STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

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** 44649 Based on observation, interview, and record review the facility failed to immediately report allegations of abuse and injury of unknow origin to the State Agency (SA) no later than two hours after the allegation is made for 1 of 1 resident (R1) reviewed. R1's family filed a facility grievance that indicated staff was aggressive with R1 and a facility nurse found bruising that were similar to finger marks on R1's upper arm where a cause was not identified. Neither event was reported. Findings include: R1's admission Minimum Data Set, dated dated dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). R1's event history dated 3/4/25 - 4/3/25 did not indicate an event for any bruising of unknown origin. R1's abuse assessment dated [DATE] indicated R1 had physical limitations which made her susceptible to abuse explained due to R1 was a stroke victim. R1 had cognitive deficits which made her susceptible to abuse with no explanations indicated. R1's care plan dated 3/6/25 did not indicate R1 was at risk for abuse. A facility grievance dated 3/12/25 indicated R1 expressed to FM-B that NA-A was aggressive with her. The facility investigation follow-up 3/14/25 indicated R1 continued to have cares in pairs. The follow-up included the statement Staff feel like this pain is continuing to make her feel like the aids are throwing her around. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	R1's progress note dated 3/13/25 at 7:45 a.m. indicated R1 had three circular dark purple bruises noted near R1's left elbow during the night shift. Visual inspection completed on the left side prior to medication administration as resident had complained of pain on the left side after transferring to the bed. The bruise measures were as follows (superior to inferior), 1.0 centimeters (cm) x 1.0 cm, 1.5 cm x 1 cm, and 1 cm. 1.2 cm. No other progress notes indicated any skin concerns. Upon interview on 4/3/25 at 12:18 p.m. family member (FM)-A was visiting. R1 had mentioned to him three- or four-times in the past few weeks how NA-A was aggressive verbally and physically with R1. He stated that same week FM-B found three small bruises on R1's upper arm that resembled fingers markings. The bruising was not reported to the family until the family asked about the bruising and was told by the director of nursing (DON) that the facility was not certain when or how the bruising occurred. Upon interview on 4/3/25 at 12:25 p.m. FM-B stated the family met with the staff on 3/10/25 and spoke of their concerns with nursing assistant (NA-A). FM-B was asked to fill out a grievance form with her concerns. She completed the form. She stated she wanted the facility to address the aggressive cares for R1 completed about. The family noticed a change in R1 both mentally and physically. Mentally her conversations became dark saying she just did not want to live anymore if care meant physical and mental pain. On 3/14/25 was when R1 showed the family the bruising on R1s left arm. FM-B witnessed when the DON assessed R1's arm. The DON stated she could not say how or when the bruising happened. It looked like finger markings. Upon observation and interview on 4/3/25 at 1:33 p.m. R1 was able to lift her left shirt sleeve above her elbow and point to where the bruising had been. She stated it must have happened at some point when NA-A threw her around. She stated she did not know whether someone had gripped her during a transfer or moving her in bed. R1 stated she was having pain on her left side one night. She called for the nurse and RN-B found the bruising. RN-B asked R1 a lot of questions about the bruising and brought in another nurse to look at them. R1 stated the next day she showed the bruising to her family and the family had the head nurse look at it, who did not know what caused it. I told her it was the aggression. In addition, R1 stated NA-A yelled at her almost every time she worked with her and made her feel like I would rather be dead than receive this care. She stated she would say things like telling her to how awful she was to care for and that I better not say anything about how aggressive she is. She stated she felt safe at the facility if NA-A stayed o out of her room. Upon interview on 4/3/25 at 12:50 p.m. NA-B stated he was aware there was to be two aides in R1's room with cares but was not certain why. He stated aggression was abuse as aggression was mentioned in the yearly abuse training, he had recently completed. He stated both concerns of aggression and bruising, when the root cause is not known, is reportable immediately. Upon interview on 4/3/25 registered nurse (RN)-C stated she had not noticed bruising on R1, however bruising any allegations of verbal and mental abuse must be reported immediately. Upon interview on 4/3/25 at 2:09 p.m. social worker (SW)-A stated yelling would be considered verbal and abuse should be reported within 24 hours. She stated the term aggression is a broad term and the facility would need to investigate that before making a report. She stated she was not aware of the grievances. (continued on next page)

