke with her that R1's family alleged NA-A was aggressive, snippy, and did not want to be at work. She not able to work with R1 after their conversation. NA-A stated approximately six months ago she had been accused her at yelling at a man, but nothing became of that situation and that resident was no longer at the facility. She stated neither allegation against her was true. She identified herself as calm, caring and took her job seriously. Upon interview on 4/4/25 at 7:05 a.m. RN-D stated he did witness the bruising on R1. He stated RN-B came to the unit he was working on to get his opinion of the bruising. He stated the bruising was small on R1's upper arm. He stated RN-B had measured the bruising without being present. RN-D stated R1 was complaining of left	F 609		

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F 609	Continued From page 6 sided body pain. He was not certain whether RN-B reported the bruising to the management team or not. Upon interview on 4/4/25 at 9:21 a.m. RN-B stated she found three small bruises above R1's elbow when R1 was complaining of pain on her left side. She stated, "I wondered if there was something going on." R1 stated to her that she had gotten in a fight, and she lost. RN-B stated she worked nights and at times people have dreams, so maybe it was a dream as R1 was confused. RN-B found RN-D and had him observe R1 with her. RN-B stated in hindsight she thought the cause of the bruising was R1 gripping her own arm. RN-B stated she documented the bruising in R1's chart. She did not know if anyone followed-up with R1. RN-B saw the bruising two nights in a row when she gave R1 pain medication during the night. RN-B did not think of reporting the bruising of unknow origin to management since she had documented the findings in her chart. NA-A's human resources file did not have any performance improvement documentation for R1. A facility policy titled Vulnerable Adult-MN with a revision date of 10/14/22 indicated: The facility prohibits the abuse, neglect, exploitation of residents, and mistreatment of residents and/or misappropriation of resident property by anyone including staff, other residents, family, friends, volunteers, etc. All residents of the facility are considered vulnerable adults due to physical or mental disability or dependence on institutional services. The facility attempts to establish an environment	F 609		

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F 609	Continued From page 7 that is as homelike as possible and includes a cultures and environment that treats each resident with respect and dignity. Each employee is responsible to report suspected/alleged violations of mistreatment, neglect, exploitation of residents, and abuse of residents and/or misappropriation of resident property immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegations involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to designated facility staff (i.e. DON, Director of Social services, or Nursing supervisor). The Administrator will be notified immediately. Report all alleged violations and substantiated incidents immediately, but no 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 no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to the state agency and all other agencies as required (electronically to OHFC or if needed, online to MAARC if report being filed upon discharge). To be in compliance with the Elder Justice Act of 2011, all staff needs to be aware of when Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. It also includes deprivation by an individual, including caretaker of goods and services that are necessary to attain or maintain physical,	F 609		

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F 609	Continued From page 8 mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, or pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful: (as used in the definition of abuse) means the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury. Injuries of unknown source: An injury should be classified as an "injury of unknown source" when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; AND The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries. observed at one particular point in time or the incidence of injuries over time. Mental Abuse: Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal Abuse: Any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to	F 609		

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F 609	Continued From page 9 frighten a resident, such as telling a resident that they will never be able to see their family again.	F 609		
F 610 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: Based on observation, interview, and record review the facility failed to provide evidence that a thorough investigation was completed on allegations of an injury of unknown origin for 1 of 4 residents (R1) reviewed. Staff found bruising resembling finger markings on R1's upper arm. R1's family had filed a grievance report regarding aggressive care one day prior to the bruising findings. Findings include: Facility record grievance review dated 1/1/25 -	F 610	F610 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia Harmony Gardens to comply with F610.	5/6/25

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	245381	A. BUILDING _____ B. WING _____	C 04/04/2025

