DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 22CB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00492

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245381**
2.STATE VENDOR OR MEDICAID NO.
(L2) **602023200**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEW HARMONY CARE CENTER**
(L4) **135 GERANIUM AVENUE EAST**
(L5) **SAINT PAUL, MN** (L6) **55117**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/19/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 05/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/12/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/22/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5381

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 04/03/14. On 05/19/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 04/03/14, effective 05/12/14. Refer to the CMS-2567B for both health and life safety code. An annual waiver for life safety code deficiency at tag K33 has been approved.

Effective 05/12/14, the facility is certified for 76 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5381

June 5, 2014

Mr. Trent Carlson, Administrator
New Harmony Care Center
135 Geranium Avenue East
Saint Paul, Minnesota 55117

Dear Mr. Carlson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 13, 2014, the above facility is certified for:

76 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

Your request for waiver of the deficiency at tag K33 has been approved based on the submitted documentation. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 20, 2014

Mr. Trent Carlson, Administrator
New Harmony Care Center
135 Geranium Avenue East
Saint Paul, Minnesota 55117

RE: Project Number S5381024

Dear Mr. Carlson:

On April 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 19, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective May 13, 2014 and therefore remedies outlined in our letter to you dated April 23, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K-033 at the time of the April 3, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245381	A. Building B. Wing	5/19/2014

Name of Facility	Street Address, City, State, Zip Code
NEW HARMONY CARE CENTER	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **05/13/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **05/13/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **05/13/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/13/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/13/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** SR/AK	**Date:** 05/20/2014	**Signature of Surveyor:** 16022	**Date:** 05/19/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/3/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 22CB

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Facility ID: 00492

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2.STATE VENDOR OR MEDICAID NO.
(L2) **602023200**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEW HARMONY CARE CENTER**
(L4) **135 GERANIUM AVENUE EAST**
(L5) **SAINT PAUL, MN** (L6) **55117**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/03/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **76** (L18)

13.Total Certified Beds 76 (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,,5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE-NE II 05/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/21/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
AW LSC K33 Emailed CMS at ROCHI 05/22/14

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Wednesday, May 07, 2014 2:48 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: tom.linhoff@state.mn.us; 'tcarlson@elimcare.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: New Harmony Care Center (245381) Request for K33 Annual Waiver - Previously Approved - No Changes

This is to inform you that New Harmony CC is again requesting an annual waiver for K33, elevator machine rooms open into exit stair enclosures. The exit date was 4-3-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Exhibit C

Name of Facility: New Harmony Care Center ID# 243381 135 Geranium Avenue East St. Paul, MN 55117 2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K 84	A **waiver** for K 033 is being requested regarding : 1-the door of the north stair basement level elevator machine room , 2- the door of the central stair first floor elevator machine room, 3- the door of the north stair first floor storage room. Due to the design of the area, the two elevator machine room doors and the storage room door as described above cannot be relocated and the owner cannot change the swing of the door. It would be a financial hardship to relocate the elevator machine rooms and the storage room. This waiver does not adversely affect the residents to leave the doors in the stair enclosures because the residents who reside at the facility rarely use the stairs. Residents primarily use the elevators. In emergencies, the doors in the stairs will be shut and out of resident traffic, because the doors are on closers and these doors are rarely used. The facility's evacuation plan is focused on horizontal movement of residents to smoke compartments on each floor. The stairs would be a rarely used option of evacuation. Signage " CAUTION! OPEN DOOR SLOWLY! DO NOT PROP DOOR " are posted inside each of the doors

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 5-7-14

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5381

At the time of the standard survey completed 04/03/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7505

April 23, 2014

Mr. Trent Carlson, Administrator
New Harmony Care Center
135 Geranium Avenue East
Saint Paul, Minnesota 55117

RE: Project Number S5381024

Dear Mr. Carlson:

On April 3, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 13, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility’s allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 3, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 3, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions about this letter.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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 _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HARMONY CARE CENTER	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000 5/5/14 SER		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F225** It is the intent of NHCC to thoroughly investigate/report allegations/individuals.	5/13/2014

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

Trenton J Carlson | Administrator | 5/2/2014

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.