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(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	Upon interview on 4/3/25 at 2:25 p.m. the DON stated when she inquired with the family and R1 about the bruising she could not explain what happened. She stated maybe it was staff using her body instead of a bed sheet to lift her that could have caused bruising, we just don't know. We moved R1 to care in pairs immediately. The DON stated in her follow-up report where other indicated other nursing assistants (unidentified) stated throwing her around meant yanking on and hurting R1. The DON was not aware that injury of unknown origin was reportable and did not feel R1's allegations of aggression and being thrown around was not reportable to the SA as the facility kept it inhouse and provided interventions. The facility was meeting with R1's family weekly and the family had no other concerns currently after the interventions the facility put in place. Upon interview on 4/3/25 at 3:33 p.m. NA-A stated the DON spoke with her that R1's family alleged NA-A was aggressive, snippy, and did not want to be at work. She not able to work with R1 after their conversation. NA-A stated approximately six months ago she had been accused her at yelling at a man, but nothing became of that situation and that resident was no longer at the facility. She stated neither allegation against her was true. She identified herself as calm, caring and took her job seriously. Upon interview on 4/4/25 at 7:05 a.m. RN-D stated he did witness the bruising on R1. He stated RN-B came to the unit he was working on to get his opinion of the bruising. He stated the bruising was small on R1's upper arm. He stated RN-B had measured the bruising without being present. RN-D stated R1 was complaining of left sided body pain. He was not certain whether RN-B reported the bruising to the management team or not. Upon interview on 4/4/25 at 9:21 a.m. RN-B stated she found three small bruises above R1's elbow when R1 was complaining of pain on her left side. She stated, I wondered if there was something going on. R1 stated to her that she had gotten in a fight, and she lost. RN-B stated she worked nights and at times people have dreams, so maybe it was a dream as R1 was confused. RN-B found RN-D and had him observe R1 with her. RN-B stated in hindsight she thought the cause of the bruising was R1 gripping her own arm. RN-B stated she documented the bruising in R1's chart. She did not know if anyone followed-up with R1. RN-B saw the bruising two nights in a row when she gave R1 pain medication during the night. RN-B did not think of reporting the bruising of unknow origin to management since she had documented the findings in her chart. NA-A's human resources file did not have any performance improvement documentation for R1. A facility policy titled Vulnerable Adult-MN with a revision date of 10/14/22 indicated: The facility prohibits the abuse, neglect, exploitation of residents, and mistreatment of residents and/or misappropriation of resident property by anyone including staff, other residents, family, friends, volunteers, etc. All residents of the facility are considered vulnerable adults due to physical or mental disability or dependence on institutional services. The facility attempts to establish an environment that is as homelike as possible and includes a cultures and environment that treats each resident with respect and dignity. (continued on next page)

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(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	Each employee is responsible to report suspected/alleged violations of mistreatment, neglect, exploitation of residents, and abuse of residents and/or misappropriation of resident property immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegations involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to designated facility staff (i.e. DON, Director of Social services, or Nursing supervisor). The Administrator will be notified immediately. Report all alleged violations and substantiated incidents immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to the state agency and all other agencies as required (electronically to OHFC or if needed, online to MAARC if report being filed upon discharge). To be in compliance with the Elder Justice Act of 2011, all staff needs to be aware of when Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. It also includes deprivation by an individual, including caretaker of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, or pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful: (as used in the definition of abuse) means the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury. Injuries of unknown source: An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; AND The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries. observed at one particular point in time or the incidence of injuries over time. Mental Abuse: Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal Abuse: Any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident, such as telling a resident that they will never be able to see their family again.