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F 610	Continued From page 10 4/3/25 did not reveal any documented grievance or investigation regarding R1's bruising an injury of unknown origin. R1's admission Minimum Data Set dated 3/6/25 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). R1's event history dated 3/4/25 - 4/3/25 did not indicate an event for any bruising of unknown origin. R1's abuse assessment dated 3/6/25 indicated R1 had physical limitations which made her susceptible to abuse explained due to R1 was a stroke victim. R1 had cognitive deficits which made her susceptible to abuse with no explanations indicated. R1's care plan dated 3/6/25 - 4/3/25 did not indicate R1 was at risk for abuse. Nor did the care plan indicate R1 was to have cares in pairs (2 staff with all cares). R1's progress note dated 3/13/25 at 7:45 a.m. indicated R1 had three circular dark purple bruises noted near R1's left elbow during the night shift. Visual inspection completed on the left	F 610	To ensure continued compliance, the following plan has been put into place. Regarding cited resident: R1 received a comprehensive skin assessment on 4/8/25. Resident R1 was interviewed. Other residents as well as staff working were interviewed. Actions taken to identify other potential residents having similar occurrences: All residents were determined to be at risk. Measures put in place to ensure deficient practice does not recur: Retraining of all facility staff concerning the reporting of bruises. The administrator or DON will oversee a thorough investigation with each injury of unknown origin. Effective implementation of actions will be monitored by: The Administrator or Designee will audit progress notes, grievances, and wound reports weekly x 4 weeks looking for bruises of unknown origin. Results of these audits will be reviewed by the facility's QAPI committee, which will determine if audits can be reduced or discontinued. Those responsible to maintain compliance will be: The Administrator or designee is responsible for maintaining compliance.	

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F 610	Continued From page 11 side prior to medication administration as resident had complained of pain on the left side after transferring to the bed. The bruise measures were as follows (superior to inferior), 1.0 centimeters (cm) x 1.0 cm, 1.5 cm x 1 cm, and 1 cm. 1.2 cm. No other progress notes indicated any skin concerns. Upon interview on 4/3/25 at 10:01 a.m. R1's Nurse Practitioner (NP) stated she was not notified of any bruising on R1. Upon observation and interview on 4/3/25 at 1:33 p.m. R1 was able to lift her left shirt sleeve above her elbow and point to where the bruising had been. She stated it must have happened at some point when NA-A "threw me around". She stated she did not know whether someone had gripped her during a transfer or "moving her in bed." R1 stated she was having pain on her left side "one night." She called for the nurse and RN-B found the bruising. RN-B asked R1 a lot of questions about the bruising and brought in another nurse to look at them. R1 stated the next day she showed the bruising to her family and the family had the "head nurse" look at it, who did not know what caused it. "I told her it was the aggression." In addition, R1 stated NA-A yelled at her almost every time she worked with her and made her feel "like I would rather be dead than receive this care." She stated she would say things like telling her to how awful she was to care for and that I better not say anything about how aggressive she is. She stated she felt safe at the facility if NA-A stayed out of her room. Upon interview on 4/3/25 at 12:50 p.m. NA-B stated he was aware there was to be two aides in R1's room with cares but was not certain why. He	F 610	Completion date for certification purposes only is: 5/6/2025	

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F 610	Continued From page 12 stated bruising, when the root cause is not known, is reportable immediately and required investigation. Upon interview on 4/3/25 at 2:25 p.m. the DON stated when she inquired with the family and R1 about the bruising she could not explain what happened. She stated it could have been staff using R1's body instead of a bed sheet to lift her that could have caused bruising, "we just don't know." The DON denied having an investigation record of staff, other resident interviews, or skin assessments for the bruising. The facility did investigate the "aggressive treatment" allegations in which eight staff members were asked if they witnessed anyone to have been rough, mean or disrespecting and had they witnessed or been aware of abuse neglect etc. of a resident. Ten residents who had a BIMs score of 10 or above were interviewed asking if staff treated them with respect, if they had any concerns or if they felt safe. The investigation did not indicate the care received by residents who were at risk due to cognitive impairment or any observations of residents. Upon interview on 4/3/25 at 3:33 p.m. NA-A stated the DON spoke with her that R1's family alleged NA-A was aggressive, snippy, and did not want to be at work. NA-A was not able to work with R1 after their conversation. NA-A stated the facility had not mentioned R1's bruising to her. She worked the night RN-B found the bruising, because RN-B asked her if she knew how R1 got the bruising. Upon interview on 4/4/25 at 7:05 a.m. RN-D stated he did witness the bruising on R1. He	F 610		

