STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245114	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony River Living Center	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report an allegation of sexual abuse to the state agency (SA) for 2 of 3 residents (R4, R5) reviewed for reporting of alleged violations when R1 displayed sexual behaviors towards R4 and R5. Findings include: R1 R1's admission Record printed 6/11/26, indicated he was admitted to the facility 2/10/26. Diagnoses included Alzheimer's disease, dementia and psychosis. R1's significant change Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated he displayed verbal behaviors toward others one-to-three days during the assessment period. The MDS indicted R1 transferred independently and ambulated with supervision. R1's care plan dated 4/13/26, identified limited physical mobility and indicated he required assistance from one staff for transfers and ambulate. The care plan revised on 3/17/26 indicated a history of requiring one-to-one staff supervision due to sexual advancements toward others. Interventions included: Intervene as necessary to protect the rights and safety of others, approach in a calm manner, divert attention and move to an alternate location as needed. R1's Progress Note dated 3/7/26, indicated R1 was found naked in his doorway, exposing himself to another resident (R4). The other resident was able to walk away. R1 was redirected. ^Resident Occurrence Report dated 3/31/26, indicated R1 grabbed another resident's breast (R5) in a common area of the unit. Analysis of cause of incident indicated sexual disinhibition. Staff intervened and separated the residents and 15-minute checks were implemented. R1's Progress Note dated 3/31/26, indicated R1 had been seen showing affection toward another resident and indicated the other residents was not affected by it. R1 was removed from the area and brought back to his room. During interview on 6/5/26 at 7:31 a.m., licensed practical nurse (LPN)-A stated when R1 first moved to the unit, he was seated in the common area and had exposed himself to R4. LPN-A said R4 told staff and other residents about the incident and continued telling staff about it the next day. R4 R4's admission Record printed 6/11/26, indicated she was admitted to the facility 9/23/25. R4's diagnoses included altered mental status, mild cognitive impairment and anxiety. R4's significant change MDS signed 4/23/26, indicated R4's vision was adequate with corrective lenses, had severe cognitive impairment and had no behaviors. R4 required supervision with transfers but was independent with ambulation with use of walker. R4's care plan dated 4/22/26, identified an alteration in mood and behaviors and indicated she self-transferred, wandered into other residents' rooms and enjoyed being able to navigate her way around the unit. R4 was not able to be interviewed. R4's record failed to include information regarding the incident with R1. R5 R5's admission Record printed 6/11/26, indicated she was admitted to the facility 7/30/19. R5's diagnoses included vascular dementia and anxiety. R5's quarterly MDS signed 3/23/26, indicated R5 had severe cognitive impairment and had no behaviors. R5 required supervision with transfers and ambulation. R5's care plan dated 5/31/26, identified limited physical ability and indicated she required staff assistance to and from all destinations. R5 was not able to be interviewed. R5's progress note dated 4/1/26, indicated on 3/31/26, staff observed a male resident (R1) touch her on the breast, over her clothing. Staff intervened and redirected the male resident without incident. R5 appeared unaffected and had been holding the male (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's hand at the time of the incident. During interview on 6/5/26 at 7:31 a.m., licensed practical nurse (LPN)-A stated at one-point R1 had been placed on 15-minute checks, Maybe for being more sexual. I truly don't know. LPN-A stated when R1 first moved to the unit, he had exposed himself to R4, indicating he had his pants down and was facing R4. LPN-A stated R4 told staff about the incident the next day. During an interview on 6/8/25 at 12:51 p.m., with the administrator and director of nursing (DON), the administrator stated he was aware of the incident between R1 and R5 and said staff had intervened and separated the residents. The administrator stated R5 had been unaffected by the incident but R5's family member (FM)-A, had been very upset about the incident. The administrator stated the incident between R1 and R5 had not been reported to the SA because R5 had not been affected by it. The administrator and DON stated they had no knowledge of the incident between R1 and R4.