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a thorough investigation for 1 of 3 residents reviewed for mistreatment, (R 67). Findings include: The facility failed to thoroughly investigate an allegation of mistreatment for R67. A review of Incident Report submitted to the state agency, dated 3/4/14, revealed "Resident reported a nursing assistant named [NA-Z] hit him on the forehead with the palm of her hand. He could not remember when the incident happened. A review of the Investigative Report, submitted to the state agency on 3/6/14 and accompanying investigative documents [statements by NA-Z, a floor nurse (FN) and the investigating social worker (LSW)] revealed the only resident interviewed was R67. No other residents or their representatives in NA-Z's care group were interviewed to identify potential	F 225	**Corrective Plan of Action:** R67 incident report was submitted to state 3/4/14. On 3/13/14 OHFC response to report is as follows, the information has been reviewed & it has been determined that no further action by this office is necessary at this time. Social worker interviewed residents in care group that received care from NA-Z. No concerns noted when interviews were completed. Team meeting held 5/1/14 for those doing the investigations, to review procedure for investigating allegations of abuse contained in VA Abuse/Neglect Policy. Policy was reviewed and states that during investigation, other residents will be interviewed to whom the alleged perpetrator provides care or services. **Plans to monitor performance to be sure solutions are sustained:** Social Services Director will audit all investigative reports for 3 months to ensure updated investigation is completed according to policy. Results will be reported to QA x6 months.	5/13/2014

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F 225	Continued From page 2 concerns regarding care. Only two staff were interviewed or asked to give statements, NA-Z and a FN. No other nursing assistants, nurses or other staff on the unit were interviewed to identify potential concerns regarding care provided by NA-Z. During interview on 4/3/14 at 12:23 p.m., LSW reported R67 had expressed concerns regarding NA-Z at his care conference. R67 had reported he was hit on the forehead by NA-Z about a week prior to the care conference but could not recall the day. LSW confirmed no other residents were interviewed. LSW reported interviewing other residents was not part of her normal procedure for investigating allegations of mistreatment. LSW reported she did not look at NA-Z's schedule for the prior week to determine what other staff may have been on the unit to interview about R67's allegation or concerns regarding care provided by NA-Z to other residents. On 4/3/14 at 1:30 p.m. the social service director, (SSD) reported the facility had previously been interviewing other residents as part of investigations of allegations of mistreatment. SSD reported the facility stopped interviewing other residents as the interviews caused them to worry. A review of the Elim Care Vulnerable Adult Abuse Prohibition Policy and Procedure, last revised November 2011, directed staff: "1. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 3 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow their policy regarding thoroughly investigating an allegation of mistreatment for 1 of 3 residents reviewed, (R67) and failed to thoroughly pre-screen 4 of 5 newly hired employees (E-A, E-B, E-C, E-D) per their policy, which had the potential to impact up to 45 of 78 residents at the facility . Findings include: The facility failed to thoroughly investigate an allegation of mistreatment for R67. A review of the Elim Care Vulnerable Adult Abuse Prohibition Policy and Procedure, last revised November 2011, directed staff: "1. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated." A review of Incident Report submitted to the state agency, dated 3/4/14, revealed "Resident reported a nursing assistant named [NA-Z] hit him on the forehead with the palm of her hand. He could not remember when the incident happened. A review of the Investigative Report, submitted to the state agency on 3/6/14 and	F 226	**F226 Develop/Implement Abuse/Neglect Policies** It is the intent of NHCC to thoroughly pre-screen all newly hired employees to prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	5/13/2014