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to provide evidence that a thorough investigation was completed on allegations of an injury of unknown origin for 1 of 4 residents (R1) reviewed. Staff found bruising resembling finger markings on R1's upper arm. R1's family had filed a grievance report regarding aggressive care one day prior to the bruising findings. Findings include: Facility record grievance review dated 1/1/25 - 4/3/25 did not reveal any documented grievance or investigation regarding R1's bruising an injury of unknown origin. R1's admission Minimum Data Set, dated dated dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). R1's event history dated 3/4/25 - 4/3/25 did not indicate an event for any bruising of unknown origin. R1's abuse assessment dated [DATE] indicated R1 had physical limitations which made her susceptible to abuse explained due to R1 was a stroke victim. R1 had cognitive deficits which made her susceptible to abuse with no explanations indicated. R1's care plan dated 3/6/25 - 4/3/25 did not indicate R1 was at risk for abuse. Nor did the care plan indicate R1 was to have cares in pairs (2 staff with all cares). R1's progress note dated 3/13/25 at 7:45 a.m. indicated R1 had three circular dark purple bruises noted near R1's left elbow during the night shift. Visual inspection completed on the left side prior to medication administration as resident had complained of pain on the left side after transferring to the bed. The bruise measures were as follows (superior to inferior), 1.0 centimeters (cm) x 1.0 cm, 1.5 cm x 1 cm, and 1 cm. 1.2 cm. No other progress notes indicated any skin concerns. Upon interview on 4/3/25 at 10:01 a.m. R1's Nurse Practitioner (NP) stated she was not notified of any bruising on R1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon observation and interview on 4/3/25 at 1:33 p.m. R1 was able to lift her left shirt sleeve above her elbow and point to where the bruising had been. She stated it must have happened at some point when NA-A threw me around. She stated she did not know whether someone had gripped her during a transfer or moving her in bed. R1 stated she was having pain on her left side one night. She called for the nurse and RN-B found the bruising. RN-B asked R1 a lot of questions about the bruising and brought in another nurse to look at them. R1 stated the next day she showed the bruising to her family and the family had the head nurse look at it, who did not know what caused it. I told her it was the aggression. In addition, R1 stated NA-A yelled at her almost every time she worked with her and made her feel like I would rather be dead than receive this care. She stated she would say things like telling her to how awful she was to care for and that I better not say anything about how aggressive she is. She stated she felt safe at the facility if NA-A stayed out of her room. Upon interview on 4/3/25 at 12:50 p.m. NA-B stated he was aware there was to be two aides in R1's room with cares but was not certain why. He stated bruising, when the root cause is not known, is reportable immediately and required investigation. Upon interview on 4/3/25 at 2:25 p.m. the DON stated when she inquired with the family and R1 about the bruising she could not explain what happened. She stated it could have been staff using R1's body instead of a bed sheet to lift her that could have caused bruising, we just don't know. The DON denied having an investigation record of staff, other resident interviews, or skin assessments for the bruising. The facility did investigate the aggressive treatment allegations in which eight staff members were asked if they witnessed anyone to have been rough, mean or disrespecting and had they witnessed or been aware of abuse neglect etc. of a resident. Ten residents who had a BIMs score of 10 or above were interviewed asking if staff treated them with respect, if they had any concerns or if they felt safe. The investigation did not indicate the care received by residents who were at risk due to cognitive impairment or any observations of residents. Upon interview on 4/3/25 at 3:33 p.m. NA-A stated the DON spoke with her that R1's family alleged NA-A was aggressive, snippy, and did not want to be at work. NA-A was not able to work with R1 after their conversation. NA-A stated the facility had not mentioned R1's bruising to her. She worked the night RN-B found the bruising, because RN-B asked her if she knew how R1 got the bruising. Upon interview on 4/4/25 at 7:05 a.m. RN-D stated he did witness the bruising on R1. He stated RN-B came to the unit he was working on to get his opinion of the bruising. He stated the bruising was small on R1's upper arm, RN-B had measured the bruising without RN-D present. RN-D stated R1 was complaining of left sided body pain. He was not certain whether RN-B reported the bruising to the management team or not. The facility did not follow-up with RN-D regarding the bruising. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 4/4/25 at 9:21 a.m. RN-B stated she found three small bruises above R1's elbow when R1 was complaining of pain on her left side. She stated, I wondered if there was something going on. R1 stated to her that she had gotten in a fight, and she lost. RN-B stated she worked nights and at times people have dreams, so maybe it was a dream as R1 was confused. RN-C found RN-D and had him observe R1 with her. RN-B stated, in hindsight she thought the cause of the bruising was R1 gripping her own arm. RN-B stated she documented the bruising in R1's chart. She did not know if anyone followed-up with R1. RN-B saw the bruising two nights in a row when she gave R1 pain medication during the night. RN-B did not think of reporting the bruising of unknow origin to management since she had documented the findings in her chart. The facility did not follow-up with RN-B regarding the bruising. An email correspondence dated 4/4/25 at 10:21 a.m. from the DON indicated On 3/13 there was some bruising noted on residents L arm, resident stated that she was not sure what happened, resident utilizes a Hoyer lift for transfers, is participating in therapy, staff feels like maybe staff is turning her not with the draw sheet but by pulling on her. Due to the amount of assistance resident requires, verbal education was provided to staff that work with the resident about using the draw sheet and utilizing 2 individuals for cares going forward. A facility policy titled Vulnerable Adult-MN with a revision date of 10/14/22 indicated: All reports of suspected/alleged resident abuse, neglect, exploitation of residents, mistreatment, injury of unknown source and/or misappropriation of resident property shall be promptly and thoroughly investigated. All interviews related to the investigation shall be conducted in private. Collect data and document investigative findings. The investigation may include, but is not limited to: Physical examination of the resident and environment. Examination of the resident by a licensed nurse or physician. Review documentation and the resident's medical record for events leading up to incident. Interview the person(s) reporting the incident. Interview the alleged victim. Interview any potential witnesses to the incident. Interview the alleged perpetrator. Interview other residents to whom the alleged perpetrator provides care or services. Review the completed documentation. If witness reports are obtained, they may be in writing. Witness should sign and date such reports. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Document the results of the investigation. Log the incident on the Event summary or other log. Use the Event summary or other log for ongoing review and analysis of abuse incidents and the implementation of changes to prevent future occurrences of abuse. The results of all investigations must be reported to the administrator (or their designated representative) and state agency and to other officials in accordance with state law within five working days of the incident. If the alleged violation is verified appropriate corrective action must be taken. If employee is found to have perpetrated the incident, follow the employee handbook. Injuries of unknown source: An injury should be classified as an injury of unknown source when ALL of the following criteria are met: The source of the injury was not observed by any person; AND The source of the injury could not be explained by the resident; AND The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to accurately assess physical restraints (manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body) for 4 of 4 residents (R1, R2, R3 and R4) reviewed who use bedrails. Findings include: Long-Term Care Facility Resident Assessment User Manual Version 1.18.11, dated October 2023, viewed 8/26/24 indicated a physical restraint or method physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint definition. This can only be deterred on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment. Retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf. R1's care plan dated 3/4/25 did not indicate placement of side/bed rails on R1's bed. R1's admission Minimum Data Set, dated dated dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). Bed rails were not identified as used on the MDS. Upon observation and interview on 4/3/25 at 3:47 p.m. R1 was found to have bilateral quarter side/bed rails at the head of her bed. The rails could open to the sides by pivoting like a door. R1 stated she did not know how to remove the rails and felt she could not even if she knew how. She used the rail on the left side of the bed because when she received cares she could hold on to that side with her right hand. She could not use the rail on the right side because of the swelling and weakness in her left hand following her stroke. Upon interview on 3/3/25 at 4:16 p.m. registered nurse, RN-A stated she performed admission assessments and was not instructed to obtain orders, indicate what diagnosis the rails were intended to treat, educate on the risk and benefits and obtain a consent. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's admission MDS dated [DATE] indicated R2 had a BIMs score of 10 indicating R2 was moderately cognitively impaired. R2 required moderate assistance with toileting hygiene, bathing, dressing, personal hygiene, and rolling left to right in bed. R2's pertinent diagnoses were congestive heart failure, chronic obstruction pulmonary disease (a group of lung disease that block airflow making it difficult to breathe, respiratory failure, and toxic encephalopathy (the brain becomes damaged due to exposure to toxins). The MDS did not indicate bed rails were used. R2's care plan dated 2/26/25 did not indicate placement of a side rail on R2's bed. R2's Device-Equipment assessment dated [DATE] indicated R2 had a left upper assist rail/grab bar due to generalized weakness/debility. Under identify the alternatives to use the of a device which were attempted but failed to meet the residents needs indicated PT/OT recommendation, no other alternatives were identified. The reasons for consideration of the device were: -Allow resident to assist with turning, care, and/or repositioning. -Improve quality of life. -Improve participation and/or self-deficiency with cares. -Prevention of falls during transfer from one location to another. -Reduce the risk of harm to self or others. The assessment identified restraints are defined as any manual or physical or mechanical device, material or equipment adjust to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal assess to one's body. R2's side/bed rail was not identified as a restraint on the assessment. The resident demonstrated the physical ability to safely use the device. The assessment did not indicate of R2 could safely remove the device on her own. The assessment indicated potential benefits of the use of the device were reviewed with the resident and/or representative. The assessment did not provide an indication of a consent form. Upon observation and interview on 4/4/25 at 9:11 a.m. R2 was lying in her bed. She had a quarter sized side rail on the left side of her bed. She stated she did not know what the surveyor was talking about and did not know what that thing was. R3's care plan dated 3/11/25 did not indicate the use of side/bed rails. R3's admission MDS dated [DATE] indicated R3 had a BIMs score of 14 indicating she was cognitively intact. R3 required maximum assistance with toileting hygiene and lower body dressing, moderating assistance with upper body dressing and personal hygiene. R3 was dependent upon staff for rolling from left to right in bed, sitting to lying, sitting to standing and transfers. R3's pertinent diagnoses were acute kidney failure, chronic respiratory failure, chronic congestive heart failure, muscle weakness, spinal stenosis of the lumbar region with neurogenic claudication (spinal narrowing in the lower back with pressure on the nerves) and history of falling. R3's MDS did not indicate a side/bed rail was used. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Gardens	1438 County Road C East Maplewood, MN 55109

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon observation and interview on 4/4/25 at 11:03 a.m. R3 was seated in her wheelchair. R3 had two quarter rails on her bed. The right-side rail was at the very head of the bed and the left side rail was approximately 12 inches lower, than the placement of the adjacent right-side rail. The left side was more toward the center of the bed. R3 stated she used the rails to feel safer in her bed and to transfer in and out of her bed. R4's admission MDS dated [DATE] indicated R4 had a BIMs score of 14 indicating R4 was cognitively intact. R4 required maximum assistance with toileting hygiene, rolling from left to right, sitting to lying. R4 was dependent upon staff for lower body dressing and transfers. R4's pertinent diagnoses were fracture of the left femur (thigh bone), major depression disorder, anxiety disorder and osteoarthritis (breakdown of tissues in the joints). R4's MDS did not indicate side/bed rails were used. R4's care plan dated 3/11/25 did not indicate the use of side rails. Upon observation and interview on 4/4/25 at 11:15 a.m. R4 was seated in her wheelchair. She had two quarter sized rails at the head of her bed. She