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F 610	Continued From page 13 stated RN-B came to the unit he was working on to get his opinion of the bruising. He stated the bruising was small on R1's upper arm, RN-B had measured the bruising without RN-D present. RN-D stated R1 was complaining of left sided body pain. He was not certain whether RN-B reported the bruising to the management team or not. The facility did not follow-up with RN-D regarding the bruising. Upon interview on 4/4/25 at 9:21 a.m. RN-B stated she found three small bruises above R1's elbow when R1 was complaining of pain on her left side. She stated, "I wondered if there was something going on." R1 stated to her that she had gotten in a fight, and she lost. RN-B stated she worked nights and at times people have dreams, so maybe it was a dream as R1 was confused. RN-C found RN-D and had him observe R1 with her. RN-B stated, in hindsight she thought the cause of the bruising was R1 gripping her own arm. RN-B stated she documented the bruising in R1's chart. She did not know if anyone followed-up with R1. RN-B saw the bruising two nights in a row when she gave R1 pain medication during the night. RN-B did not think of reporting the bruising of unknow origin to management since she had documented the findings in her chart. The facility did not follow-up with RN-B regarding the bruising. An email correspondence dated 4/4/25 at 10:21 a.m. from the DON indicated "On 3/13 there was some bruising noted on residents L arm, resident stated that she was not sure what happened, resident utilizes a Hoyer lift for transfers, is participating in therapy, staff feels like maybe staff is turning her not with the draw sheet but by pulling on her. Due to the amount of assistance	F 610		

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F 610	Continued From page 14 resident requires, verbal education was provided to staff that work with the resident about using the draw sheet and utilizing 2 individuals for cares going forward." A facility policy titled Vulnerable Adult-MN with a revision date of 10/14/22 indicated: All reports of suspected/alleged resident abuse, neglect, exploitation of residents, mistreatment, injury of unknown source and/or misappropriation of resident property shall be promptly and thoroughly investigated. All interviews related to the investigation shall be conducted in private. Collect data and document investigative findings. The investigation may include, but is not limited to: Physical examination of the resident and environment. Examination of the resident by a licensed nurse or physician. Review documentation and the resident's medical record for events leading up to incident. Interview the person(s) reporting the incident. Interview the alleged victim. Interview any potential witnesses to the incident. Interview the alleged perpetrator. Interview other residents to whom the alleged perpetrator provides care or services. Review the completed documentation. If witness reports are obtained, they may be in writing. Witness should sign and date such reports. Document the results of the investigation. Log the incident on the Event summary or other log. Use the Event summary or other log for ongoing review and analysis of abuse incidents and the implementation of changes to prevent future occurrences of abuse. The results of all investigations must be reported	F 610		

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F 610	Continued From page 15 to the administrator (or their designated representative) and state agency and to other officials in accordance with state law within five working days of the incident. If the alleged violation is verified appropriate corrective action must be taken. If employee is found to have perpetrated the incident, follow the employee handbook. Injuries of unknown source: An injury should be classified as an "injury of unknown source" when ALL of the following criteria are met: The source of the injury was not observed by any person; AND The source of the injury could not be explained by the resident; AND The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.	F 610		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to accurately assess physical restraints (manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body) for 4 of 4 residents (R1, R2, R3 and R4)	F 641	F641 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet	5/6/25