ˆ During interview on 6/9/26 at 5:44 p.m., FM-A stated if R5 had been able to understand what happened when R1 touched her breast she would have been extremely uncomfortable. FM-A stated R5 was a very private and quiet person and would not have been okay with the situation. FM-A said R5 would have felt sexually harassed. Facility policy Vulnerable Adult Abuse Prevention Plan dated October 2025, identified sexual assault as sexual contact that resulted from force, threats or the inability of the person to give consent and included any sexual activity that occurred when and individual could not give consent. The policy indicated allegations of abuse will be reported immediately within state and federal guidelines and indicated if the allegation involved abuse the report must be made no later than two hours after the allegation was made.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to develop and implement resident specific approaches to behavior for 1 of 3 residents (R1) diagnosed with dementia who displayed negative behaviors affecting himself and other residents in the facility. Findings include: R1's admission Record printed 6/11/26, indicated he was admitted to the facility 2/10/26. Diagnoses included Alzheimer's disease, dementia and psychosis. R1's significant change Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated he displayed verbal behaviors toward others one-to-three days during the assessment period. The MDS indicted R1 transferred independently and ambulated with supervision. R1's care plan: Revised on 3/17/26, identified an alteration in mood or behavioral expression due to Alzheimer's and dementia. Targeted behaviors included exit seeking, wandering into other residents' rooms, sexual behaviors toward staff, delusions and hallucinations. Revised on 3/1/26, see behavior intervention care plan: Revised on 3/17/26, encourage activities of interest. Revised on 3/24/26, Therapeutic fibbing (bending the truth or telling small white lies to someone with dementia), redirection, reassurance, explain procedures, conversation, food, drink and toileting. Intervene as needed to protect the rights and safety of others. Approach and speak in calm manner. Revised on 4/17/26, had required 1:1 care due to sexual advancements toward others. Revised on 5/20/26, Utilize my favorite activities as opportunities for my behaviors: listening to personal music, going for walks, going outside, talking about hunting/fishing, ice cream, looking through picture books, watching television, calling family. The care plan identified potential to demonstrate verbally abusive behaviors related to cognitive impairment, dementia and poor impulse control. The care plan directed staff to observe for and document side effects of medication. When agitated, staff were directed offer photo album, busy board, and/or white noise machine. ˆ R1's care plan lacked evidence of comprehensive assessment of behaviors or resident specific interventions between 3/24/26 and 5/20/26 and lacked evidence of recommendations for non-pharmacological behavior interventions. R1's Progress Notes indicated the following: 3/4/26, R1 walked around the neighborhood several times during the shift. Pleasant with staff. Confused at times but was able to make needs known. 3/7/26, R1 was found naked in the doorway of his room exposing himself to another resident. The other resident was able to walk away from him. Staff intervened. 3/9/26. R1's family member expressed concerns for his demeanor and mood and said she had noticed R1 had been less cooperative and irritable since he moved to the secured unit. R1 had been refusing care from staff over the weekend. 3/11/26, Interdisciplinary team met to discuss R1's current status. R1 showed improvement in activities of daily living and mobility. 3/17/26, R1 had severe cognitive impairment, alert and oriented to self and family. Exhibits confusion, memory loss, impaired safety awareness and disorientation. Presented with minimal symptoms of depression. Targeted behaviors included exit seeking, wandering into other rooms, sexual behaviors toward staff. Behaviors often redirected by conversation, offer food/drink, escort to different location and allowing him to express feelings. ˆR1 was generally pleasant and cooperative on a daily basis. 3/17/26, During assessments, R1 made sexual comments toward staff. 