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	03/26/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators were labeled, dated, and not expired. This had the potential to affect all 61 residents who received food from the facility kitchen. Findings include:On 3/25/26 at 10:40 a.m., director of food and nutrition (DFN) provided a tour of the facility kitchen. In the walk-in refrigerator there was a container of beets labeled with an opened date of 2/23. Multiple white patches of a substance were observed on the top surface of the beets. DFN confirmed and stated the substance was mold. DNF further stated the beets had been opened longer than seven days and should have been discarded. In addition, a container of potato salad was observed in the same refrigerator, labeled with an opened date of 3/10. DNF confirmed and stated the potato salad was expired and should have been discarded. In a standalone refrigerator, an individual sized prepared salad, a half-full container of fresh strawberries and a quarter-full container of fresh blueberries were observed with no label or date. DFN stated these food items should have a label to indicate when they were opened. DFN stated all food should be labeled and dated to indicate when the container was opened. Food was only good for seven days after opening and should be discarded after that date. During interview on 3/26/26 at 10:32 a.m., regional director of food and nutrition (RDFN) stated she would expect food to be removed after 7 days in refrigerator, and all food should be labeled with the date it was opened. During interview on 3/26/26 at 12:45 p.m., administrator stated would expect all food stored in the refrigerators to be labeled, dated and discard appropriately.Facility policy Refrigerator and Freezer Storage dated 1/9/26, indicated that all food should be stored appropriately to maintain food safety. All food should be clearly labeled and must be discarded after seven days.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 resident (R44) reviewed for restraints.Findings include:R44's quarterly Minimum Data Set (MDS) dated [DATE], indicated R44 had severe cognitive impairment, required substantial/maximal assistance for bed mobility, and was dependent for transfers. R44's MDS further indicated R44 did not experience any falls since admission, was receiving hospice care and did not use any restraints. R44's diagnoses included generalized muscle weakness, adjustment disorder with mixed anxiety and depressed mood, and chronic obstructive pulmonary disease (COPD, chronic lung disease). R44's care plan dated 3/10/26, indicated R44 was at risk for falls and used body pillows to define the edge of the bed. R44's nursing care sheet printed 3/9/26, indicated R44 required two-person assistance using a mechanical lift for transfers and one person assist every 2-3 hours for repositioning. R44 used a body pillow for positioning. During observation on 3/23/26 at 2:19 p.m., R44 was lying in bed and had one body pillow on each side of him. The pillows were on the bed and tucked under the fitted sheet.During observation on 3/24/26 at 1:07 p.m., R44 was in bed sleeping and had a body pillow on each side of him tucked under the fitted sheet. During observation and interview on 3/24/26 at 1:21 p.m., registered nurse (RN)-A went into R44's room and removed the pillows from under the fitted sheet and placed alongside R44 in bed. RN-A stated she was just checking to ensure R44's care sheet was being followed and that the body pillows were on top of the sheet as care planned. RN-A confirmed she found the pillows tucked under the fitted sheet and stated they should not have been that way. RN-A stated when pillows were tucked under fitted sheets they could act as a restraint. RN-A stated R44 could not remove the tucked in pillows. During interview on 3/24/26 at 3:08 p.m., nursing assistant (NA)-A stated R44 should have pillows on either side of him for positioning and to prevent him from rolling out of bed. NA-A further stated the pillows should never be tucked under the fitted sheet since that would act as a restraint, which was not allowed. During interview on 3/24/26 at 3:16 p.m., licensed practical nurse (LPN)-A stated R44 had pillows on his bed on each side of him to prevent him from rolling out of bed. LPN-A further stated the pillows were supposed to be tucked under the fitted sheet to ensure they remained in place. During interview on 3/24/26 at 3:23 p.m., LPN-B stated R44 had pillows on his bed to help define the edges of the bed as a falls intervention. LPN-B further stated the pillows should never be tucked under the fitted sheet which would restrict R44's movement and be considered a restraint. During interview on 3/25/26 at 1:45 p.m., regional director of clinical services (RDCS) stated it was not the facility's expectation to use pillows under the fitted sheet. During interview on 3/26/26 at 12:12 p.m., director of nursing (DON) stated would not expect pillows to be placed under the fitted sheets and only used for positioning or to define the edge of the bed and placed only on top of the bed sheets. DON further stated if placed under the sheet, residents could not easily remove them. Facility policy Restraints: physical last reviewed 2/18/26, indicated a physical restraint was any material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and document review, the facility failed to ensure a subset (i.e., discharge) Minimum Data Set (MDS) was completed and transmitted to the Centers for Medicare and Medicaid (CMS) database in a timely manner for 1 of 1 resident (R30) reviewed for MDS accuracy. Findings include: The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI manual), dated 10/2025, identified all applicable MDS along with their completion and transmission dates were required. This included, Discharge Assessment - return not anticipated, listed with a transmission date of, MDS Completion Date + 14 calendar days. R30's Census List, printed 3/26/26, identified R30's most recent admission to the facility as 