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F 641	Continued From page 16 reviewed who use bedrails. Findings include: Long-Term Care Facility Resident Assessment User Manual Version 1.18.11, dated October 2023, viewed 8/26/24 indicated a physical restraint or method physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint definition. This can only be deterred on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment. Retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf. R1's care plan dated 3/4/25 did not indicate placement of side/bed rails on R1's bed. R1's admission Minimum Data Set dated 3/6/35 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were	F 641	requirements established by State and Federal law. It is the policy of Cassia Harmony Gardens to comply with F641. To assure continued compliance, the following plan has been put into place: Regarding cited resident: The transfer assist device was removed from R1 bed on 4/7/25. Transfer assist devices were removed from R2, R3 & R4 on 4/11/2025 as this was the date facility received the resident roster from MDH. Actions taken to identify other potential residents having similar occurrences: All residents with a transfer assist device are at risk. Measures put in place to ensure deficient practice does not recur: All transfer assist devices will be removed from beds prior to compliance date. Education provided to licensed staff members including therapy, regarding requirements needed for the addition of any future transfer assistance device or restraint, including but not limited to the necessity for risk vs. benefits discussion, consent, physician order requirement, and CP update. This education will include the importance of completing accurate assessments prior to and post placement of devices that can be considered	

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F 641	Continued From page 17 hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). Bed rails were not identified as used on the MDS. Upon observation and interview on 4/3/25 at 3:47 p.m. R1 was found to have bilateral quarter side/bed rails at the head of her bed. The rails could open to the sides by pivoting like a door. R1 stated she did not know how to remove the rails and felt she could not even if she knew how. She used the rail on the left side of the bed because when she received cares she could hold on to that side with her right hand. She could not use the rail on the right side because of the swelling and weakness in her left hand following her stroke. Upon interview on 3/3/25 at 4:16 p.m. registered nurse, RN-A stated she performed admission assessments and was not instructed to obtain orders, indicate what diagnosis the rails were intended to treat, educate on the risk and benefits and obtain a consent. R2's admission MDS dated 2/23/25 indicated R2 had a BIMs score of 10 indicating R2 was moderately cognitively impaired. R2 required moderate assistance with toileting hygiene, bathing, dressing, personal hygiene, and rolling left to right in bed. R2's pertinent diagnoses were congestive heart failure, chronic obstruction pulmonary disease (a group of lung disease that block airflow making it difficult to breathe, respiratory failure, and toxic encephalopathy (the brain becomes damaged due to exposure to toxins). The MDS did not indicate bed rails were	F 641	restraints. Effective implementation of actions will be monitored by: The DON or designee will complete weekly audits x 4 weeks ensuring that any resident that is requiring an assistive device is accurately assessed for device/restraint use and that this device/restraint use is accurately coded on the MDS. Results of these audits will be reviewed by the facility's QAPI committee, which will determine if audits can be reduced or discontinued. Those responsible for maintaining compliance will be: The DON or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 5/6/2025	

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F 641	Continued From page 18 used. R2's care plan dated 2/26/25 did not indicate placement of a side rail on R2's bed. R2's Device-Equipment assessment dated 3/11/25 indicated R2 had a left upper assist rail/grab bar due to generalized weakness/debility. Under identify the alternatives to use the of a device which were attempted but failed to meet the residents needs indicated PT/OT recommendation, no other alternatives were identified. The reasons for consideration of the device were: -Allow resident to assist with turning, care, and/or repositioning. -Improve quality of life. -Improve participation and/or self-deficiency with cares. -Prevention of falls during transfer from one location to another. -Reduce the risk of harm to self or others. The assessment identified restraints are defined as "any manual or physical or mechanical device, material or equipment adjust to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal assess to one's body." R2's side/bed rail was not identified as a restraint on the assessment. The resident demonstrated the physical ability to safely use the device. The assessment did not indicate of R2 could safely remove the device on her own. The assessment indicated potential benefits of the use of the device were reviewed with the resident and/or representative. The assessment did not provide an indication of a consent form. Upon observation and interview on 4/4/25 at 9:11	F 641		