3/18/26. R1 admitted to hospice care. Medication changes implemented. 3/19/26, R1 awake at night, intermittently coming out of room and walking around common area. Staff assisted back to room several times. Offered snack and accepted. Sexual comments made to staff. 3/19/26, R1 was noted to have an increase in sexual behaviors and comments over the last week. 3/23/26, R1 stated he had to be somewhere tomorrow. Staff told him it was 1:00 a.m., R1 told staff they did not know how to read time and said staff knew nothing. Wandering in unit throughout shift. Assisted back to bed/room several times. Staff had been shutting R1's door to hear him exit due to wandering at night. R1 stated if door did not get opened, he would smash the window out. Staff opened door slightly to appease R1. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/23/26, R1was agitated and asking to leave. ˆWriter tried therapeutic fibbing and explained needed a few days to complete paperwork. R1 stated he was livid and would burn the place down then went back to his room. 3/23/26, R1 talked about enlisting in the Navy and that he had been told to wait and it had been days of waiting. 3/25/26, R1 self-transferred and stood in his doorway a couple times without a shirt on. Assisted back to wheelchair and refused food. Inappropriate remarks and gestures made to staff. 3/26/26, Nursing staff denied any new or worsening behaviors. 3/27/26, R1 continued to ambulate out of room, a few times without pants on. Mid-morning, R1 came out and reported to staff that staff in facility were drinking on the job and stated he needed to wake up staff laying on the floor. Also talked about enlisting in the Navy. 3/28/26, R1 continued to refuse care and declined to wear incontinent brief. 3/31/26, R1 was wandering on the unit looking for his wife and his car. R1 was seen showing affection toward another resident. Writer firmly told R1 to stop and separated the residents. 4/1/26, R1 awake throughout shift. Came out to common area looking for his wife and indicated he needed to get to work. Staff re-oriented him to time of day. Was offered a drink and snack which he declined. 15-minute checks performed per administrator. 4/1/26, R1 picked up phone and stated he was calling security because people were trying to break into his space. 4/1/26, R1 wandered around the unit looking for a way out. 4/1/26, Interdisciplinary team (IDT) discussion held regarding R1's escalating behavior and need for additional management strategies. Family member (FM)-C expressed hesitancy about using antipsychotic medications and questioned if behavior was related to new medication. It was explained that R1 was currently receiving one-on-one supervision which was not sustainable long term and if behavior continued or escalated without adequate symptom control through medication, a higher level of care may be necessary including potential hospital evaluation or alternate placement. 4/2/26, Staff had conversation with R1's FM-C regarding his care plan after recent incident. ˆFacility staff requested family provide additional presence in the building by family or friends to manage R1 during periods of increased behaviors. Team would also be calling FM-A to request additional assistance. 4/3/26, Family meeting was held to discuss R1's care needs and ongoing challenges with care coordination. Family was informed that if hospice recommendations continued to be declined or over-ridden the facility may proceed with a 30-day discharge notice and assist with alternate placement. Family was also told if R1 were to reach out physically toward staff or other residents, the facility had been instructed to send him the emergency department. Agreement was reached to continue one-on-one supervision for seven days with the understanding that it was a temporary measure. 4/4/26, R1 was seen naked and urinating in the sink in his room. 4/5/26, FM-A arrived and took over the one-on-one staff assigned to R1. 4/6/26. R1 noted to be hallucinating. Thought FM-A was in his bed and reported seeing two dogs. 4/7/26, Care meeting held. Physician scheduled Buspirone and provided education to family about Seroquel. Plan in place to discontinue the one-on-one if medications start to work. 4/9/26, R1 agitated and wandering. Became upset when staff was following him in hallways and day room and commented, you better stop following me or else. Later talked about the woman who was following him. 4/10/26, IDT reviewed R1's overall mood and behaviors over the past several days. While there appeared to be a decrease in behaviors it did not mean behaviors had been resolved. The apparent reduction was largely due to the staff provision of one-on-one supervision which limited his ability to seek out or escalate behaviors. However, the behaviors were still present. 