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	04/07/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide care consistent with a resident's needs and care plan to eliminate/reduce the risk of an accident during cares in bed for 1 of 3 residents (R111). This resulted in actual harm to R111 when staff repositioned R111 on her side with one staff member instead of two staff members per care plan, causing R111 to roll out of the bed to the floor. As a result, R111 was admitted to the hospital on [DATE] for a fracture of the right femur and a closed fracture of the left hip. R111 had surgery on 12/6/25 on the right femur and surgery on 12/11/25 on the left hip femur. The facility had implemented actions to prevent recurrence prior to the survey on 4/6/26, therefore, the citation was issued at past non-compliance.R111's quarterly Minimal Set Data (MDS) dated [DATE], identified R111 as cognitively intact. R111 was dependent on staff for toileting, rolling to the left and right in bed, and lower body dressing and needed maximal assistance with upper body dressing. R111 had a diagnosis including fractures and diabetes.R111's care plan was revised on 8/28/24, identified R111 needed two staff for sling management and when moving up in bed.R111's care sheet, dated 11/26/25, identified R111 needed two staff for dressing, bathing, and transferring.R111's physical therapy Discharge summary dated [DATE], identified R111 needed moderate to maximal assistance from two caregivers for rolling to the left and right sides in bed.R111's incident report dated 12/1/25 at 7:40 p.m., identified R111 was assisted into bed with a full mechanical lift and the assistance from nursing assistant (NA)-A and NA-B. NA-B left the room to help another resident, and NA-A rolled R111 to change her brief. R111 rolled to the right side and fell from bed. R111 landed on the floor on her back, arms at her side, legs bent towards herself. Resident denied being hurt at the time of the fall. No medical attention required at the time of the fall. Medical provider notified on 12/1/25 at 8:25 p.m., sister notified 12/1/25 at 9:00 p.m., administrator notified, no time identified. The short term intervention was education for NA-A and NA-B to always use two staff for bed mobility. A note was made on the incident report that the resident and family did not want to go to the emergency department for evaluation. The medical doctor later gave orders to have R111 sent to the emergency room for evaluation. The evaluation at the emergency room showed a left femur fracture. State authority notified on 12/3/25 once facility received notification of the fracture diagnosis. On 12/3/25, electromagnetic waves (X-ray) revealed new displaced comminuted intertrochanteric/ periprosthetic fracture of the proximal left femur (fracture top of thigh bone). In addition, the x-ray revealed a displaced fracture of the right distal femoral diaphysis and metaphysis (fracture of the thighbone above the knee joint).On 12/6/25, surgical report revealed R111 had an insertion retrograde intramedullary nail placed in the right femur (treatment for fractures of the femoral shaft).On 12/11/25, surgical report identified removal intramedullary nail from left knee with replacement of an antegrade nail (used to stabilize fractures while maintaining alignment and length) to the left hip femur.R111's treatment medical record (TAR) identified staff to monitor R111's right hip, thigh, and knee surgical incision for any signs or symptoms of complications, from 12/16/25 until 1/7/26. Progress note dated 12/1/25 at 10:29 p.m., identified R111 fell in room at 7:40 p.m., R111 rolled out of bed. No injury noted. Fax sent to medical provider.Progress note dated 12/2/25 at 4:45 (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 0689 Level of Harm - Actual harm Residents Affected - Few	a.m., identified R111 complained of pain in her legs when being moved.Progress note dated 12/2/25 at 10:02 a.m., identified R111 complained of pain all over, especially her right arm, right leg, and left hip. Bruise seen on the right inner knee and top of right foot just below the great toe. R111said the pain is not alleviated with oxycodone.Progress note dated 12/2/25 at 10:05 a.m., identified R111 wanted the x-ray done in the facility, did not want to be sent to the emergency department. Provider was updated on the request.Progress note dated 12/2/25 at 10:17 a.m., identified R111's sister was provided an update on the increased pain and R111's request to have x-ray completed in-house versus seeking emergency evaluation. Sister was in agreement.Progress note dated 12/2/25 at 9:42 p.m., identified fax was received from medical provider recommending R111 to be seen in the emergency department. R111 was given this information. R111 continued not to want to be seen in person. Brother was in the presence of this conversation with R111. This information was passed onto the medical provider.Progress note dated 12/3/25 at 9:56 a.m., identified R111 was sent to the emergency room due to pain in left hip and right foot and knee pain.Progress note dated 12/3/25 at 2:40 p.m., identified R11 would be transferring to Methodist Hospital.Progress note dated 12/13/25 at 2:16 