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F 641	Continued From page 19 a.m. R2 was lying in her bed. She had a quarter sized side rail on the left side of her bed. She stated she did not know what the surveyor was talking about and did not know what that "thing" was. R3's care plan dated 3/11/25 did not indicate the use of side/bed rails. R3's admission MDS dated 3/11/25 indicated R3 had a BIMs score of 14 indicating she was cognitively intact. R3 required maximum assistance with toileting hygiene and lower body dressing, moderating assistance with upper body dressing and personal hygiene. R3 was dependent upon staff for rolling from left to right in bed, sitting to lying, sitting to standing and transfers. R3's pertinent diagnoses were acute kidney failure, chronic respiratory failure, chronic congestive heart failure, muscle weakness, spinal stenosis of the lumbar region with neurogenic claudication (spinal narrowing in the lower back with pressure on the nerves) and history of falling. R3's MDS did not indicate a side/bed rail was used. Upon observation and interview on 4/4/25 at 11:03 a.m. R3 was seated in her wheelchair. R3 had two quarter rails on her bed. The right-side rail was at the very head of the bed and the left side rail was approximately 12 inches lower, than the placement of the adjacent right-side rail. The left side was more toward the center of the bed. R3 stated she used the rails to feel safer in her bed and to transfer in and out of her bed. R4's admission MDS dated 3/2/25 indicated R4 had a BIMs score of 14 indicating R4 was cognitively intact. R4 required maximum	F 641		

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F 641	Continued From page 20 assistance with toileting hygiene, rolling from left to right, sitting to lying. R4 was dependent upon staff for lower body dressing and transfers. R4's pertinent diagnoses were fracture of the left femur (thigh bone), major depression disorder, anxiety disorder and osteoarthritis (breakdown of tissues in the joints). R4's MDS did not indicate side/bed rails were used. R4's care plan dated 3/11/25 did not indicate the use of side rails. Upon observation and interview on 4/4/25 at 11:15 a.m. R4 was seated in her wheelchair. She had two quarter sized rails at the head of her bed. She stated she used the rails or safety, and her family wanted them on her bed. Upon interview on 4/3/25 at 4:21 p.m. the director of nursing, DON stated the bars on the bed were not side rails they were pivot assistive devices; therefore, the facility was not required to follow the restraint guidelines. The DON provided a product form. Upon interview on 4/4/25 at 10:49 a.m. physical therapist (PT)-A stated he asked the residents if they felt they needed or wanted a rail on their bed, mainly to assist with bed mobility or feel safer in bed. Residents were then assessed if they could turn, or "scoot" and the rails would help them. PT-A did not get an order from the provider for the rails, he was not certain whether nursing got orders or not. He stated when evaluated residents and recommended a rail he verbally communicated with the nursing staff and sent a work order to maintenance. Upon interview on 4/4/25 at 11:56 a.m. the	F 641		

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F 641	Continued From page 21 Administrator stated prior to the surveyor she believed the rails were not a restraint but came to the conclusion during the survey that the rails were considered a device and the process needed to be followed, including a facility assessment to determine if they were a restraint or not upon each residents individual assessment. A policy was not obtained on accuracy of assessments.	F 641		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F 700		5/6/25

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	245381	A. BUILDING _____ B. WING _____	C 04/04/2025

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F 700	Continued From page 22 Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds, assess the residents for risk of entrapment, review risks and benefits for bed rail use, ensure bed dimensions were appropriate for 4 of 4 residents (R1, R2, R3 and R4) review for bed rails. Findings include: Food and Drug Administration (FDA) guidelines ("Recommendations for Health Care Providers about Bed Rails") 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment	F 700	F700 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia Harmony Gardens to comply with F700 . To assure continued compliance, the following plan has been put into place: Regarding cited resident: Because the device was not easily removable by the resident, the device was removed from R1 on 4/7/25. Transfer assist device was removed from R2, R3 & R4 on 4/11/2025 as this was the date facility received the resident roster from MDH. Actions taken to identify other potential residents having similar occurrences: All residents with a transfer assist device are at risk. Measures put in place to ensure deficient practice does not recur: All transfer assist devices will be removed from beds prior to compliance date. Education to be provided to licensed staff including therapy, regarding requirements	