stated she used the rails or safety, and her family wanted them on her bed. Upon interview on 4/3/25 at 4:21 p.m. the director of nursing, DON stated the bars on the bed were not side rails they were pivot assistive devices; therefore, the facility was not required to follow the restraint guidelines. The DON provided a product form. Upon interview on 4/4/25 at 10:49 a.m. physical therapist (PT)-A stated he asked the residents if they felt they needed or wanted a rail on their bed, mainly to assist with bed mobility or feel safer in bed. Residents were then assessed if they could turn, or scoot and the rails would help them. PT-A did not get an order from the provider for the rails, he was not certain whether nursing got orders or not. He stated when evaluated residents and recommended a rail he verbally communicated with the nursing staff and sent a work order to maintenance. Upon interview on 4/4/25 at 11:56 a.m. the Administrator stated prior to the surveyor she believed the rails were not a restraint but came to the conclusion during the survey that the rails were considered a device and the process needed to be followed, including a facility assessment to determine if they were a restraint or not upon each residents individual assessment. A policy was not obtained on accuracy of assessments.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds, assess the residents for risk of entrapment, review risks and benefits for bed rail use, ensure bed dimensions were appropriate for 4 of 4 residents (R1, R2, R3 and R4) review for bed rails. Findings include: Food and Drug Administration (FDA) guidelines (Recommendations for Health Care Providers about Bed Rails) 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Retrieved from https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm R1's occupational therapy (OT) evaluation and plan of treatment dated 3/3/25 did not indicate R1 had said/bed rails on her bed. R1's physical therapy (PT) evaluation and plan of treatment dated 3/3/25 did not indicate R1 had side/bed rails on her bed. R1's care plan dated 3/4/25 did not indicate placement of side/bed rails on R1's bed. R1's facility assessments dated 3/4/25 did not include a device assessment. R1's admission Minimum Data Set, dated dated dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 9 indicting R1 was moderately cognitively impaired. R1 required maximum assistance with toileting, showering, dressing, personal hygiene and rolling in bed. R1 was dependent on staff for bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were hemiplegia and hemiparesis following cerebral infarction affecting the nondominant side (muscle weakness and partial paralysis following a stroke), and polyneuropathy (weakness, numbness and burning pain). Bed rails were not identified as used on the MDS. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon interview on 4/3/25 at 3:33 p.m. nursing assistant (NA)-A stated she was not allowed to work with R1 due to some complaints about her cares. She asked surveyor for advice and asked, If I see a residents head in a siderail, should I intervene or get assistance. NA-A stated she did assist R1 onto her back. She did not recall the exact date and did not report the event to other staff since R1 was okay She did not recall her training on rails, when she noticed rails on a bed, she assumed they are there for the resident to not fall out of bed or to help them transfer. She was unaware rails could be unsafe. Upon observation and interview on 4/3/25 at 3:47 p.m. R1 was found to have bilateral quarter side/bed rails at the head of her bed. The rails could open to the sides by pivoting like a door. R1 stated she did not know how to remove the rails and felt she could not even if she knew how. She used the rail on the left side of the bed because when she received cares she could hold on to that side with her right hand. She could not use the rail on the right side because of the swelling and weakness in her left hand following her stroke. She did not recall an event where her head was between the rail and the bed. She did recall she had repositioned herself and her head was hanging off the right side of the bed and feet off the left side. She stated her family came to visit and her found her in that position. The family got assistance from staff to reposition her. R1 did not recall which staff assisted her. Upon interview on 3/3/25 at 4:02 p.m. the maintenance director stated the facility had only the quarter side rails, no other ones were onsite. The rails came with the beds, which were purchased approximately in 2023. He stated the process was either nursing or therapy sends a work order, and the rails are then placed on the bed. The maintenance department was completing the rail inspections as indicated in the manufactures manual. Upon interview on 3/3/25 at 4:16 p.m. registered nurse, RN-A stated she performed admission assessments and was not instructed to