p.m., identified R111 returned from the hospital.Bed assist device assessment completed 10/7/24 for grab bars. R111 was deemed appropriate for having grab bars attached to the upper portion of the bed. Bed assist device informed consent signed 12/18/25. Bed system device assessment completed 12/18/25, for grab bars, R111 was deemed appropriate for grab bars being attached to the upper portion of the bed.During an observation on 4/7/26 at 8:00 a.m., NA-C and NA-D went into R111's room and informed R111 that they were going to get her ready for her bath. NA-C went to the left side of R111's bed, and NA-D went to the right side of the bed. NA-C instructed R111 to roll to the right side of the bed. NA-C and NA-D assisted R111 to lie on her right side and applied the lift sling for the mechanical lift under R111. NA-D and NA-C then assisted R111 to roll to her left side. Each time R111 rolled onto her side, she held onto the grab bars. NA-D positioned the lift straps between legs. R111 did not complain of pain or show any signs of anxiety during the rolling in the bed. Staff hooked the sling to the mechanical lift and lifted R111 out of bed and onto a shower chair. The lift sling was removed from under and behind the resident. NA-C brought the resident into the shower. At 8:23 a.m., NA-C and NA-D placed a mechanical sling under R111 and transferred R111 from the shower chair to the bed and lowered R111 onto the bed. NA-D went to the right side of the bed and NA-C was on the left side of the bed when rolling R111 in bed per care plan.During an interview on 4/6/26 at 1:21 p.m., R111 verified she fell out of bed and was injured. R111 indicated two staff were in her room, and one of the staff who was by the window left the room to help another resident. R111 rolled over to her right side, reached for the side table, and fell onto the floor. R111 indicated she used the mechanical lift before the fall. R111 indicated she feels safe having NA-A and NA-B provide care, as the fall was an accident.During an interview on 4/6/26 at 7:50 p.m., NA-B verified she was working the night R111 fell. NA-B indicated that she and NA-A laid R111 in bed using the mechanical lift. It came over the walkie that someone needed assistance. NA-B indicated she was not aware R111 was a two-assist for bed mobility and verified she did not read the nursing assistant care sheet at the start of the shift on 12/1/26. NA-B indicated she left the room to assist another resident. NA-B indicated R111 was recently changed to a two assist, as R111 had been a one assist with bed mobility. NA-B verified after the fall, she received education on R111 being a two-assist, and the need to read the nursing assistant care sheet before the start of the shift. NA-B indicated the facility took the grab bars away before the fall and was unsure why, but R111 now has the grab bars back on the bed. NA-B indicated R111 needed assistance with care and was a mechanical lift before the fall, and the fall has not changed her mobility. NA-B indicated R111 had two fractures from the fall. NA-B indicated R111 had more anxiety with rolling in bed right after returning from the hospital, but is back to her baseline.During an interview on 4/6/26 at 7:55 p.m., NA-A indicated on 12/1/25, NA-B assisted with transferring R111 into bed with the mechanical lift. When they were changing R111's brief, a call light went off, and it sounded on their pagers. NA-B left the room to answer the call light. NA-A went to roll (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R111 to the right, and R111 reached out for the nightstand because there were no grab bars on the bed and R111 fell on the floor. NA-A indicated R111's grab bars were taken away a few weeks before the fall and were put back on the bed after R111 returned from the hospital. R111 had some leg pain after the fall. NA-A indicated she was called to the office and had to complete refresher classes on nursing assistant responsibilities before returning to work. Education was also given on following the nursing assistant care sheet.During an interview on 4/7/26 at 10:37 a.m., TMA-A indicated R111 was a two assist for bed mobility, which started when the grab bars were removed a few weeks prior to the fall on 12/1/25. When R111 was changed to a two-assist, the nursing assistant care sheets were updated. When a change is made on the nursing care sheets, the changes are highlighted and placed on the communication clipboard and also hung up in the nurses station. TMA-A verified that she received education regarding the importance of following the nursing assistant care sheets when providing care, and that education was given to staff after R111's fall. During an interview on 4/7/26 at 10:50 a.m., NA-C indicated R111 required two staff to turn in bed prior to the fall on 12/1/25. NA-C indicated a mock survey was done at the facility a few weeks before the fall, and the mock survey results showed R111 grab bars should be removed. When the grab bars were removed, R111 was changed to a two assist when rolling in bed. NA-C indicated the nursing assistant care sheets were updated. NA-C indicated when the nursing assistant care sheets were updated, the changes would be highlighted and hung up on