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F 226	Continued From page 4 accompanying investigative documents [statements by NA-Z, a floor nurse (FN) and the investigating social worker (LSW)] revealed the only resident interviewed was R67. No other residents or their representatives in NA-Z's care group were interviewed to identify potential concerns regarding care. Only two staff were interviewed or asked to give statements, NA-Z and a FN. No other nursing assistants, nurses or other staff on the unit were interviewed to identify potential concerns regarding care provided by NA-Z. During interview on 4/3/14 at 12:23 p.m., LSW reported R67 had expressed concerns regarding NA-Z at his care conference. R67 had reported he was hit on the forehead by NA-Z about a week prior to the care conference but could not recall the day. LSW confirmed no other residents were interviewed. LSW reported interviewing other residents was not part of her normal procedure for investigating allegations of mistreatment. LSW reported she did not look at NA-Z's schedule for the prior week to determine what other staff may have been on the unit to interview about R67's allegation or concerns regarding care provided by NA-Z to other residents. On 4/3/14 at 1:30 p.m. the social service director, (SSD) reported the facility had previously been interviewing other residents as part of investigations of allegations of mistreatment. SSD reported the facility stopped interviewing other residents as the interviews caused them to worry. The facility failed to thoroughly pre-screen 4 of 5 newly hired employees. A review of the Elim Care Vulnerable Adult Abuse	F 226	**Corrective Action Plan:** An Employee Telephone Reference Checking Form has been initiated beginning 5/1/2014. Department managers will be responsible for completion of the form prior to employee job offer. 2 current or former employers will be contacted in an attempt to obtain information regarding potential new hires. Department head meeting was held 4/30/14 to explain reference check procedure. Reference checks have been done on cited employees and are located in employee files. **Plans to monitor performance to make sure the solutions are sustained:** Audits of new hire personnel files will be completed monthly for 3 months. The Business Office designee/Administrator will be responsible for ongoing compliance. Results of audits will be reported to QA x6 months. **Refer to Exhibit A-***Phone Reference Check Log form*	5/13/14

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F 226	Continued From page 5 Prohibition Policy and Procedure, last revised November 2011, directed staff: "Screen all potential employees for a history of abuse, neglect, or mistreatment of residents during the hiring process. Screening will consist of, but not limited to: Criminal background checks. Verify current licensure status with the licensing board. Verify current registry status with the nurse aide registry. Reference checks such as from previous and/or current employers. Inquiries into United States Department of Health and Human Services Office of Inspector Generals' list of excluded individuals and entities." A review of personnel file for E-A, revealed hire date of 11/26/13. No evidence was found of an effort by the facility to obtain information from current or former employers. On 4/2/14 at 1:15 p.m., E-A's supervisor, (S)-A, reported she did not attempt to obtain information from E-A's current or former employers. A review of personnel file for E-B, revealed a hire date of 1/3/14. No evidence was found of an effort by the facility to obtain information from current or former employers. A review of personnel file for E-C, revealed a hire date of 1/3/14. No evidence was found of an effort by the facility to obtain information from current or former employers. A review of personnel file for E-D, revealed a hire date of 12/18/13. No evidence was found of an effort by the facility to obtain information from current or former employers. On 4/2/14 at 1:30 p.m. the director of nursing	F 226		

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F 226	Continued From page 6 (DON) reported she may have called but did not document phone calls to current or former employers for E-A, E-B, E-C and E-D. There was no form to use to document contact with current or former employers.	F 226		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272		

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F 272	Continued From page 7 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately assess the use of an antipsychotic for one 1 of 5 residents reviewed for antipsychotic usage, (R73). Findings include: A review of the most recent physician orders revealed R73 was prescribed quetiapine 25 mg [milligrams] three times daily for paranoia and hallucinations. Quetiapine is an antipsychotic medication. A review of R73's most recent care area assessment completed by the nurse manager [RN]-A, dated 2/13/14 indicated "Pt [patient] has paranoia and delusions. She takes Seroquel [quetiapine] as ordered. She takes Trazadone at HS [hour of sleep] for insomnia. Will proceed to care plan." The assessment did not address a description of R73's paranoia or delusions, what medical or psychiatric diagnoses may relate to these symptoms, what triggers these behaviors, the impact they have on R73 and others and what non pharmacological interventions have been effective in managing R73's behavioral symptoms. An analysis of risk versus benefit of treatment by psychoactive medication was not addressed. The section for input from resident	F 272	**F272** It is the intent of NHCC to conduct initially and periodically, a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. **Corrective Plan of Action:** R73 is no longer in the facility. In-service will be held on 5/7/14 for staff from all departments regarding non-pharmacologic interventions for residents with behavior expressions. In-service will be given by Tim McNamara, licensed psychologist. 13 staff members attended Dr Allen Powers "Dementia Beyond Drugs" training on 4/17/14. In-service will also be held for licensed staff on 5/13/15 given by consultant pharmacist, review of the importance of accurate assessment and documentation of diagnosis, description of behaviors with common terminology to be used.	5/13/2014