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F 700	Continued From page 23 hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Retrieved from https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm R1's occupational therapy (OT) evaluation and plan of treatment dated 3/3/25 did not indicate R1 had said/bed rails on her bed. R1's physical therapy (PT) evaluation and plan of treatment dated 3/3/25 did not indicate R1 had side/bed rails on her bed. R1's care plan dated 3/4/25 did not indicate placement of side/bed rails on R1's bed. R1's facility assessments dated 3/4/25 did not include a device assessment. R1's admission Minimum Data Set dated 3/6/35 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). Bed rails were not identified as used on the MDS.	F 700	needed for the addition of any future device use that can be considered a restraint. This education is to include the requirement that alternatives to these devices must be tried, that residents must be assessed for risk of entrapment, that bed dimension assessment must be requested/completed by maintenance, and that risks vs. benefits must be discussed with residents/family prior to implementation. Education also to include importance of documentation of all of the above. Effective implementation of actions will be monitored by: The DON or designee will complete weekly audits of 10 residents per week x 4 weeks, ensuring that no additional transfer assist devices/restraints were implemented without proper alternative device trial, without proper assessment for entrapment, without risks and benefit discussion for device use being discussed, and without bed dimension assessment. Results of these audits will be reviewed by the facility's QAPI committee, which will determine if audits can be reduced or discontinued. Those responsible for maintaining compliance will be: The DON or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 5/6/2025	

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F 700	Continued From page 24 Upon interview on 4/3/25 at 3:33 p.m. nursing assistant (NA)-A stated she was not allowed to work with R1 due to some complaints about her cares. She asked surveyor for advice and asked, "If I see a residents head in a siderail, should I intervene or get assistance." NA-A stated she did assist R1 onto her back. She did not recall the exact date and did not report the event to other staff since R1 was "okay" She did not recall her training on rails, when she noticed rails on a bed, she assumed they are there for the resident to not fall out of bed or to help them transfer. She was unaware rails could be unsafe. Upon observation and interview on 4/3/25 at 3:47 p.m. R1 was found to have bilateral quarter side/bed rails at the head of her bed. The rails could open to the sides by pivoting like a door. R1 stated she did not know how to remove the rails and felt she could not even if she knew how. She used the rail on the left side of the bed because when she received cares she could hold on to that side with her right hand. She could not use the rail on the right side because of the swelling and weakness in her left hand following her stroke. She did not recall an event where her head was between the rail and the bed. She did recall she had repositioned herself and her head was hanging off the right side of the bed and feet off the left side. She stated her family came to visit and her found her in that position. The family got assistance from staff to reposition her. R1 did not recall which staff assisted her. Upon interview on 3/3/25 at 4:02 p.m. the maintenance director stated the facility had only the quarter side rails, no other ones were onsite. The rails came with the beds, which were purchased approximately in 2023. He stated the	F 700		

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F 700	Continued From page 25 process was either nursing or therapy sends a work order, and the rails are then placed on the bed. The maintenance department was completing the rail inspections as indicated in the manufactures manual. Upon interview on 3/3/25 at 4:16 p.m. registered nurse, RN-A stated she performed admission assessments and was not instructed to indicate what diagnosis the rails were intended to treat, educate on the risk and benefits and obtain a consent. If a resident or family requested having rail or if she assessed the resident would transfer easier with rails, she would place an order with the maintenance department. She did not witness or hear that R1 allegedly was stuck between the rails and the bed. Upon interview on 3/3/25 at 4:40 p.m. family member (FM)-A stated she requested R1 have rails for safety in her bed. She denied any education on the risk and benefits of having rails. She stated the only concern she had was the family arrived at the facility and found R1 laying with her bed hanging off the side of the bed (below where the side rail was) and feet hanging off the other side of the bed. R2's OT evaluation and plan of treatment dated 2/20/25 did not indicate R2 a had side rail on her bed. R2's PT evaluation and plan of treatment dated 2/20/25 did not indicate R2 a had a side rail on her bed. R2's admission MDS dated 2/23/25 indicated R2 had a BIMs score of 10 indicating R2 was	F 700		

