Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215183163M
Compliance #: HL215185186C

Date Concluded: April 17, 2023

Name, Address, and County of Licensee Investigated:
Harmony Place
455 Main Avenue N
Harmony, MN 55939
Fillmore County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the facility failed to assist and assess the resident leading to increased falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did have a fall, the facility sought evaluation in the emergency room (ER) for him and communicated with the hospital regarding his mobility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included a review of the resident's records, the facility's policies and procedures, and the resident's hospital record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and Parkinson's disease. The resident's assessment indicated the resident required and ambulated independently but required supervision and cues to not enter the other resident apartments. The resident's service plan included required the assistance of one person with bathing once a week and medication management.

The resident's progress notes the resident exhibited increased weakness and a fall one weekend which resulted in some rug burns but no serious injury and was able to stand up and walk. Two days later went to the ER because his weakness continued and admitted to the hospital.

The resident's progress notes indicated the facility received communication from the hospital the resident remained a heavy one or two-person assist with cares, and he would be returning to the facility later the same day.

After the resident returned to the facility, the resident's progress notes indicated the resident fell about an hour and a half when he attempted to shower himself. The same note indicated the resident's mobility varied greatly as staff reported he at times required two-person assist to transfer but then he would walk independently. The facility contacted the hospital to find out about his physical therapy assessment, which indicated his dementia might cause to be assist of two-persons at times and at others completely independent.

During an interview, unlicensed caregiver #1 stated the resident moved around independently when he first moved in but gradually declined. In time he needed a walker, then assist of one person, and then finally two people to walk. She said he varied from one or two-person assistance. She confirmed staff checked on him often, but he would get up and go without asking for help.

During an interview, unlicensed caregiver #2 stated she worked with him the whole time the residence was at the facility. She stated he began to decline rapidly and eventually required one or two people to assist with transfers or walking.

During an interview, the registered nurse stated the resident started declining and had a history of falls. The registered nurse said the unlicensed caregivers called her when the resident got back from the hospital because the resident's needs varied from independent to assist of two person. She had discussed the resident's status with the hospital times and stated the facility would not be able to meet his needs if he required two-person assist with transfers or walking.

During an interview, the family member stated the resident was declining and admitted to the hospital for further evaluation. When the resident returned to the hospital, he required one-person assistance. She said the resident fell in the bathroom soon after he returned and needed someone with him. She confirmed the facility only gave her his medication for discharging process.