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F 272	Continued From page 8 and/or family/representative regarding the care area was left blank. The Cognitive Loss/Dementia care area assessment completed by social services department, dated 2/13/14 revealed a potential contributing factor that should have been considered related to R73's behavioral concerns of paranoia and delusions , " Alt. r/t [altered related to] short and long term memory loss and moderate impairment with decision making due to dx [diagnosis] of Alzheimer's disease. Alzheimer's is a progressive disease so continued decline is expected." The Behavioral Symptoms care area assessment completed by social services department, dated 2/13/14, revealed behavioral concerns, but were not related to paranoia or hallucinations: "Alt. r/t resident wandering and rejecting care due to dx of Alzheimer's disease...Also continue to monitor for pain, as she has pain in her knees which could increase agitation." During interview on 4/3/14 at 10:45 a.m. the nurse manager, RN-Y explained R73 had behaviors of hoarding, talking to her stuffed animals, thought staff were taking her belongings and was recently suspicious of family as she did not remember who they were. RN-Y reviewed care area assessments. RN-A confirmed R73's delusions and use of an anti-psychotic were not adequately addressed.	F 272	**Plans to monitor performance to be sure solutions are sustained:** Behavior/Mood Reviews/Audits will be done on each resident in facility receiving antipsychotic medications monthly x3 months and quarterly thereafter, using assessment tool. RN Unit Managers/DON will be responsible for audit completion. DON will be responsible for overall compliance. Results will be reported to QA x6 months. **Refer to Exhibit B-** *Assessment of Resident Receiving Psychotropic Medication form.*	5/13/2014
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329	**F329** It is the intent of NHCC that each resident's drug regimen be free from unnecessary drugs.	

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F 329	Continued From page 9 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately justify the use of an antipsychotic and coordinate behavior concerns amongst the interdisciplinary team related to the use of an antipsychotic for one 1 of 5 residents reviewed for antipsychotic usage, (R73). Findings include: A review of the most recent physician orders revealed R73 was prescribed quetiapine 25 mg [milligrams] three times daily for paranoia and hallucinations. Quetiapine is an antipsychotic medication. A review of physican [MD] progress notes, dated	F 329	**Corrective Plan of Action:** R73 is no longer in the facility. In-Service to be held 5/7/14 for staff from all departments regarding non-pharmacologic interventions for residents with behavior expressions. In-service will be given by Tim McNamara, licensed psychologist. 13 staff attended Dr Allen Powers "Dementia Beyond Drugs" training on 4/17/14. In-service will also be held for licensed staff on 5/13/14, given by consultant pharmacist, review of the importance of accurate assessment and documentation of diagnosis, description of behaviors with common terminology to be used.	5/13/2014

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F 329	Continued From page 10 9/5/13 revealed: "Anxiety with depressive affect. It is not clear if the Seroquel is continuing to provide significant relief. She has not been noted to have hallucinations nor stated any particular delusion of late. This certainly occurred before the lower dose of Seroquel was started." The MD note for 1/30/14 revealed "She has done well with Seroquel at 25 [mg] t.i.d. [three times daily]. This also helps has helped to stifle episodic anxiety-inducing hallucinations, which she has had over time." The nurse practitioner [NP] notes for 10/7/13 stated "Psychosis NOS-delusional and hallucinatory behavior that do cause the patient considerable distress. She seems to be doing well on 25 mg of Seroquel BID. [twice daily]" Notes for 12/23/13, 2/3/14 and 3/3/14 provided similar information. On 11/4/13, the NP note stated "Psychosis NS. Delusional and hallucinatory behavior that do cause the patient considerable distress. She is now managed quite effectively on 25 mg of Seroquel b.id. She may also be benefiting from pain management." None of the NP or MD notes included an actual description of what the hallucinations and delusions were, when they started or how they caused distress to R73. A review of R73's most recent care area assessment completed by the nurse manager [RN]-A, dated 2/13/14 indicated "Pt [patient] has paranoia and delusions. She takes Seroquel [quetiapine] as ordered. She takes Trazadone at HS [hour of sleep] for insomnia. Will proceed to care plan." The assessment did not address a description of R73's paranoia or delusions, what medical or psychiatric diagnoses may relate to these symptoms, what triggers these behaviors, the impact they have on R73 and others and what non pharmacological interventions have been	F 329	**Plans to monitor performance to be sure solutions are sustained:** Behavior/Mood reviews/audits will be done on each resident in facility receiving antipsychotic medications, monthly x3 months and quarterly thereafter, using assessment tool. RN Unit Managers/DON will be responsible for audit completion. DON will be responsible for overall compliance. Results will be reported to QA x6 months. **Refer to Exhibit B-***Assessment of Resident Receiving Psychotropic Medication form.*	5/13/2014