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F 700	Continued From page 26 moderately cognitively impaired. R2 required moderate assistance with toileting hygiene, bathing, dressing, personal hygiene, and rolling left to right in bed. R2's pertinent diagnoses were congestive heart failure, chronic obstruction pulmonary disease (a group of lung disease that block airflow making it difficult to breathe, respiratory failure, and toxic encephalopathy (the brain becomes damaged due to exposure to toxins). The MDS did not indicate bed rails were used. R2's care plan dated 2/26/25 did not indicate placement of a side rail on R2's bed. R2's Device-Equipment assessment dated 3/11/25 indicated R2 had a left upper assist rail/grab bar due to generalized weakness/debility. Under identify the alternatives to use the of a device which were attempted but failed to meet the residents needs indicated PT/OT recommendation, no other alternatives were identified. The reasons for consideration of the device were: -Allow resident to assist with turning, care, and/or repositioning. -Improve quality of life. -Improve participation and/or self-deficiency with cares. -Prevention of falls during transfer from one location to another. -Reduce the risk of harm to self or others. The assessment identified restraints are defined as "any manual or physical or mechanical device, material or equipment adjust to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal assess to one's body." R2's side/bed rail was not	F 700		

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F 700	Continued From page 27 identified as a restraint on the assessment. The resident demonstrated the physical ability to safely use the device. The assessment did not indicate if R2 could safely remove the device on her own. The assessment indicated potential benefits of the use of the device were reviewed with the resident and/or representative. The assessment did not provide an indication of a consent form. Upon observation and interview on 4/4/25 at 9:11 a.m. R2 was lying in her bed. She had a quarter sized side rail on the left side of her bed. She stated she did not know what the surveyor was talking about and did not know what that "thing" was. R3's assessment list dated 3/7/25 - 4/4/25 did not indicate the facility device assessment had been completed. R3's PT evaluation dated 3/9/25 did not indicate R3 used side/bed rails. R3's OT evaluation dated 3/10/25 did not indicate R3 used side/bed rails. R3's admission MDS dated 3/11/25 indicated R3 had a BIMs score of 14 indicating she was cognitively intact. R3 required maximum assistance with toileting hygiene and lower body dressing, moderating assistance with upper body dressing and personal hygiene. R3 was dependent upon staff for rolling from left to right in bed, sitting to lying, sitting to standing and transfers. R3's pertinent diagnoses were acute kidney failure, chronic respiratory failure, chronic congestive heart failure, muscle weakness, spinal stenosis of the lumbar region with neurogenic	F 700		

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F 700	Continued From page 28 claudication (spinal narrowing in the lower back with pressure on the nerves) and history of falling. R3's MDS did not indicate a side/bed rail was used. Upon observation and interview on 4/4/25 at 11:03 a.m. R3 was seated in her wheelchair. R3 had two quarter rails on her bed. The right-side rail was at the very head of the bed and the left side rail was approximately 12 inches lower, than the placement of the adjacent right-side rail. The left side was more toward the center of the bed. R3 stated she used the rails to feel safer in her bed and to transfer in and out of her bed. She did not recall any education given on the use of the rails. R4's assessment list dated 2/25/25 - 4/4/25 did not indicate the facility device assessment been completed. R4's care plan dated 2/25/25 did not indicate R2 used side/bed rails. R4's OT evaluation dated 2/25/25 did not indicate R4 used side/bed rails. R4's PT evaluation dated 2/25/25 did not indicate R4 used side/bed rails. R4's admission MDS dated 3/2/25 indicated R4 had a BIMs score of 14 indicating R4 was cognitively intact. R4 required maximum assistance with toileting hygiene, rolling from left to right, sitting to lying. R4 was dependent upon staff for lower body dressing and transfers. R4's pertinent diagnoses were fracture of the left femur (thigh bone), major depression disorder, anxiety disorder and osteoarthritis (breakdown of	F 700		