During an interview, the director stated the family said the resident would need to have a staff with him at all times when he returned from the hospital. The director stated she explained to the family member the facility was unable to provide one-on-one care for him and the family member acknowledged this. A few days later, the family requested to discharge the resident to a different facility.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital for further evaluation when he declined.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL215183703M / HL215186083C HL215183604M / HL215185965C HL215183163M / HL215185186C On February 6, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL215183703M/HL215186083C, HL215183604M/HL215185965C, and HL215183163M/HL215185186C. At the time of the investigation, there were 30 residents receiving services under the Assisted Living license. During the course of the investigation, an immediate order for correction was issued for HL215183703M/HL215186083C, HL215183604M/HL215185965C, and HL215183163M/HL215185186C at tag identification at 0110 on February 28.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Continued From page 1 The following correction order is issued for HL215183163M / HL215185186C tag identification at 0740. The following correction order is issued for HL215183703M / HL215186083C tag identification at 2310 and 2360.	0 000		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a Assisted Living Director-in-Residence (ALDIR) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ALDIR had a license effective through August 15, 2022. However, ALDIR's license lacked an	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 110	Continued From page 2 organization listed as the Director of Record with BELTSS. On February 23, 2023, at 1:04 p.m. ALDIR stated before she came in, another employee was in the process of getting her LALD license but then her position changed. ALDIR confirmed she was now the LALD for this licensee. ALDIR was asked via phone to provide information, such as an email from BELTSS, to confirm who was the LALD for this facility. No confirmation was provided. The licensee's undated document titled, "Position Description - Director" indicated the facility director was responsible for day-to-day overall agency operations and assured adequate resources and efficient and effective use in meeting the agency goals and objectives. The position description further indicated the director was required to be a Licensed Assisted Living Director with Minnesota BELTSS, and had an in-depth working knowledge of the home health care industry, clinical practices and applicable federal, state and local health care regulations. Time Period to correct: Two (2) days.	0 110		
0 740 SS=D	144G.43 Subd. 4 Transfer of resident records With the resident's knowledge and consent, if a resident is relocated to another facility or to a nursing home, or if care is transferred to another service provider, the facility must timely convey to the new facility, nursing home, or provider: (1) the resident's full name, date of birth, and insurance information; (2) the name, telephone number, and address of the resident's designated representatives and legal representatives, if any;	0 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 740	Continued From page 3 (3) the resident's current documented diagnoses that are relevant to the services being provided; (4) the resident's known allergies that are relevant to the services being provided; (5) the name and telephone number of the resident's physician, if known, and the current physician orders that are relevant to the services being provided; (6) all medication administration records that are relevant to the services being provided; (7) the most recent resident assessment, if relevant to the services being provided; and (8) copies of health care directives, "do not resuscitate" orders, and any guardianship orders or powers of attorney. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to send all necessary medical information to an admitting licensee upon discharge from the licensee for one of one (R1) resident records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included Parkinson's disease, dementia, and major depressive disorder. R1's signed service agreement dated August 20, 2021, indicated R1 received services including	0 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 740	Continued From page 4 medication administration, dressing, housekeeping, and toileting. During an interview on February 16, 2023, at 10:01 a.m., a registered nurse (RN) of the admitting licensee stated she tried to contact the licensee for a report, but she did not get any answer from them. She then contacted the resident's doctor for his medical records. During an interview on February 21, 2023, at 2:47 p.m., unlicensed personnel (ULP) stated she gathered all the resident's medications, put them in the bag, and gave them to the family for the resident's discharge. She said the family came the night before to notify staff they would move him the next day. During an interview on February 23, 2023, at 1:04 p.m., Licensed Assisted Living Director (LALD) stated the resident was discharged to another facility per the family's request. She confirmed they did not send any discharge paper nor the resident's medical record to the admitting licensee. The licensee's form titled Resident Discharged Summary Form indicated the licensee would provide a summary of the resident's stay, a final summary of the resident's status from the latest assessment or review, provide a reconciliation of all pre-discharged medications with all the resident's post discharged prescribed and provide a post discharged care plan at the request of the resident or resident's representative, take steps to ensure a coordinated discharge. TIME PERIOD FOR CORRECTION: Seven (7) days	0 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 5	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure appropriate care and services were provided to 1 of 3 resident, R3, reviewed for staff services provided. The licensee failed to assess R3's skin and failed to provide oversight to determine the individualized plan of care and ensured staff provided appropriate care and services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R3's diagnoses included hypertension. R3 admitted to the licensee on June 6, 2022. R3's service plan, undated and unsigned, indicated R3 required the assistance of one person with bathing once a week, housekeeping,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 6 and medication management. The service plan also indicated staff needed to check skin with a bath/shower and report any reddened/open area to the nurse. R3's flowsheet report indicated R3 did not have any showers from June to November 2022. A review of R3's progress notes from June to November 2022 did not identify documentation regarding R3's refusal of bathing or cares. R3's progress notes dated August 