the wall in the nurse station, and written on the communication clipboard alerting staff to the changes. NA-C indicated R111 had anxiety and pain before the fall on 12/1/25. NA-C indicated R111 had increased anxiety right after the fall, but had returned to baseline. R111 required three staff to assist with bed mobility after returning from the hospital, as she had two fractures and her legs were kept straight. NA-C indicated R111 did not have rods put in, but had a procedure on both legs after the fall. NA-C indicated R111 grab bars were replaced after the fall, which R111 uses, and the grab bar helps R111 feel safe when rolling in bed. NA-C verified she received education regarding the importance of checking and following resident care sheets to ensure residents receiving the care they need.During an interview on 4/7/26 at 9:02 a.m., registered nurse care coordinator (RNCC)-A indicated R111 fell out of bed on 12/1/25 around 7:40 p.m., when NA-A rolled R111 on the right side towards the window and reached for the nightstand and fell out of bed. R111 had her nightstand between the bed and the window. After the fall, the nurse performed range of motion (ROM) without issues, and blood pressure was measured when lying and sitting. At the time of the fall, R111 did not report any pain. The doctor was updated on the fall with no injury by fax. During the night, R111 had pain. Family and R111 did not want R111 sent to the emergency room and wanted an X-ray done in-house. The doctor was updated by fax on the pain and the family's decision not to be sent out of the facility. The doctor did not want to have the X-ray done in-house and wanted R111 to be seen at the emergency room. After ongoing pain, the family and R111 agreed to be sent in for X-rays on 12/3/36. The X-ray showed R111 had two fractures. R111 had grab bars removed on 11/18/25, which R111 would sporadically use to assist in bed mobility. The facility had a mock survey, and since R111 did not initiate the grab bars, it was decided by staff to remove the grab bars. After the fall, an assessment was done, and it was determined R111 could hold onto the grab bars once staff turned her, and the grab bars were replaced after the assessment.During an interview on 4/7/26 at 9:22 a.m., administrator indicated R111 was a two assist for bed mobility when the grab bars were removed from the bed on 11/18/25. The nursing assistant care sheet was changed to reflect R111 was a two assist for turning in bed. Administrator verified that the nursing assistant care sheet was not being followed when resident fell out of bed. NA-A and NA-B transferred R111 into the bed, and NA-B went to help another resident. NA-A rolled resident on the right side. R111 reached for the nightstand and pulled on the nightstand, and fell. An investigation was completed. All care staff received education following the nursing assistant care sheets. Residents were interviewed about the care they received and if they had any concerns. Audits were completed on the nursing assistant care sheets to ensure they were accurate. Audits were completed ensuring care was done according to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	nursing assistant care sheets. Administrator's expectation would be for staff to follow the nursing assistant care sheets to prevent accidents and ensure the safety of staff and residents.During an interview on 4/7/26 at 10:31 a.m., director of nursing (DON) indicated R111's fall occurred when R111 was transferred into bed by NA-A and NA-B. R111 was a two assist for turning in bed at the time of the fall. NA-B left the room, and R111 was rolled to her side. R111 reached for the side table and fell to the floor. DON was unable to determine if having a second staff member present would have prevented the fall. DON verified R111 received two new fractures from the fall. DON verified the nursing assistant care sheet indicated two staff for bed mobility and the nursing care sheet was not followed at the time of the fall. DON verified that the staff called administration after the fall, and the staff was interviewed regarding the fall. Education was given to NA-A and NA-B and was removed from the schedule. Residents were interviewed regarding their care to ensure residents felt they were receiving the care they needed. All care staff were provided with education on the importance of following the nursing assistant care sheet. NA-A was provided with education in-house and received extra classes before returning to work. Audits were carried out to ensure nursing care sheets and care plans are updated when changes are received. Audits were done to ensure staff were following the care sheets.During an interview on 4/7/26 at 1:02 p.m., physical therapist (PT) indicated R111 was discharged from physical therapy on 9/30/25, with instructions for two staff members for bed mobility. PT indicated R111 had grab bars prior to a mock survey that was completed by presbyterian homes. The mock survey indicated the grab bars to be removed and R111 to be an assist of two with transfers and bed mobility. PT indicated R111 had a fall on 12/1/26. When R111 returned from the hospital, R111 received physical therapy three times a week. Occupational