indicate what diagnosis the rails were intended to treat, educate on the risk and benefits and obtain a consent. If a resident or family requested having rail or if she assessed the resident would transfer easier with rails, she would place an order with the maintenance department. She did not witness or hear that R1 allegedly was stuck between the rails and the bed. Upon interview on 3/3/25 at 4:40 p.m. family member (FM)-A stated she requested R1 have rails for safety in her bed. She denied any education on the risk and benefits of having rails. She stated the only concern she had was the family arrived at the facility and found R1 laying with her bed hanging off the side of the bed (below where the side rail was) and feet hanging off the other side of the bed. R2's OT evaluation and plan of treatment dated 2/20/25 did not indicate R2 a had side rail on her bed. R2's PT evaluation and plan of treatment dated 2/20/25 did not indicate R2 a had a side rail on her bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's admission MDS dated [DATE] indicated R2 had a BIMs score of 10 indicating R2 was moderately cognitively impaired. R2 required moderate assistance with toileting hygiene, bathing, dressing, personal hygiene, and rolling left to right in bed. R2's pertinent diagnoses were congestive heart failure, chronic obstruction pulmonary disease (a group of lung disease that block airflow making it difficult to breathe, respiratory failure, and toxic encephalopathy (the brain becomes damaged due to exposure to toxins). The MDS did not indicate bed rails were used. R2's care plan dated 2/26/25 did not indicate placement of a side rail on R2's bed. R2's Device-Equipment assessment dated [DATE] indicated R2 had a left upper assist rail/grab bar due to generalized weakness/debility. Under identify the alternatives to use the of a device which were attempted but failed to meet the residents needs indicated PT/OT recommendation, no other alternatives were identified. The reasons for consideration of the device were: -Allow resident to assist with turning, care, and/or repositioning. -Improve quality of life. -Improve participation and/or self-deficiency with cares. -Prevention of falls during transfer from one location to another. -Reduce the risk of harm to self or others. The assessment identified restraints are defined as any manual or physical or mechanical device, material or equipment adjust to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal assess to one's body. R2's side/bed rail was not identified as a restraint on the assessment. The resident demonstrated the physical ability to safely use the device. The assessment did not indicate if R2 could safely remove the device on her own. The assessment indicated potential benefits of the use of the device were reviewed with the resident and/or representative. The assessment did not provide an indication of a consent form. Upon observation and interview on 4/4/25 at 9:11 a.m. R2 was lying in her bed. She had a quarter sized side rail on the left side of her bed. She stated she did not know what the surveyor was talking about and did not know what that thing was. R3's assessment list dated 3/7/25 - 4/4/25 did not indicate the facility device assessment had been completed. R3's PT evaluation dated 3/9/25 did not indicate R3 used side/bed rails. R3's OT evaluation dated 3/10/25 did not indicate R3 used side/bed rails. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's admission MDS dated [DATE] indicated R3 had a BIMs score of 14 indicating she was cognitively intact. R3 required maximum assistance with toileting hygiene and lower body dressing, moderating assistance with upper body dressing and personal hygiene. R3 was dependent upon staff for rolling from left to right in bed, sitting to lying, sitting to standing and transfers. R3's pertinent diagnoses were acute kidney failure, chronic respiratory failure, chronic congestive heart failure, muscle weakness, spinal stenosis of the lumbar region with neurogenic claudication (spinal narrowing in the lower back with pressure on the nerves) and history of falling. R3's MDS did not indicate a side/bed rail was used. Upon observation and interview on 4/4/25 at 11:03 a.m. R3 was seated in her wheelchair. R3 had two quarter rails on her bed. The right-side rail was at the very head of the bed and the left side rail was approximately 12 inches lower, than the placement of the adjacent right-side rail. The left side was more toward the center of the bed. R3 stated she used the rails to feel safer in her bed and to transfer in and out of her bed. She did not recall any education given on the use of the rails. R4's assessment list dated 2/25/25 - 4/4/25 did not indicate the facility device assessment been completed. R4's care plan dated 2/25/25 did not indicate R2 used side/bed rails. R4's OT evaluation dated 2/25/25 did not indicate R4 used side/bed rails. R4's PT evaluation dated 2/25/25 