

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2025
NAME OF PROVIDER OR SUPPLIER  Harmony River Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1555 Sherwood Street Southeast Hutchinson, MN 55350	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to report allegations of abuse to the state agency, immediately, but not later than 2 hours after the allegation is made, for one of three residents (R1) reviewed. R1 reported he was abused in his room multiple times during the night. Findings include: Minimum Data Set (MDS) dated [DATE] indicated R1 was admitted to the facility for treatment of osteoarthritis of the right knee. R1's relevant diagnoses included chronic pain, mild intellectual disability, anxiety, unspecified psychosis, and developmental disorders. R1 required substantial to maximal assistance with repositioning in bed. R1 used a wheelchair to ambulate. R1's Brief Interview for Mental Status (BIMS) score was 10 out of 15, indicating he had mild cognitive impairment. R1's care plan indicated he had a history of behavioral disturbances. R1's care plan indicated R1 experienced delusions and paranoid about people in his room intending to harm him. R1's care plan indicated R1 was at risk for abuse and had a history of making allegations against staff. R1's care plan indicated staff were to implement the buddy care system for all care tasks and during overnight cares. R1's care plan instructed staff to report any further concerns to the campus administrator for allegations. R1's care plan indicated staff should follow the facility vulnerable adult policy. A progress note dated 7/21/25 at 8:31 p.m. indicated R1 informed staff an unknown woman hit him on the top of his head. A progress note dated 9/23/25 at 9:22 p.m. indicated R1 informed staff someone had struck him on the head the previous night at about 1:00 a.m. A social services note dated 9/24/25 at 3:19 p.m. indicated social services staff followed up with R1 regarding his allegations of being struck on the head. The note indicated R1 had a history of paranoia, delusions, and conflict with others. A progress note dated 10/15/25 at 10:06 p.m. indicated R1 reported to staff that someone had been touching him down there, and staff reassured him because they use the buddy system for his cares, this could not have happened. During an interview on 10/28/25 at 1:08 p.m., trained medication aide (TMA)-A stated if a resident tells her they had experienced any abuse in the facility, she will inform the nurse so they can document it and follow the chain of command. During an interview on 10/28/25 at 1:14 p.m., registered nurse (RN)-A stated when residents report allegations of abuse, she must report it to the on-call administrator right away. RN-A stated when R1 makes an allegation of abuse, they must document it in the chart, then leave a voice mail for the clinical coordinator. RN-A stated if what R1 claims is serious, they should then call the administrator as well. RN-A stated R1 had not made any allegations of abuse to her. During an interview on 10/28/25 at 1:22 p.m., R1 stated he did not have any concerns with the care at the facility. During an interview on 10/28/25 at 1:39 p.m., TMA-B stated if a resident alleges any type of abuse, tell the charge nurse and the administrator as soon as they mention it. TMA-B stated R1 had never mentioned any type of abuse in the facility to her, and if he did, she would tell the nurse and the administrator immediately. During an interview on 10/28/25 at 2:08 p.m., TMA-C stated if a resident alleges abuse, they will use her walkie talkie device to notify the charge nurse right away. TMA-C stated this information would then go to the supervisor. During an interview on 10/28/25 at 3:00 p.m., RN-B stated if a resident reported abuse to her, she would notify the administrator right away. RN-B stated R1 told her on 10/15/25 someone was touching him down there in his private parts and abusing him. RN-B stated she then notified the clinical coordinator about R1's allegations. During an interview on 10/28/25 at 3:02 p.m., the household coordinator stated when she receives allegations of abuse, she tells the supervisor right away. The household coordinator stated because R1 has such a long history of making allegations against staff, they do not report all R1's allegations to the state agency, otherwise they would be reporting quite frequently. During an interview on 10/28/25 at 3:22 p.m., the clinical coordinator stated he contacts the director of nursing as soon as there is an allegation made and will begin investigating if he is in the building. The clinical administrator stated he investigates by speaking with the resident and any other staff present during the time of the alleged incident. The clinical administrator stated he then brings the information to the administrator who makes the report to the state agency. During an interview on 10/28/25 at 3:41 p.m., the assistant clinical administrator stated if a resident alleges abuse, they use two staff to enter the room and complete assessment to determine if the abuse was physically possible. The assistant clinical coordinator stated if they believe the allegation may have occurred, they report it to the administrator of the director of nursing. During an interview on 10/28/25 at 3:53 p.m., the administrator stated if nursing staff are expected to notify the director or nursing or himself if appropriate. The administrator stated allegations of