4/10/26, Hospice recommended the use of antipsychotic medications to address ongoing behaviors which family had declined. The IDT determined continued one-on-one supervision was required to maintain the safety of residents and staff. Family was provided with information on private long-term one-on-one staff that they would need to secure by Monday. Administrator advised family that if recommendations were not followed and behaviors continued, the facility would seek alternate placement. 4/10/26, Following ongoing discussion and IDT review a comprehensive evaluation of R1's clinical presentation, care needs and safety considerations was completed. Based on this review it was determined that the current care setting was no longer able to meet R1's long-term care needs. Conclusion was primarily due to (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progression and persistence of behavioral concerns that pose an increased risk to other residents and staff. 4/13/26, R1 left his room and walked to a recliner and sat down. Staff followed him and asked if he needed something to which he stated, what he wanted was to get away from staff. R1 went back to his room. Irritated that staff kept following him. Resident Occurrence Report dated 3/31/26, indicated R1 grabbed another resident's breast in a common area of the unit. Analysis of cause of incident indicated sexual disinhibition. Staff intervened and separated residents, and 15-minute checks were implemented. Facility document provided to family dated 4/10/26, indicated: Notice of discharge and indicated the facility was unable to meet R1's needs and required 1:1 supervision to meet R1's needs and ensure the health and safety of other residents and staff, and the facility was unable to provide the level of supervision R1 required. The documented indicated R1 would be discharged [DATE]. The discharge notice was rescinded 5/8/26, only after an appeal was filed on R1's behalf. Hospice visit note dated 5/15/26, indicated a care conference was held for R1. FM's expressed concerns related to anti-psychotic medications. [FM]'s have been given until 5:00 p.m. today to give consent or approval of hospice recommendations before going into the weekend. R1's behaviors indicated appropriate for situation, calm. ^The assessment lacked evidence of non-pharmacological behavioral interventions attempted. During observation on 6/4/26 at 1:05 p.m., R1 was lying in bed and appeared to be asleep. At 1:46 p.m., R1 was lying in bed and was snoring. During observation on 6/8/26 at 4:19 p.m., R1 was seated in a common area of the unit. R1 stood up and ambulated independently to his room. At 4:29 p.m., R1 came out of his room wearing a jacket. At 4:34 p.m., R1 went to his room to retrieve his walker, headed toward the exit doors of the unit then turned around and sat in a chair in the common area. ^At 4:41 p.m., staff attempted to get R1 to go to the dining room to eat, which was refused. Staff then assisted him to a recliner in the common area. R1 then got up from the chair and headed back to the exit door. At 4:50 p.m., R1 was ambulating, and staff asked him if he needed to use the bathroom. R1 replied he was trying to go outside and staff said he couldn't because everyone was eating. R1 swore quietly. During observation on 6/9/26 at approximately 7:30 a.m., staff was in R1's room talking to him. A medication cart was parked outside the door. Staff left the room and turned off the light. At 8:00 a.m., the same staff member was talking to licensed practical nurse (LPN)-A and said, I tried 129 [R1] but he wouldn't wake up. During interview on 6/5/26 at 7:31 a.m., licensed practical nurse (LPN)-A stated at one-point R1 had been placed on 15-minute checks, Maybe for being more sexual. I truly don't know. LPN-A stated when R1 first moved to the unit, he had exposed himself to R4, indicating he had his pants down and was facing R4. LPN-A stated R4 told staff about the incident the next day. During interview on 6/9/26 at 1:34 p.m., the household coordinator (HC) stated R1's discharge notice was given because he needed one-on-one staff supervision which was not a long-term solution. Essentially R1 needed more care than the facility could provide. Registered nurse (RN)-B was present and stated family had declined in-patient mental health placement. The one-on-one supervision was implemented after he had a physical touch situation with another resident. When asked about interventions for his behaviors, RN-B said staff diverted his attention with photo albums and music (not implemented until 5/20/26). When asked about psychiatric referrals, RN-B said because R1 was on hospice they would not normally reach out to psychiatry. RN-B said after the incident with the female resident, they needed some other interventions so R1 was placed on the one-on-ones. RN-B stated compared to other residents in the facility who also had dementia, R1 was impulsive and displayed sexual behaviors toward residents and staff. RN-B acknowledged no further incidents with other residents had occurred since 3/31/26. During interview on 6/9/26 at 3:23 pm., RN-A stated R1 displayed agitation and was always looking for items or family. The previous evening (6/8/26), staff was attempting to transfer another resident and R1 sat in the resident's chair and would not get up. The more staff attempted to talk to him, the more upset R1 got. RN-A said staff tried to distract R1 by offering him ice cream or toileting but said he had been refusing those things. During interview on 6/9/26 at 3:39 p.m., with the administrator and director of nursing (DON), the administrator stated the discharge was (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated due to the facility's inability to provide one-on-one staff supervision, which R1 required for the welfare of the staff and residents. R1's family declined in-patient mental health and medications. The administrator stated they asked family to help with one-on-one supervision. The family was provided with a list of organizations that could provide one-on-one care, but family did not want to pay for it. The DON stated R1's behavior was better when he was receiving one-on-one supervision. The DON acknowledged R1 had not sought out other residents since the incident on 3/31/26 and stated that it had been an isolated incident. When asked how the facility managed other residents' behaviors, the DON stated staff administered medications. Regarding non-pharmacological interventions, the DON said what worked was dependent on the day. The DON stated she had not observed staff interactions with R1, nor had she requested feedback from the staff in an effort to assess behavioral interventions. During interview on 6/9/26 at 4:26 p.m., nursing assistant (NA)-A stated R1 made some sexual comments and said he could be aggressive with staff. NA-A stated they had a class provided by the company regarding dementia and stated, I have been working here a long time, so I am pretty good at dementia. NA-A said she had not received any specific education related to R1. During interview on 6/9/26 at 4:31 p.m., NA-B said R1 would refuse toileting and would raise his voice but never touched anyone, he's just loud. NA-B said R1's behaviors were not present when he admitted to the facility and said they started when he moved to the secured unit. NA-B said when R1 was agitated or exit-seeking he had stuff in his room to distract him.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure pharmacy recommendations were addressed to include a clinical rationale for declined recommendations and failed to identify and address medications as a contributing factor for falls for 1 of 3 residents (R1) reviewed who sustained multiple falls following the implementation of hospice prescribed medications. Findings include: R1's admission Record printed 6/11/26, indicated he was admitted to the facility 2/10/26. Diagnoses included Alzheimer's disease, dementia and psychosis. R1's significant change Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated he displayed verbal behaviors toward others one-to-three days during the assessment period. The MDS indicted R1 transferred independently and ambulated with supervision. R1 received scheduled and as needed medication to relieve pain as well as non-medication interventions. R1 denied having, pain or hurting, during the assessment period. R1's care plan included: Revised on 3/17/26, history of requiring one-on-one staff supervision due to sexual advancements toward others. Interventions had been implemented along with extensive conversation to manage behaviors. Interventions included: Intervene as necessary to protect the rights and safety of others, approach in a calm manner, divert attention and move to an alternate location