did not indicate R4 used side/bed rails. R4's admission MDS dated [DATE] indicated R4 had a BIMs score of 14 indicating R4 was cognitively intact. R4 required maximum assistance with toileting hygiene, rolling from left to right, sitting to lying. R4 was dependent upon staff for lower body dressing and transfers. R4's pertinent diagnoses were fracture of the left femur (thigh bone), major depression disorder, anxiety disorder and osteoarthritis (breakdown of tissues in the joints). R4's MDS did not indicate side/bed rails were used. Upon observation and interview on 4/4/25 at 11:15 a.m. R4 was seated in her wheelchair. She had two quarter sized rails at the head of her bed. She stated she used the rails or safety, and her family wanted them on her bed. She did not recall any education provided to her on the use. Upon interview on 3/3/25 at 4:21 p.m. the director of nursing, DON stated the bars on the bed were not side rails they were pivot assistive devices; therefore, the facility was not required to follow the restraint guidelines. The DON provided a product form. Upon interview on 4/4/25 at 9:21 a.m. RN-B stated she was uncertain of the policy on rails at the facility. She stated she mainly worked the night shift, and was aware many residents had the quarter rails and some residents would use them when they were repositioned or had their incontinent brief changed and other residents did not use the rails on the bed. She denied ever seeing a resident get stuck in a rail. Email correspondence from the DON on 4/4/25 at 4:07 p.m. indicated We do not have any physician's orders or consents. It is our understanding per the manufacturer documentation and our policy, our grab bars do not require orders or consents. They enable the resident to help maneuver themselves, assist with repositioning, and increase independence. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon interview on 4/4/25 at 10:49 a.m. physical therapist (PT)-A stated he asked the residents if they felt they needed or wanted a rail on their bed, mainly to assist with bed mobility or feel safer in bed. Residents were then assessed if they could turn, or scoot and the rails would help them. He stated when evaluated residents and recommended a rail he verbally communicated with the nursing staff and sent a work order to maintenance. Upon interview on 4/4/25 at 11:56 a.m. the Administrator stated prior to the surveyor she believed the rails were not a restraint but came to the conclusion during the survey that the rails were considered a device and the process needed to be followed, including a facility assessment to determine if they were a restraint or not upon each residents individual assessment. The bed manufacture product form undated indicated the side rail is a 3-position assist device is not a side rail nor is it a restraint. A facility assessment with a revision date of 3/10/25 indicated: Upon admission residents will be placed in a bed that has had all devices removed. Beds for residents upon admission will not have side rails/grab bars/assist rails in place. Nursing staff will complete a device/equipment observation as part of the admission observation process. If it is determined that a grab bar or assist rail is needed to allow the resident increased independence or to meet another need based on the device/equipment assessment, nursing staff will put a request in Maintenance care for the specific type of device to be installed on the bed. If nursing determines that a side rail is needed, an order needs to be obtained for this as well a consent being obtained. Once those have happened, then nursing will put a request to maintenance care for the device to be applied to the bed. When residents are moved from one room to another, it is important that any devices/equipment that are in place moves to the new room with them. When there is a significant change in condition, the device/equipment observation should be redone and the use of side rails/grab bars or assist rails should be evaluated to determine if they are still needed. If they are no longer needed, use maintenance care to notify maintenances staff of need to have them removed. For residents with grab bars/assist rails or side rails-confirm that the device/equipment observation is complete. For residents with grab bars/assist rails or side rails, check the care conference summary observation-is the device/equipment observation reviewed by IDT question marked as YES. If there is a side rail or grab bar/assist rail in place, is the information for this included in the bed mobility section of the care plan? If there is a side rail in place, is there a signed consent observation in place? If there is a side rail in place, is there a physician order for the side rail? (no order needed for grab bar/assist rails). If a side rail or grab bar/assist rail is in place, is there documentation that less restrictive devices were tried prior to implementing these?