abuse that would need to be reported to him are allegations of physical abuse, residents being yelled at, or residents being</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to conduct a formal investigation into the allegations of physical and sexual abuse for one of three residents reviewed (R1) for abuse. Findings include: Minimum Data Set (MDS) dated [DATE] indicated R1 was admitted to the facility for treatment of osteoarthritis of the right knee. R1's relevant diagnoses included chronic pain, mild intellectual disability, anxiety, unspecified psychosis, and developmental disorders. R1 required substantial to maximal assistance with repositioning in bed. R1 used a wheelchair to ambulate. R1's Brief Interview for Mental Status (BIMS) score was 10 out of 15, indicating he had mild cognitive impairment. R1's care plan indicated he had a history of behavioral disturbances. R1's care plan indicated R1 experienced delusions and paranoid about people in his room intending to harm him. R1's care plan indicated R1 was at risk for abuse and had a history of making allegations against staff. R1's care plan indicated staff were to implement the buddy care system for all care tasks and during overnight cares. R1's care plan instructed staff to report any further concerns to the campus administrator for allegations. R1's care plan indicated staff should follow the facility vulnerable adult policy. A progress note dated 7/21/25 at 8:31 p.m. indicated R1 informed staff an unknown woman hit him on the top of his head. A progress note dated 9/23/25 at 9:22 p.m. indicated R1 informed staff someone had struck him on the head the previous night at about 1:00 a.m. A social services note dated 9/24/25 at 3:19 p.m. indicated social services staff followed up with R1 regarding his allegations of being struck on the head. The note indicated R1 had a history of paranoia, delusions, and conflict with others. A progress note dated 10/15/25 at 10:06 p.m. indicated R1 reported to staff that someone had been touching him down there, and staff reassured him because they use the buddy system for his cares, this could not have happened. During an interview on 10/28/25 at 1:14 p.m., registered nurse (RN)-A stated when residents report allegations of abuse, she must report it to the on-call administrator right away. RN-A stated when R1 makes an allegation of abuse, they must document it in the chart, then leave a voice mail for the clinical coordinator. RN-A stated if what R1 claims is serious, they should then call the administrator as well. During an interview on 10/28/25 at 3:00 p.m., RN-B stated if a resident reported abuse to her, she would notify the administrator right away. RN-B stated R1 told her on 10/15/25 someone was touching him down there in his private parts and abusing him. RN-B stated she then notified the clinical coordinator about R1's allegations. During an interview on 10/28/25 at 3:02 p.m., the household coordinator stated when she receives allegations of abuse, she tells the supervisor right away. The household coordinator stated her investigation would depend on what the administrator tells her to do next. The household coordinator stated after the allegations, she educated R1 to tell staff about his concerns immediately, rather than waiting multiple hours or days prior to notifying staff. During an interview on 10/28/25 at 3:22 p.m., the clinical coordinator stated he contacts the director of nursing as soon as there is an allegation made and will begin investigating if he is in the building. The clinical administrator stated he investigates by making a timeline of events, looking at the psychiatric diagnoses of the residents making the allegation, and determining if they have a past history of abuse allegations. The clinical administrator stated he when he spoke with R1 following his allegations on 10/15/25, R1 was unable to give a consistent account of what the alleged perpetrators looked like. During an interview on 10/28/25 at 3:53 p.m., the administrator stated if nursing staff are expected to notify the director or nursing or himself if appropriate. The administrator stated he then takes these allegations and vets them further based on the resident's plan of care and history making abuse allegations. The administrator stated if this is the resident's first instance of an abuse allegation, the administrative team would complete an investigation. The administrator stated if the resident has a known history of abuse allegations, the nurse will evaluate and determine if the situation possibly occurred. The administrator stated investigations are mostly managed by himself or the director of nursing, however he was not available when R1 made allegations to staff on 10/15/25, and the concern would have been brought to the interdisciplinary team. The administrator stated the interdisciplinary team determined because R1 had a history of making allegations, there were no residents who would have wandered into R1's room, and they had buddy care in place on his care plan, a formal investigation was not necessary. A facility policy titled Vulnerable Adult Abuse Prevention Plan, dated October 2025 indicated the facility must review of each allegation. The policy indicated internal investigations should contain an Investigation Form and Staff Interviews document. The policy indicated the administrator, or designee will complete a full review of investigative documentation to determine if trends exist</p>		