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F 329	Continued From page 11 effective in managing R73's behavioral symptoms. An analysis of risk versus benefit of treatment by psychoactive medication was not addressed. The section for input from resident and/or family/representative regarding the care area was left blank. The Cognitive Loss/Dementia care area assessment completed by social services department, dated 2/13/14 revealed a potential contributing factor that should have been considered related to R73's behavioral concerns of paranoia and delusions , " Alt. r/t [altered related to] short and long term memory loss and moderate impairment with decision making due to dx [diagnosis] of Alzheimer's disease. Alzheimer's is a progressive disease so continued decline is expected." The Behavioral Symptoms care area assessment completed by social services department, dated 2/13/14, revealed behavioral concerns, but were not related to paranoia or hallucinations: "Alt. r/t resident wandering and rejecting care due to dx of Alzheimer's disease...Also continue to monitor for pain, as she has pain in her knees which could increase agitation." A review of Behavior/Intervention Monthly Flow Record for March and April 2014 indicated target behaviors of increased agitation, isolating self, resistive to activities of daily living and cares, restless/pacing, delusions and number of hours of sleep. R73 was noted to experience delusions on 26 days for the month of March and April 1st to 3rd. R73 was noted as experiencing increased agitation on 13 days, resistive to activities of daily living and cares 21 days and restless/pacing 24 days for the same time period. Review of progress notes for the same period revealed corresponding descriptions of the behaviors: resistiveness to cares 11 times, hoarding twice,	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 wandering twice and delusions only once. The note on delusions listed only "delusions per usual" with no description of the usual delusions. During interview on 4/3/14 at 10:45 a.m. the nurse manager, RN-Y explained R73 had behaviors of hoarding, talking to her stuffed animals, thought staff were taking her belongings and was recently suspicious of family as she did not remember who they were. RN-Y reviewed care area assessments, progress notes and behavior monitoring forms. RN-A confirmed R73's delusions were not adequately addressed. During interview on 4/3/14 at 12:30 p.m., R73's trained medication aide, (TMA)-Y was asked about R73's delusional behavior. TMA-Y reported in the past R73 would make comments about children in her room and would talk and tickle her stuffed animals. TMA-Y reported R73 never complained about seeing children in her room and reported R73 did not fear her stuffed animals but instead "adores them." TMA-Y reported R73 has taken silverware from the dining room as she thought they were her own silverware. TMA-Y reported staff were able to manage this behavior by removing the silverware on R73's bath days.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	**F441** It is the intent of NHCC to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of disease and infection.	5/13/2014

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 _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HARMONY CARE CENTER	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 3 of 3 residents (R50, R82 & R103) observed who required blood glucose monitoring. Findings include:	F 441	**Corrective Action Plan:** Licensed nursing staff and TMA's will attend in-service on 5/6/14, staff will be educated by 5/13/14. Policy and Procedure on Blood Glucose Meter Disinfection will be reviewed and handed out. Policy and Procedure for Hand Washing and Use of Gloves will be reviewed and handed out also. Staff will be reminded of the importance of following infection control guidelines. Demonstration of procedure with return demonstration will be completed. **Plans to monitor performance to make sure the solutions are sustained:** Audits of blood glucose checks/blood glucose disinfection will be done 5 times per month for 3 months. Results of audits will be reported to QA x6 months. Infection Control designee/DON will be responsible for ongoing compliance.	5/13/2014