11, 2022, indicated staff member(s) informed RN-I of R3's abdominal folds and groin which had a very red and yeasty-smelling rash. Review of R3's 90 day nursing assessment dated August 15, 2022, was completed by RN-I, indicated skin was intact, no concerns. R3's progress notes dated November, 16, 2023 indicated R3 had a change in status including slurred speech and the facility arranged for transport to the hospital. R3's hospital record dated November 16, 2023 indicated R3 arrived at the hospital covered in dried feces in her skin folds from her buttocks across her thighs and down to her knees. R3's progress notes dated November 17, 2023 indicated notification to check R3's skin for new sores but R3 was not present but rather in the hospital. A review of R3's 90-day nursing assessment dated November 20, 2022, at 9:14 a.m., was completed by RN-J. The document indicated "unknown due to new admission" to the question	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 7 "has the resident had any skin alteration in the last 90 days". The same document did not include identification of skin concerns. For pulmonary, the document indicated breath sounds left posterior, right anterior, and right posterior were clear when R3. R3's hospital records indicated R3 was not at the facility but rather the hospital at the time of the assessment dated November 20, 2023. R3's progress notes dated November 21, 2023, indicated the facility contacted the hospital for an update on R3. The note indicated the resident would not return to the facility but rather would go to a skilled nursing facility (SNF) R3's hospital record indicated R3 admitted to from November 16, 2022, through November 23, 2022 for a skin infection of the abdominal wall and discharged to a SNF afterwards. During an interview on February 13, 2023, at 11:01 a.m., an emergency medical technician (EMT)-A stated she helped transfer R3 to the hospital. She noticed upon entering R3's apartment noticed R3's room had a strong urine smell. EMT-A stated the nursing staff at the hospital cleaned R3's skin and EMT-A stated her entire genital and buttocks were reddened with open areas. EMT-A stated it looked like the rash had developed over time and not just over the last 24-hours. During an interview on February 17, 2023, at 6:54 p.m., the unlicensed personnel (ULP)-E stated she did not know how often R3 had a shower. ULP-E stated she knew R3 had a redness under her abdomen and treated with nystatin before. ULP-E stated she did not know anything about	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 8 the recent rash R3 but did confirm R3 did not have the rash when she admitted. During an interview on February 17, 2023, at 7:29 p.m., the unlicensed personnel (ULP)-F stated she was the bath aid and was supposed to give R3 a whirlpool bath once a week. ULP-F stated R3 refused to take a bath every time she was asked. ULP-F stated she notified the nurse about R3's refusals and charted it in R3's flow sheets. ULP-F also said once R3 refused, she would not come back to ask R3 again because she had so many bath schedules she needed to get done in a day. During an interview on February 17, 2023, at 8:39 p.m., the unlicensed personnel (ULP)-D stated she worked mostly night shift and did not provide any peri care for R3. ULP-D worked on the day R3 was sent to the hospital. R3 could not stand or walk on that day. ULP-D confirmed she knew the bath aid notified the administrator and the nurse about R3's redness in her fold a few times, but they did not do anything for R3. During an interview on February 21, 2023, at 2:47 p.m., the unlicensed personnel (ULP)-H stated she did not know R3 had any skin concern or redness. She said the nurse never did the skin assessment for R3. During an interview on February 21, 2023, at 4:11 p.m., a family member (FM)-C stated R3 needed assistance with taking a bath, and the staff was supposed to bathe her at least once a week. FM-C confirmed R3's room smelled very badly of urine . The staff was supposed to do the laundry and what she found in R3's laundry was "disgusting". FM-C said it took the emergency staff three hours to clean up R3. R3 would	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 9 scream in pain if anyone accidentally touched the reddened areas. During an interview on February 21, 2023, at 4:37 p.m., family member (FM)-B stated she called and talked to R3. She felt something was not right, so she called an ambulance to take R3 to the hospital. R3 was supposed to have a whirlpool bath once a week and she believed the staff did not do it. FM-B stated she went to R3's room 2 days after R3 was admitted to the hospital and it smelled so bad. FM-B took R3's clothes to wash and maggots fell out from the hamper. FM-B said R3's husband had memory impairment and he did not know anything happened with his wife. FM-B confirmed she was the one who asked the staff to call 911 for R3. During an interview on February 23, 2023, at 1:04 p.m., assisted living director in residence (ALDIR) stated staff notified her about R3's refusal of bathing. She asked them to document it and re-approached her again about it. She did not know anything about R3's redness in her abdomen. During an interview on February 23, 2023, at 2:27 p.m., registered nurse (RN)-I stated she noticed R3 had redness on her fold and got the order for nystatin on August 12, 2022, for 14 days. RN-I confirmed she did R3 90 days assessment on August 15 and did not make any note about her skin. She assumed R3's skin issue had been resolved by that time. During an interview on February 27, 2023, at 3:43 p.m., the registered nurse (RN)-J stated staff notified her about R3's redness a few days before R3 was sent to the hospital. RN-J said she worked with multiple facilities, so she did not have	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 10 a chance to assess R3 before she left. RN-J confirmed she knew about R3's refusal of the shower. She said she talked to R3's husband and he told her to not worry about it. RN-J stated R3's care plan indicated R3 was independent with her shower and that her husband was supposed to help her, so she just left it to him. RN-J confirmed she did not see R3 in the hospital from November 16 to November 23, 2022. She said she was not sure why she did a 90-day assessment for R3 when R3 was in the hospital. RN-J said the assessment was not appropriate. The licensee policy titled Assessment, Reviews and Monitoring, dated August 1, 2021, a reassessment would include skin conditions and the service plan would be updated as necessary based on resident needs. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure R3 was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21518	A. BUILDING: _____ B. WING _____	C 02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY PLACE	455 MAIN AVENUE NORTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02360	Continued From page 11 the maltreatment, in connection with incidents which occurred at the facility.	02360		