11/4/25. R30 remained in the facility in the same room until 12/5/25. The census identified R30's status on 12/5/25 as Discharge-Return Not Anticipated. R30's progress note dated 12/5/25 at 1:22 p.m., indicated R30 discharged from community at1:23 p.m.Review of R30's MDS 3.0 resident assessments list printed on 3/25/26, indicated an admission and 5-day assessment had been completed, and a discharge assessment status of Late. The discharge assessment had an ARD (assessment reference date) due date of 12/5/25, and a completion due date of 12/19/25.Review of R30's medical record on 3/26/26, lacked evidence a discharge MDS had been started, completed or transmitted to CMS despite R30 discharging several months prior. During interview via telephone on 3/26/26 at 10:59 a.m., MDS registered nurse (MDS-RN) stated discharge assessments should be completed per the RAI manual but were usually completed and transmitted within 30 days of discharge. MDS-RN reviewed R30's medical record and confirmed a discharge assessment was not completed and should have been. MDS-RN could not explain why R30's discharge assessment was not completed as required. During interview on 3/26/26 at 12:12 p.m., director of nursing (DON) stated expectation for the MDS assessments to be completed per the RAI manual and facility policy. Facility policy MDS-RAI Process dated 3/17/26, indicated, The MDS Coordinator/RAI Lead is responsible to assure that MDS assessments are completed and locked in the software in compliance with the regulatory schedule requirements.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to assess residents' ability to independently empty and report urine output for 1 of 1 resident (R50) reviewed who had a urinary catheter. Findings include: R50's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of Parkinson's disease, urine retention, and overactive bladder. It further indicated R50 had an indwelling catheter and was independent with toileting. R50's physician's order dated 2/19/21, indicated catheter care: catheter output three times a day. R50's care plan reviewed/revised 2/26/26, indicated R50 had a chronic supra pubic catheter (long term use urinary catheter via abdominal incision) changed monthly by urologist due to inability to manage with straight catheter, urinary retention enlarged, prostrate and history of urinary tract infections (UTI). Interventions included catheter cares, monitor for UTI, monitor and report any concerns, monitor urine output every shift and notify provider of concerns, assist with elimination as needed. Furthermore, R50 requested change from night urine bag to leg bag during the day per resident preference despite education of increased risk of infection. R50's care sheet dated 1/8/26, indicated R50 had a suprapubic catheter and was continent of bowel. Assist with catheter cares as needed. R50 was Independent per preference for urine output each shift. R50's medical record lacked assessment or education on how to empty the leg drainage bag, measure output, or report to the nurse independently. During observation and interview on 3/23/26 at 1:27 p.m., R70 was sitting in his electric wheelchair in his room. R50 stated he did things on his own. This included transferring, emptying his catheter bag, and changing catheter urine bags. R50 further stated the only thing staff did with the catheter was change it. During observation on 3/24/2026 at 1:35 p.m., R50 was headed down the hallway towards his room in his electric wheelchair. He went into his bathroom and stated his stomach hurt and he thinks it's because the leg bag of his catheter was full. R50 took a graduated cylinder out of the cabinet in his room and leaned over and emptied his bag of urine into the graduated cylinder. R50 was not wearing any gloves. At 1:42 p.m. he came out of his room with a small piece of paper and waited by the medication cart. Licensed practical nurse (LPN-C) came out of the charting room next to the medication cart and R50 handed her the piece of paper stating, that is my output for the day. LPN-C took the piece of paper and then entered the amount into the computer. During interview on 3/24/26 at 2:06 p.m., nursing assistant (NA)-C stated the nursing assistants were required to use care sheets to know how to care for each resident. NA-C further stated they do minimal cares for R50 such as bring him food and clean his bottom. They don't assist him with his catheter (emptying the bag, measuring the output, changing the bag), stating He does all that. During interview on 3/24/26 at 2:58 p.m., NA-D stated the nursing assistants used care sheets to know how to care for each resident. NA-D further stated they did not do many cares for R50 except wash his back, bottom, and get him a new gown. When asked specifically about R70's catheter, NA-D stated, He does that himself. During interview on 3/25/26 at 9:00 a.m., licensed practical nurse (LPN)-C verified R50 does his own catheter cares (in regard to emptying the bag and measuring his output) and stated if residents are complete their own cares, there should be some type of assessment, and it should be documented in be in their care plan. Documentation could also be put in a modified self-medication assessment or attached a progress note. LPN-C was unable to find an assessment or a progress note and verified it wasn't in R70's care plan and should have been. During interview on 3/26/26 at approximately 2:45 p.m., the director of nursing (DON) stated in general if a resident was completing their own catheter cares, an assessment should be performed to ensure they were doing it correctly. R50 had been performing his own catheter cares since he was admitted here, and it was always something he had just done for himself. The DON further stated the nurses check on him periodically to make sure he's doing the catheter cares correctly but was unable to find any documentation. A facility policy (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding assessing residents when they are providing their own cares was asked for but not received.