as needed. Revised on 3/18/26, R1 entered hospice care. Revised on 4/13/26, identified limited physical mobility. R1 required assistance from one staff for transfers and ambulation. The care plan Revised on 4/23/26, behavior required intervention evidenced by sexual behaviors toward staff. R1 would comment on staff's appearance and voice sexual desires toward that staff member. ˆR1 was often redirected through conversation. R1 had a history of masturbating in private room and being observed with hands inside pants in common areas, creating potential discomfort for others and need for redirection. Refer to Hospice regarding medication adjustments for behaviors. The care plan further identified a risk for falls related to weakness, Alzheimer's and a history of falls. Interventions included alert R1 to changes in environment, call light in reach, appropriate footwear, wheelchair out of path in room and review of information on past falls to determine cause and remove any potential causes of falls. ˆ Occurrence Report datedˆ2/11/26, indicated at 3:30 a.m., R1 fell in his room. Analysis indicated he was confused and may have fallen when returning from using the bathroom. Reminder to use the call light. R1's progress notes reviewed 3/16/26 through indicated: 3/18/26, indicated R1 admitted for hospice services. Hospice orders included: Start Lexapro (used to treat major depressive disorder and generalized anxiety. Typical side effects include nausea, fatigue, sexual dysfunction, and sleep changes)ˆ5 milligram (mg) tablets. Take 5 mg daily for seven days then re-evaluate. Start Seroquel (typical antipsychotic used to treat schizophrenia, bipolar disorder, and major depressive disorder. Potential side effects included heavy sedation and dizziness) 25 mg tablet. Administer 25 mg every four hours as needed for inappropriate sexual behaviors, agitation, and delirium. Mood disorder/ Discontinue after 14 days. Start Dilaudid (opioid analgesic used to manage severe pain that does not respond to other medications. Potential side effects included dizziness and drowsiness)ˆ1 mg tablet, administer 1 mg every hour as needed for pain or shortness of breath. 3/19/26, Seroquel placed on hold at this time. 3/24/26, No pain noted, R1 reported feeling tired and family member (FM)-B reported R1 had been sleeping all the time. Order was received to increase Lexapro. 4/1/26, hospice orders: Start Rivastigmine (used to treat mild to moderate dementia caused by Alzheimer's or Parkinson's disease. Potential side effects included dizziness and fatigue) 1.5 mg by mouth three times daily for dementia. Buspirone (used primarily to treat generalized anxiety disorder. Potential side effects included dizziness, drowsiness, lightheadedness and excitement)ˆ5mg tablet by mouth three times daily for anxiety. Haloperidol (antipsychotic medication used to manage sever behaviors. Typical side effects included drowsiness, dizziness and restlessness)1 mg Solu tab every four hours for agitation, hallucinations and delirium. 4/2/26, FM-C denied consent for Haloperidol. 4/4/26, R1 was seen naked and urinated in the sink in (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his room. Buspirone given. 4/7/26, care meeting, Buspirone scheduled twice daily and R1 could still have as needed. Education provided related to Seroquel. 4/8/26, indicated R1 fell on his right side at 4:04 p.m. Intervention indicated weakness, medication changes and hip pain. Occurrence Report dated 4/8/26, indicated at 4:04 p.m., R1 fell in the hallway. Suggestion included therapy assessment and assistance with transfers and ambulation. Occurrence Report dated 4/15/26, indicated at 7:15 p.m., R1 fell near the desk. Suggestions included when R1 displayed behaviors, avoid bringing him out where he could see other residents coming and going. Occurrence Report dated 4/19/26, indicated at 12:30 p.m., R1 was observed on the floor in his room. Suggestions included continue 15-minute checks and ensure needs were met. Occurrence Report dated 4/20/26, indicated at 3:40 a.m., R1 was observed crawling out of his room into the hallway. Suggestion included promote sleep, how do we get this man to sleep. Pharmacist's Recommendation to Prescriber dated 4/23/26, indicated R1 had experienced multiple falls, is at high risk for falls and received the following medications known to increase falls: Buspirone 10mg three times daily. Hydromorphone 1 mg every four hours as needed. Handwritten note on form indicated on hospice- meds [medications] effective. Check box on form