STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gundersen Harmony Care Center	815 Main Avenue South Harmony, MN 55939

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 - Minimal harm or potential for 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** 51379 Based on observation, interview, and record review, the facility failed to comprehensively reassess, implement appropriate person-centered interventions and analyze falls to help prevent future falls and potential injury for 2 of 2 residents (R22, R7). In addition, the facility failed to assess for proper use of a heating pad for 1 of 1 residents (R28) reviewed for accidents. Findings include: R22's Minimum Data Set (MDS) assessment dated [DATE] indicated no cognitive impairment. R22's function status showed she requires a walker for mobility, substantial assistance for toileting, partial assistance for dressing, and is dependent on facility staff to put on or take off footwear. R22's bladder status showed occasional incontinence. R22's special treatments include oxygen therapy. R22's diagnosis included: chronic respiratory failure with hypoxia, urinary incontinence, cognitive loss/dementia, and heart failure. R22's care plan dated 2/18/25 indicated R22 had mild cognitive impairment and problems with memory/recall, has impaired balance, and risk for falls related to impaired mobility, oxygen use, and self-transferring. R22's care plan dated 7/25/24 indicated staff interventions include assure glasses are nearby, assure floor is free of objects, encourage resident to use hand grips and handrail, provide proper footwear, give verbal reminders not to ambulate or transfer without assistance, provide environment free of clutter, and give medications as ordered. R22's Fall even report dated 8/12/24 indicated R22 had an unwitnessed fall with no noted injury. R22 stated at the time she was getting up to move her blanket. Interventions at the time of fall included call light within reach, frequently used items within reach, and appropriate footwear. No new person-centered interventions updated after fall. R22's fall event report dated 8/14/24 indicated R22 had an unwitnessed fall requiring an emergency room visit and two staples for a head laceration. R22 stated at the time she was unsure of what she was trying to do when she fell . Interventions in place at time of fall included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. No new person-centered interventions updated after fall. (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 - Minimal harm or potential for actual harm Residents Affected - Few	R22's fall event report dated 2/25/25 indicated R22 had an unwitnessed fall with minor injuries. R22 stated at the time she was trying to use the restroom, and her feet got tangled in her oxygen tubing. Interventions in place at the time of fall included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. No new person-centered interventions updated after fall. R22's fall event report dated 3/10/25 indicated R22 had an unwitnessed fall with minor injuries, due to dizziness required a visit to the emergency room to rule out a head blead. Resident was sent back to facility with no injuries. Resident stated at the time she was getting up to use the restroom and her feet got entangled in her oxygen tubing. Interventions in place at the time of fall included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. Resident was reminded to use call light and ask for assistance. No new person-centered interventions updated after fall. During observation and interview on 4/7/25 at 4:30 p.m., R22 stated she had fallen a few times, she has gone to the emergency room a couple of times because she became dizzy after her falls. R22 stated her last two falls were because her oxygen tubing got caught in her feet and she lost balance. R22 stated she would like shorter oxygen tubing to help prevent another fall. R22 stated staff will tell her she has to use her call light more and ask for assistance. Oxygen tubing observed extending from resident feet towards oxygen concentrator with tubing coiled in behind oxygen concentrator. Resident had call light on side table, side table was positioned in front of resident. [NAME] was across the room below the television. During observation on 4/8/25 at 2:04 p.m., oxygen tubing was stretched out across room, beneath walker, extending towards resident with the remaining tubing coiled beneath concentrator. During interview on 4/9/25 at 9:03 a.m., nursing assistant (NA)-C stated R22 has a history of falling; most always due to getting her feet caught in her oxygen tubing. NA-C stated the interventions in place for R22 included call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. NA-C stated she didn't think these interventions were enough because R22 kept falling for the same reason. During observation on 4/9/25 at 9:07 a.m., resident attempting to get up on her own, did not use call light. Staff walking with another resident asked resident if she would sit back down and they would be in to help her in a few minutes. Resident stated she wanted to get dressed now. Staff continued to assist another resident. Oxygen tubing was beneath resident feet, stretching towards oxygen tubing. During observation on 4/9/25 at 11:06 a.m., resident attempting to get up on her own, she did not use call light. Oxygen tubing was beneath walker extending towards oxygen concentrator. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/9/25 at 1:40 p.m., DON and registered nurse (RN)-A stated the process after a fall happens is to make sure the resident is assessed and treated immediately, notify appropriate staff and family, follow up per provider orders. Post falls assessments are completed based on provider orders. Post fall evaluation is completed during next stand-up meeting and/or interdisciplinary meeting if falls are repeated. RN-A confirmed interventions in place at time of all falls was call light within reach, walker within reach, frequently used items within reach, and appropriate footwear. RN-A confirmed only verbal reminders to ask for assistance were used to prevent future falls. DON and RN-A confirmed the current care plan does not reflect additional interventions to prevent future falls. DON and RN-A confirmed the resident does need an updated care plan to address her falls. 49893 R7 R7's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R7 was severely cognitively impaired with disorganized thinking and inattention. R7 had a history of wandering, no limitation of functional range of motion, supervision for bed mobility, partial/moderate assist for transfers and activities of daily living (ADLs). R7 had bowel and bladder incontinence. R7's diagnoses list included: Alzheimer's disease, major depression, anxiety, restlessness with agitation, osteoporosis, high blood pressure, and cerebral infarction (stroke). During an observation on 4/8/25 at 11:02 a.m., R7 sleeping at the table, staff offered to lay R7 down or wait for lunch. R7 laid down. During an observation on 4/8/25 at 12:17 p.m., R7 laying in bed hands under head, bed in normal position, wheelchair pushed against the wall, floor alarm in place, call light on lap. R7's provider orders included: furosemide (used to reduce extra fluid in the body (edema) caused by conditions such as heart failure), carvedilol for high blood pressure, lorazepam for anxiety as needed, and venlafaxine for depression. R7's provider orders included check motion detector in room and at the desk for proper function daily. Replace batteries if not working correctly. R7's care plan included altered communication evidenced by difficulty with word find and speaking in sentences that do not make sense, assistance with ADLs and mobility requiring assist of 1 with walker for ambulation and transfers and extensive assist for ADLs. A fall care plan indicated R7 was at risk for falling related to impaired balance during transitions, use of antidepressant medications, history of falls resulting in fractured wrist, and frequent self-transferring. Interventions included: dicem (sticky material used to prevent slipping) between the seat of wheelchair and cushion at all times to help it from sliding out started 4/7/25. check motion detector in room and at the desk for proper function daily edited 10/21/24 observe frequently and place in supervised area when out of bed edited 9/25/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide toilet assistance every 2-3 hours edited 9/25/24 ensure auto-lock brakes on wheelchair remain in good , working order. If any issues or concerns arise with them, contact maintenance to assess or fix them dated 7/2/2024. Assure that resident is wearing proper, well-maintained footwear dated 5/23/24. encourage resident to participate restorative exercise as recommended by therapies. Encourage participation in group exercises when available that are led by activity staff edited 5/23/24. Encourage resident to use environmental devises such as hand grips, hand rails, etc. Remind resident to use assistive devices edited 5/23/24 Give resident verbal reminders not to ambulate/transfer without assistance. Follow physical and occupational therapy (PT/OT) recommendations for transfers and ambulation edited 5/23/24 Monitor overall condition for underlying infection that could contribute to altered mental status, weakness, and overall increased risk for falling edited 5/23/24, Provide an environment free of clutter. Always keep call light or pendant within reach. Keep personal items and frequently used items within reach edited 5/34/24. R7's cognitive loss/dementia care plan indicated R7 is unable to make daily decisions without cues/supervision related to her dementia, Alzheimer's, and anxiety diagnoses. Interventions include to monitor resident for exit seeking behaviors, wandering into unsafe areas, and entering other resident rooms uninvited, redirect when potential for injury is evident. Fall progress notes indicated the following: -On 9/8/24, resident found sitting on toilet with laceration to her head, sent to ER for sutures. Interventions included cold/ice, direct pressure to the wound Section titled Evaluation notes indicated Her careplan has been reviewed/revised, as necessary. -On 10/17/24 resident was observed reaching for floor alarm on floor and slid out of bed. Immediate intervention: put bed in lowest position. Careplan lacked documentation of intervention put in place. -On 11/14/24 resident found crawling on the floor. Motion detector was turned around so not alarming, bed in lowest position. Immediate interventions indicated none of the above. Evaluation notes indicated Her careplan has been reviewed/revised, as necessary. -On 12/27/24, resident observed sitting on the floor scooting into the hallway from her room. Resident was assisted to toilet, provided ADLs and assisted into bed. Resident was on Covid restrictions and had to use the restroom. Immediate interventions indicated none of the above. Summary of investigation indicated resident was assisted off the floor, toileting, received ADL's, and into bed for the night. Her careplan has been reviewed/revised, as necessary. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/1/25, staff responded to motion sensor and found resident sitting on the floor of her room. Wheelchair and walker were not near her and resident was wearing 1 gripper sock. Sent to ER for evaluation of left leg. No fracture noted. Careplan has been reviewed/revised as necessary. Immediate intervention: rest. -On 3/19/25, resident had just been changed. Alarm was not put back in place. Immediate interventions, Got up in wheelchair to move around, rest -On 4/1/25, resident was found on floor by dietary staff. Immediate intervention: rest. Summary of investigation was left blank. During interview on 4/9/25 at 1:36 p.m., registered nurse (RN)-B stated R7 is very busy often responds with gibberish when asked questions. R7 tends to have days and nights mixed up and wanders throughout the unit going into other resident's rooms. R7 can be hard to redirect and has gotten aggressive. Falls are usually stemming from falling out of bed. Staff implemented rounding program every hour. Staff anticipate resident's needs for bathroom and eating. Motion sensor in resident's room. If self-transferring, staff get her up and let her wander around. Staff have also been instructed not to wake resident up in the middle of the night unless necessary. Staff also offer resident food and bring her out to the common area for distraction as resident likes to fidget. There are also photo albums and has a short attention span. Resident is on hospice and hospice has ordered morphine and lorazepam. Resident is also on scheduled Gabapentin (used to treat partial seizures, nerve pain from shingles and restless leg syndrome) to help with restlessness. Most of resident's falls occur in the evening and night. During interview on 4/10/25 at 10:22 a.m., RN-A stated unwitnessed falls require an assessment and neuros (assess an individual's neurological functions, motor and sensory response, and level of consciousness). The expectation is to paint a picture of what happened, and where they were. An email is sent out to everyone regarding the fall. RN-A mentioned to management last week they need to change how they look at falls. Currently, RN-A and the activity manager are assigned to monitor falls. Interventions are based on what type of fall. If resident's crawl out of bed, motion detectors are used. Referrals to PT/OT are made when appropriate. R7 had a couple falls when diagnosed with Covid due to being isolated to her room. When awake, R7 should be up and supervised out of her room. Current interventions include ambulation program, motions sensor, dicem under chair, toileting every 2-3 hours, autolock breaks on wheelchair, and nonstick footwear. They also increased her PRN (as needed) Ativan. RN-A confirmed the facility needs to do a better job at documenting interventions that have been put in place and need to get more people involved in fall investigation to do a better review of falls and appropriateness of interventions (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 11:11 a.m., the director of nursing (DON) stated R7 has a history of behaviors and falls. The DON stated there isn't always a rhyme or reason for resident's falls as she does not feel they are all related to sundowning. R7 tends to be more active in the evening and has a history of spitting out medications. Staff attempt to distract R7. R7 can be very unpredictable. Current interventions include nonstick footwear, motion detector when in bed, antiroll back brakes, dicem in wheelchair and increased supervision. R7 is also toileted every 2-3 hours because R7 cannot really communicate toileting need. Staff encourage R7 to participate in restorative programs. Reminders to ask for assistance do not work for her [due to dementia diagnosis.] Staff also keep frequently used items close and allow resident to roam free when she is anxious. The DON also indicated staff do hourly rounding. She confirmed they need to do a better job at looking deeper into each fall and making sure all interventions are on the care plan. Heating Pad Admission Minimum Data Set (MDS) assessment dated [DATE] indicated R28 was cognitively intact and had functional limitation in range of motion for both upper and lower extremities. R28's diagnoses list included displaced pelvic fracture, morbid obesity, anxiety, borderline personality disorder, bipolar II disorder, and left femur fracture. During observation on 4/7/25 at 7:30 p.m., R28 was sitting in her recliner with her legs up. R28 was wearing long pants and an abd bandage (a thick rectangular bandage used to absorb fluids and protect skin) on the left shin area. R28 placed a sheet over her legs and reached for her heating pad. R28 placed heating pad on top of the sheet over her left shin area. Heating pad did not contact bare skin. R28 turned heating pad on. R28's provider orders lacked order for use of heating pad. R28's careplan lacked documentation of use of heating pad. R28's hospital discharge summary lacked documentation for use of heat/heating pad. Progress notes dated 4/8/25 at 1:28 a.m., indicated R28 reported pain to lower left leg and did have her heating pad on the location for about 20 minutes. Progress notes dated 4/8/25 at 7:15 a.m., R28 does have a heating pad in her room. Progress notes dated 4/8/25 at 11:29 a.m., indicated R28 reported pain of 9 out of 10 to left leg with leg spasms. R28 was repositions and used heating pad. Progress notes dated 4/9/2025 at 3:42 a.m., indicated R28 does have her heating pad in her room. During interview on 4/8/25 at 2:59 p.m., licensed practical nurse (LPN)-C stated R28 takes muscle relaxer and narcotic pain medications every 4 hours for pain. R28 refuses ice and repositioning to help with pain control. LPN-C reported seeing the heating pad for the first time on 4/7/25 and thought R28's mother brought it in. LPN-C stated the heating pad should have been reported to the director of nursing (DON), however it slipped my mind. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/9/25 at 9:35 a.m., registered nurse (RN)-C stated R28 will ask for pain medications routinely as soon as she is allowed to take them. RN-C reported seeing the heating pad in R28's room but assumed it had already been checked out by maintenance and approved. RN-C stated R28 does not usually use heating pad. RN-C confirmed electric items brought in from home have to be checked out by maintenance or policy has to be verified. During interview on 4/9/25 at 1:18 p.m., RN-B stated resident has struggled with pain control. Provider has evaluated and adjusted medications. RN-B stated she was not aware R28 had a heating pad in her room. RN-B stated R28 did ask about using a heating pad when she was first admitted . Staff informed R28 a heating pad has to have an automatic shut-off to be used in the facility. RN-B stated social services director (SS)-A told R28 if a heating pad was brought in, it needs to be checked out. RN-B stated R28's husband brought in the heating pad. During interview on 4/10/25 at 9:20 a.m., SS-A stated R28 asked about using a heating pad upon admission. R28 was informed she could bring one in but it would have to be evaluated to ensure it had the correct connection, indicate accurate temperature, and had an automatic shut off. SS-A stated R28's husband must have brought it in without telling anyone. SS-A was not made aware of heating pad until 4/8/25. During interview on 4/10/25 at 9:55 a.m., maintenance director (M)-A stated heating pads are required to have a grounded (3-prong) plug to be approved. M-A stated he was not aware R28 had a heating pad. During interview on 4/10/25 at 11:04 a.m., R28 stated her husband brought in the heating pad however, could not recall what date. During interview and observation on 4/10/25 at 11:27 a.m., the director of nursing (DON) stated she was not aware R28 had a heating pad. The director of nursing provided the heating pad which was observed to have an ungrounded 2-prong cord and temperature indicator of low, medium, high. The director of nursing stated using an ungrounded heating pad can increase the risk of an electrical short. There is also an increased risk of burns if resident were to fall asleep with the heating pad on due to the inability to determine exact temperature. A policy titled Portable Space Heaters/ Electric Blankets, HAREM- dated 4/2025 indicated With a doctor's order, electric blankets may be used provided they are new (dedicated to that resident only), UL listed, and are plugged directly into an electrical outlet (extension cords are not permitted). Facility fall prevention policy revised 4/2025 titled Fall Prevention indicated After an observed or probable fall, the staff will clarify the details of the fall, such as the staff will clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. This will be done by calling a Fall Huddle (see attached algorithm). -Nursing supervisor at the time will have all staff, working in the area of the fall, meet together to determine root cause analysis -Huddle will be called immediately after resident is stabilized (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff will evaluate chain of events or circumstances preceding the fall (see attached fall huddle form) including: Time of day Whether fall was witnessed or not What the resident was doing What type of footwear did the resident have on What was the resident doing prior to the fall Distance of fall from starting location Location of fall ie. Bedside, between bed and bathroom, etc Last time resident had been to the bathroom and whether he/she was incontinent or not Mental status Gait assist devices -Staff will address any immediate interventions needed to prevent resident from falling again and communicate this to staff If fall is related to defective equipment, nursing supervisor will be responsible for taking this equipment out of service and notify the maintenance of need to examine and improvements can occur -Nursing supervisor will enter information gathered from huddle and interventions taken into the event form -Nursing supervisor will then place completed Safety Huddle Form in Director of Nursing's mailbox Review of falls -The interdisciplinary team reports on all falls daily at the stand-up meeting and reviews the details known about the fall. -The IDT team will review fall events in their group discussion at the next daily stand-up meeting and close the event, including: Occurrence, huddle findings' Root cause Interventions in place-Do they match RCA Are they weak, intermediate, or strong interventions? Suggestions? (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protocol adherence-Are systems and operational changes needed? Any addition interventions desired through IDT analysis Monitoring subsequent falls and fall risk: -The staff will monitor and documents each resident's response to interventions intended to reduce falling or the risks of falling -If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measure are still needed if a problem that required the interventions (e.g. dizziness or weakness) has resolved -If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue tor change current interventions. As needed, the Attending Physician will help the staff reconsider possible causes that may not previously have been identified -If a resident is noted to fall twice in a 2-month time period, referral to therapy will be made. If referral to therapy is not made, reasons for not referring will be documented on the fall investigation form -If a resident is noted to fall twice in a 2-month time period, need for pharmacy consult will be evaluated. If it is determined that thee is a need for a pharmacy consult, a referral be made, If referral is not made, reasons for not referring will be documented on fall investigation event form. -The staff and/or physician will document the basis for conclusion that specific irreversible risk factors exist that continue o present a risk for falling or injury due to falls