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F 700	Continued From page 29 tissues in the joints). R4's MDS did not indicate side/bed rails were used. Upon observation and interview on 4/4/25 at 11:15 a.m. R4 was seated in her wheelchair. She had two quarter sized rails at the head of her bed. She stated she used the rails or safety, and her family wanted them on her bed. She did not recall any education provided to her on the use. Upon interview on 3/3/25 at 4:21 p.m. the director of nursing, DON stated the bars on the bed were not side rails they were pivot assistive devices; therefore, the facility was not required to follow the restraint guidelines. The DON provided a product form. Upon interview on 4/4/25 at 9:21 a.m. RN-B stated she was uncertain of the policy on rails at the facility. She stated she mainly worked the night shift, and was aware many residents had the quarter rails and some residents would use them when they were repositioned or had their incontinent brief changed and other residents did not use the rails on the bed. She denied ever seeing a resident get stuck in a rail. Email correspondence from the DON on 4/4/25 at 4:07 p.m. indicated "We do not have any physician's orders or consents. It is our understanding per the manufacturer documentation and our policy, our grab bars do not require orders or consents. They enable the resident to help maneuver themselves, assist with repositioning, and increase independence." Upon interview on 4/4/25 at 10:49 a.m. physical therapist (PT)-A stated he asked the residents if they felt they needed or wanted a rail on their	F 700		

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F 700	Continued From page 30 bed, mainly to assist with bed mobility or feel safer in bed. Residents were then assessed if they could turn, or "scoot" and the rails would help them. He stated when evaluated residents and recommended a rail he verbally communicated with the nursing staff and sent a work order to maintenance. Upon interview on 4/4/25 at 11:56 a.m. the Administrator stated prior to the surveyor she believed the rails were not a restraint but came to the conclusion during the survey that the rails were considered a device and the process needed to be followed, including a facility assessment to determine if they were a restraint or not upon each residents individual assessment. The bed manufacture product form undated indicated the side rail is a 3-position assist device is not a side rail nor is it a restraint. A facility assessment with a revision date of 3/10/25 indicated: Upon admission residents will be placed in a bed that has had all devices removed. Beds for residents upon admission will not have side rails/grab bars/assist rails in place. Nursing staff will complete a device/equipment observation as part of the admission observation process. If it is determined that a grab bar or assist rail is needed to allow the resident increased independence or to meet another need based on the device/equipment assessment, nursing staff will put a request in Maintenance care for the specific type of device to be installed on the bed. If nursing determines that a side rail is needed, an order needs to be obtained for this as well a consent being obtained. Once those have	F 700		

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F 700	Continued From page 31 happened, then nursing will put a request to maintenance care for the device to be applied to the bed. When residents are moved from one room to another, it is important that any devices/equipment that are in place moves to the new room with them. When there is a significant change in condition, the device/equipment observation should be redone and the use of side rails/grab bars or assist rails should be evaluated to determine if they are still needed. If they are no longer needed, use maintenance care to notify maintenances staff of need to have them removed. For residents with grab bars/assist rails or side rails-confirm that the device/equipment observation is complete. For residents with grab bars/assist rails or side rails, check the care conference summary observation-is the device/equipment observation reviewed by IDT question marked as YES. If there is a side rail or grab bar/assist rail in place, is the information for this included in the bed mobility section of the care plan? If there is a side rail in place, is there a signed consent observation in place? If there is a side rail in place, is there a physician order for the side rail? (no order needed for grab bar/assist rails). If a side rail or grab bar/assist rail is in place, is there documentation that less restrictive devices were tried prior to implementing these?	F 700		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 10, 2025

Administrator
Harmony Gardens
1438 County Road C East
Maplewood, MN 55109

Re: Event ID: 94UY11

Dear Administrator:

The above facility survey was completed on April 4, 2025 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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2 000	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 4/3/25 - 4/4/25, 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	2 000		

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2 000	Continued From page 1 the survey. H53812466C / MN111892/111494 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.	2 000		