indicated benefits outweigh risk and deemed necessary for R1. No changes. The recommendation lacked a clinical rationale for continuing the medications as prescribed and was signed by the physician on 5/19/26. Occurrence Report dated 4/25/26, indicated at 6:30 a.m., R1 fell in his room. Suggestions included medication review and getting him dressed for the day. R1's MAR dated April 2026 indicated he received the following medications: Buspirone 5 mg twice daily from 4/7/26 through 4/16/26 and as needed doses on 4/4/26, 4/5/26, 4/6/26, 4/7/26, 4/8/26, 4/9/26, 4/10/26 x 2, 4/11/26, 4/13/26, 4/15/26 and 4/16/26. Buspirone 10 mg three times dailyˆfrom 4/16/26 through 4/30/26 and as needed doses received on 4/18/26, 4/19/26, 4/24/26 x 2, 4/25/26, 4/28/26 x 2 and 4/29/26 x 2. Hydromorphone (Dilaudid) 1 mg three times daily from 4/2/26 through 4/9/26. Hydromorphone 1 mg every four hours (six times daily) from 4/9/26 through 4/30/26. Hydromorphone 1 mg as needed doses administered 24 times. Occurrence Report dated 5/4/26, indicated at 10:20 a.m., R1 fell in the dining room. Analysis indicated R1 had not slept well over the weekend, contacted hospice and requested nurse visit. Occurrence Report dated 5/29/26, indicated at 3:12 a.m., family observed resident fall (via camera in room). R1 got himself up off the floor. Second incident at 7:57 a.m., family again observed R1 on the floor via camera. Suggestions included management of bowel status and restlessness. R1's May 2026 Mar indicated he received the following medications. Buspirone 10 mg three times daily. As needed doses were administered 19 times. Hydromorphone 1 mg everyˆfour hours (six times daily) from 5/1/26 through 5/27/26. As needed doses were administered 12 times. Hydromorphone 1 mg five times daily from 5/27/26 through 5/31/26. Occurrence Report dated 6/1/26, indicated at 6:23 p.m., R1 was observed on the floor by family via video footage. Suggestions included staff to perform one to one. ˆProgress Note dated 6/2/26 indicated that FM called around 12:15 a.m. and reported R1 had fallen at approx. 6:23 p.m. on 6/1/26. Occurrence Report dated 6/3/26, indicated at 12:00 a.m., R1 was observed on the floor. Suggestions included an increase in dose of anti-anxiety medication and one to one care.ˆ Progress Note dated 6/4/26, indicated orders from hospice. Increase Hydromorphone to every four hours (six times daily) and may also have every hour as needed. Start Seroquel 50 mg at bedtime and 25 mg every four hours as needed. ˆDuring interview on 6/8/26 at 2:38 p.m., the consultant pharmacist (CP) stated concern for R1's medication included: dilaudid caused drowsiness and dizziness; seroquel caused increased hallucinations and agitation especially in the elderly and also caused dizziness and sleepiness; buspirone could also cause drowsiness. The CP said concerns with R1's medications included falls and the recently added Seroquel dose. During interview on 6/9/26 at 11:34 a.m., medical doctor (MD)-A stated R1 was at risk for falls. The dilaudid was started for hip pain, MD-A was not sure if it was scheduled or as needed but said it was not a medication he would use for pain management. MD-A did not remember what dose R1 was receiving and said, it was just his preference, but he would have used something else. During interview on 6/10/26 at 11:38 a.m., the assistant director of nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245114	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony River Living Center	1555 Sherwood Street Southeast Hutchinson, MN 55350

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(ADON) stated falls were discussed with the interdisciplinary team and during weekly fall meetings. The ADON said any discussion of high-risk medications contributing to falls done through the coordination with hospice and said they collaborated with them. The ADON said hospice had access to the medical record and could read the notes. ^The ADON said they always talked about medications and said they discussed the whole resident but said she did not document any medication review and/or adjustments as part of R1's falls discussions. ^Facility Unnecessary Medication Use policy dated March 2025, indicated residents receiving medications for an undocumented reason or without clear indication for the medication requires the facility to document if continuing the medication is justified by evaluating the condition, risks and existing medication regime. The medical record must reflect a rational for continued use of medications.