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F 441	Continued From page 14 During an observation on 3/31/14, @ 4:59 p.m. licensed practical nurse (LPN)-A wearing disposable gloves, completed a blood glucose draw with a multi use blood glucose machine on R50. LPN-A cleaned the glucometer machine using an alcohol wipe, removed the disposable gloves and did not wash hands or sanitize after removing the gloves. At 5:07 p.m. with R82, and again at 5:38 p.m. with R103, registered nurse RN-D wearing disposable gloves, completed a blood glucose draw with a multi use blood glucose machine on R82, R103 and cleaned the glucometer machine using an alcohol wipe. RN-D did not wash hands after removing gloves nor did she sanitize her hands with alcohol gel. Review of the facility policy dated 2/24/10, titled "Blood Glucose Meter" directed staff to use an EPA approved disinfectant wipe and to follow the manufacturer recommendations inbetween multi use. When interviewed on 3/31/14 at 5:05 p.m., LPN-A was not aware of the manufacturer recommendations to saturate the machine for 2 minutes before allowing it to completely dry prior to the next resident use. RN-D was interviewed at 5:40 p.m. and acknowledged she was not aware of the manufacturer recommendations for the use of the EPA wipes to disinfect multi use glucometer machines. When interviewed on 3/31/14, at 5:45 p.m. the ADON verified the multi-use glucometers were to be saturated with the facility EPA wipes which contained bleach, for 2 minutes and then thoroughly dried prior to use with another resident. The ADON verified hands are to be washed or sanitized with alcohol gel when gloves	F 441		

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F 441	Continued From page 15 are removed. The following observations were made during medication administration in the resident activity room on second floor: On 4/2/14, at 7:59 a.m., licensed practical nurse (LPN)-A was observed to pick up her pen and document a blood sugar number of 101, in the MAR. LPN-A then opened the medication cart wearing gloves, put her gloved right hand in her pocket reaching for something. LPN-A then removed one glove on the right hand, did not wash hands or sanitize, left the left glove on and drew up insulin. At 8:03 a.m., during administration of Novolog insulin for R103, LPN-A was observed to remove the needle cap with her mouth. The needle bent and LPN-A stopped. At 8:04 a.m., LPN-A drew another dose of Novolog insulin, with the same glove on the left hand, and proceeded with administering the insulin to R103. At 8:05 a.m. LPN-A was observed to remove her left hand glove, after cleaning the glucometer with Sani-cloth for approximately 1 minute. The glucometer was placed on the med cart for a few minutes and then put away in the medication cart. LPN-A sanitized hands, removed medication Advair Diskus from medication cart and administered it. During an interview on 4/2/14, at 8:23 a.m., LPN-A stated she was aware of not changing her gloves in between checking the glucometer and administering medications. LPN-A stated, "I am sorry." LPN-A indicated that she normally uses two pair of gloves but was out of gloves and	F 441		

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F 441	Continued From page 16 should have gotten another pair. LPN-A stated, " I normally do the Accu checks in their rooms and able to get the gloves in the bath room." LPN-A stated, "I feel bad because normally I have the gloves in my cart and I don't know who took it." During an interview on 4/2/14, at 1:27 p.m., LPN-A explained she did cleanse the glucometer for minutes after, when she used it, and let it dry out for 2 minutes on her cart. If she is not sure if glucometer is clean, she will clean it prior to using in the morning and will never use alcohol wipes. In addition, she stated, "As for the insulin needle caps, I took the needle cap with my teeth because I am not taking the chance of poking myself and I just took it out of the wrapper and it is sterile." During an interview on 4/3/14, at 10:00 a.m. the director of nursing (DON), explained, they do not wear gloves when doing insulin, but do wear gloves with resident cares and that they treat every resident with universal precautions. In addition, DON stated her expectation was "Staff should wear gloves and take them off when done. Staff should always wash their hands before and after taking off gloves or use hand sanitizer. Staff should clean glucometer before and after per manufacturer recommendation." DON further indicated, they use Sani-cloth wipes for cleaning glucometer and when done cleaning they need to let it dry for 2 minutes. "The manufacturer states that you have to clean and let it dry for 2 minutes." The facility policy and procedure titled: Blood Glucose Meter and Insulin Pen Disinfection. Dated, February 24, 2010; directed "Key Points: When you first use a Blood Glucose Meter on your shift, disinfect it to assure that it has not been contaminated prior to your using it.	F 441		