therapy (OT) saw R111 twice a week when R111 returned from the hospital, PT requested that the grab bars be reinstated on 12/17/26. PT changed R111 to an assist of three when turning in bed, two staff to assist with turning, and one staff member to assist with leg positioning. The assistance of three was discontinued on 1/20/26. PT stated they would expect staff to follow PT recommendations to ensure the safety of staff and residents.During an interview on 4/7/26 at 3:40 p.m., medical provider (MP) indicated she was aware of the fall on 12/1/26. MP indicated she was under the understanding that R111 was being rolled in bed for cares when the fall occurred. The facility sent a fax after the fall occurred, indicating no injury. Later that day, MP received a fax that R111 was having pain and requested the portable X-ray machine, as the family and R111 did not want to be seen outside of the facility. MD responded to facility that R111 needed to be seen, as without an assessment, MP-A would not know which joints or limbs would need to be x-rayed without an evaluation. The following day, MP-A was sent a third fax from the facility indicating R111 was refusing the in person evaluation. MP indicated she requested the facility to inform R111's sister that R111 needed to be evaluated in person for a trauma evaluation and the importance of having this evaluation. After the facility talked with the resident and sister, the facility then sent R111 to the emergency room. R111 had a new displaced fracture of the left femur and a right knee distal diaphysis and metaphysis. From the emergency room, R111 was sent to Regions Hospital in St. [NAME]. R111 was admitted later that night, around midnight on 1/4/26, and discharged on 1/13/26. The consultant orthopedic surgeon recommended what we call a palliative surgical repair to help R111 with pain and symptoms. On 12/6/26, a nail was placed into the right femur. On 12/11/26, a nail was placed into the left hip femur. MP-A was not aware that the staff was not following the care plan when R111 fell. MP-A indicated that two staff should have been providing care, but it would be speculative to say that having two staff would have prevented the fall. MP-A indicated R111 had anxiety and pain before the fall, which did increase after the fall, but R111's pain and anxiety have since returned to baseline.Verification of corrective action was confirmed by interview with facility staff and review of training documentation. The nursing assistant involved verified she was promptly re-educated on the importance of following the nursing assistant care sheets. Documentation showed the facility had developed, implemented, and completed a plan to ensure that any staff responsible for providing cares were trained. This was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	confirmed by review of training records and staff interview. Observation of care in bed observed and verified that staff were following the nursing assistant care sheets. Interviews were conducted with other residents in the neighborhood about the NA-A and NA-B performance, which indicated residents had no concerns with cares. Facility was able to demonstrate monitoring of the corrective action and sustained compliance.Review of policy titled Fall Prevention and Management Program Policy dated 1/26, identified, that upon admission, quarterly, annually and with significant change all residents will be assessed for their risk for falls. The Clinical Administrator is responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment in collaboration with facility equipment experts to aid in fall prevention. Clinical Coordinator or designee is responsible for implementation and oversight of individualized residents fall prevention care as follows: Assessing fall risk upon admission, quarterly, with significant change in condition. Determining risk for fall and establishing appropriate interventions in the care plan related to fall risk in the plan of care. Implementing the interventions specific to fall risk data collection. Supervising personnel in delivering safe and personalized care. Evaluating the effectiveness of interventions in relation to the resident specific plan of care. Collaborating with the interdisciplinary team in the prevention of falls. Appropriately managing residents who experience a fall by implementing interventions to prevent further falls. The facility will complete fall tracking with review every month. The information will be brought to the QAPI committee quarterly for review. A site and/or household root cause analysis will be completed by an interdisciplinary team. Action plans will be created as needed. The past noncompliance that began on 12/1/25. The deficient practice was corrected by 12/9/25, after the facility implemented a systemic plan that induced the following actions: immediate education on facility policy for all NA's and nurses to review the nursing assistant care sheet prior to the start of the shift. Interviews with staff on 4/6/26 and 4/7/26, confirmed understanding of reviewing the nursing assistant care sheet before the start of the shift for changes. Observation of transfers on 4/7/26 demonstrated compliance with transfers and bed mobility.