

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 02/20/2025
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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842</p> <p>Based on interview and document review, the facility failed to create a comprehensive care plan for a resident with a history of respiratory conditions for 1 of 1 residents (R102) reviewed for care plans.</p> <p>Findings include:</p> <p>R102's Medicare 5-day Minimum Data Set (MDS) dated [DATE], indicated R102 cognitive impairment could not be decided. Diagnoses included pneumonia and respiratory failure.</p> <p>R102's comprehensive care plan undated, lacked a patient specific care plan or interventions related to R102's history of pneumonia and respiratory failure.</p> <p>During an interview on 2/20/25 at 1:16 p.m., registered nurse (RN)-B stated the care plan was updated either when there was a change in the resident's condition or when a new MDS assessment performed. RN-B reviewed R102's MDS and 5-day care plan. She acknowledged the respiratory conditions listed in the MDS but were not found on the care plan. RN-B stated the care plan should have been updated with a respiratory care plan, goals, and interventions when the MDS was updated on 1/22/25.</p> <p>During an interview on 2/20/25 at 1:43 p.m. the director of nursing (DON) stated an expectation the care plan would be filled out as appropriate based on resident needs.</p> <p>Facility policy Care Plan Policy and Procedure last modified 11/22, indicated the care plan would be reviewed at least with each MDS assessment period and with any significant change. The care plan would be changed and updated as the care changes for the resident and as the resident changes occurred. The care plan was to be current at all times.</p>

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013</p> <p>Based on observation, interview and document review facility failed to provide activities of daily living (ADL) assistance for 1 of 1 resident (R38) who required assistance with eating.</p> <p>Findings include:</p> <p>R38's quarterly Minimum Data Set (MDS) dated [DATE], identified R38 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R38's diagnoses included progressive neurological conditions, seizure disorder/epilepsy, bipolar disorder and other drug induced secondary parkinsonism. MDS did not indicate R38 exhibited any behaviors.</p> <p>R38's care plan dated 12/16/23, identified R.8 required assistance of 1 for eating due to extensive tremors.</p> <p>During observation on 2/18/25, at 5:19 p.m., R38 was seated at dining room table with two other residents. Staff served the other two residents their plates, who started eating, R38 sat there watching the other residents eat. At 5:25 p.m., R38 continued watching other two resident eat. At 5:28 p.m., staff brought R38's plate to table and sat down and started to assist R38 with eating. R38 ate food when staff assisted.</p> <p>During observation on 2/19/25, at 5:21 p.m., R38 was seated at dining room table with two other residents. Staff served the other two residents their plates, who started eating, R38 sat watching the other residents eat. At 5:33 p.m., staff brought a bowl of soup and a plate of food and set it down in front of R28. At 5:34 p.m. , staff sat down and started to assist R38 with eating. R38 ate food when staff assisted.</p> <p>During interview on 2/20/24 at 2:54 p.m. nursing assistant (NA)-C stated R38 needed staff assistance with eating. NA-C stated they would serve the independent residents first and then would serve the residents who needed assistance eating.</p> <p>During interview on 2/20/25 at 3:01 p.m., director of nursing (DON) and administrator stated residents who require assistance with eating are served last as they need staff to assist them with eating. DON stated it would be important for all residents who are seated at the same table to eat at the same time for a more pleasurable dining experience and also for the resident's dignity.</p> <p>During interview on 2/20/25 at 3:22 p.m., director of nursing (DON) and administrator stated they spoke with dietary who confirmed R38 was served at the end due to him needing assistance with eating.</p> <p>The facility Dining Room Protocol policy, dated 1/13, indicated staff will participate in the delivery of meal service. Staff to provide dignified, prompt meal service. After all residents are served, proceed to assigned tables to provide eating assistance, as indicated or as appropriate.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842</p> <p>Based on observation, interview and document review, the facility failed to follow provider orders for a resident on mild thickened liquids for 1 of 2 residents (R102) reviewed for diet changes.</p> <p>Findings include:</p> <p>R102's Medicare 5-day Minimum Data Set (MDS) dated [DATE], indicated R102 cognitive impairment could not be decided. Diagnoses included pneumonia and respiratory failure.</p> <p>R102's Order Summary Report dated 1/16/25 indicated R102 had an active diet order for level 6 soft and bite sized texture with mild thick consistency liquids.</p> <p>R102's care plan revised on 12/29/24, indicated R102 had a nutritional problem and diet was to be served as ordered.</p> <p>R102's therapy interdepartmental team (IDT) communication dated 2/3/25, indicated nursing and dietary was notified by speech therapy (ST) R102 was on mild thick liquids.</p> <p>Facility care sheets undated, indicated R102 was suppose to have mild thickened liquids.</p> <p>On 2/19/25 at 2:47 p.m., R102 was observed with a plastic glass half full of non-thickened water that was drank from and then placed on the over table cart. Next to the plastic cup was a large gray mug with a lid on it.</p> <p>During an interview on 2/19/25 at 2:52 p.m. nurse assistant (NA)-D stated floor staff were aware of resident specific diets based on the facility care sheets that are reviewed every shift. The facility care sheet was reviewed and confirmed R102 needed mild thickened liquids. NA-D entered R102's room and confirmed the water in the plastic cup and in the large gray mug was unthickened water and should have been thickened prior to it being given to resident. NA-D then removed the glass and mug of water. NA-D had also been notified that R102 had been observed taking a drink out of the plastic cup.</p> <p>During an interview on 2/19/25 at 2:58 p.m., the speech language pathologist (ST) stated R102 had been placed on mild thickened liquids as of 2/3/25 because R102 showed increased high risk signs of aspiration when R102 drank thin liquids.</p> <p>During an interview on 2/20/25 at 1:16 p.m. registered nurse (RN)-B stated the care plan and the facility care sheets that the NA's use every day to guide resident care are updated when changes occurred.</p> <p>During an interview on 02/20/25 at 1:43 p.m., the director of nursing (DON) stated staff should follow the prescribed diet orders from the provider or ST to protect the resident from adverse effects.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Diet Policy last revised 3/23 indicated thickened liquids may be recommended for residents with swallowing difficulty to decrease the risk of choking or coughing on liquids. All liquids would be thickened to appropriate consistency before served.</p>