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F 441	Continued From page 17 If Blood Glucose Meter (glucometer) is visibly soiled, clean the outside of the meter with either isopropyl alcohol or soapy water and then proceed to disinfect the meter per the procedure below. Blood Glucose Meter (glucometer) & Insulin Pens are to be disinfected after each use." "3. Apply non-sterile gloves. 5. Disinfect the blood glucose meter: b. Wipe the meter down, avoiding the battery compartment, code ship port, and the test strip port. (If insulin pen, wipe the pen with the disinfectant wipe.) c. Allow the blood Glucose Meter (glucometer) dry (according to manufacturer's directions to mitigate HIV, other viruses and bacteria) before doing the next blood glucose check." Manufacturer manual/instruction regarding cleaning glucometer MAINTENANCE, undated, reads, "Healthcare professionals should wear gloves when cleaning the Assure Pro meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning the meter between patients." Policy and procedure for hand washing titled hand washing dated June 2000; reads, "GENERAL INFECTION CONTROL GUIDELINES. 5. Wear gloves when coming in contact with blood or body fluids." Policy and procedure for, Using Gloves, undated, reads, "4. Nonsterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the resident and when cleaning contaminated surfaces. 5. Wash hands after removing gloves. Gloves do not replace hand washing." In addition, "Gloves should be used:	F 441		

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F 441	Continued From page 18 When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin; 4. When handling potentially contaminated items; 5. When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious material. 6. Whenever in doubt."	F 441		

Exhibit A

New Harmony Care Center

Phone Reference Check Log

Date: _____ Applicant Name: _____

Name of Company: _____

Spoke with: _____

Employment Dates: _____

Position: _____ Eligible for rehire? _____Yes _____No

Other Information: _____

_____

Person Inquiring: _____

Phone Reference Check Log

Date: _____ Applicant Name: _____

Name of Company: _____

Spoke with: _____

Employment Dates: _____

Position: _____ Eligible for rehire? _____Yes _____No

Other Information: _____

_____

Person Inquiring: _____

Exhibit B

ASSESSMENT OF RESIDENT RECEIVING PSYCHOTROPIC MEDICATION

The goal of this assessment is to review residents who are receiving psychopharmacological medications. The tool can be used to guide discussion in reviewing resident behavior during Risk or Care Management and/or Standards of Care Committee meeting where appropriate interdisciplinary members are in attendance, for example, Pharmacy Consultant, Medical Director, Behavioral Health Specialists, etc.

Use this tool for all residents admitted on psychotropic drugs and periodically after the medication has been started and/or severity of symptoms noted.

Resident Name: _____

Date of Admission: _____ Date of initial medication assessment: _____

Previous living arrangements prior to admission (check appropriate selection):

Home ___ AL ___ SNF ___ Other _____

BIMs Score * _____ Date _____ or MMSE Score*_____Date _____

List psychotropic drugs including antipsychotics, anxiolytics, sedative/hypnotics, antidepressants, and other drugs used to treat psychiatric/behavioral disorders or symptoms

Drug Name/Dose	Directions	Diagnosis/Indication	Start Date (If known)	Effective/Side Effects

Behaviors that prompted initiation of above medications; if not known, describe behaviors observed since admission: _____

_____

Discussion at meeting is focused on effectiveness and relevance of continuing the medication. Also consider potential benefits of tapering and/or a trial off of psychotropic drugs, especially of antipsychotics and hypnotics. The following questions may prompt discussion.

- Have non-drug interventions been attempted in the past? If so, what have been the results and what interventions have been used?
- Has pain been assessed and managed?
- What are the possible needs the resident may be trying to communicate behaviorally?
- Are behaviors causing negative outcomes/ disturbing for the resident?
- Could behaviors be addressed by staff intervention instead of medication?

~~Exhibit~~

Exhibit B

- Could behaviors be addressed by staff intervention instead of medication?
- Can these interventions be implemented routinely? If not, what are the barriers?
- Have medical causes been addressed? (i.e. metabolic and endocrine disorders, infections. etc.)
- Is staff response contributing to or increasing behaviors?
- Are families concerned about behaviors typically found in AD?
- Are family interactions with resident contributing to or increasing behaviors?
- Previous successes or failures with medications?
- Is the resident experiencing side effects from the medications? Are there other medications that might be contributing to behaviors?

Would a tapering or trial off antipsychotic or hypnotic meds be appropriate at this time?

If so, why? If not, why not? _____

_____

Note: If a tapering or trial off is implemented, monitor carefully using behavior monitoring sheets.

Summary of discussion: _____

_____

_____

Recommendation(s) and Action Plan: _____

_____

_____

Identify team members completing this assessment: _____, _____,

_____, _____, _____, _____.

Date of follow up assessment: _____

Summary of behaviors since changes implemented: _____

_____

_____

Further recommendation(s) and Action Plan: _____

_____

_____

Identify team members completing this assessment: _____, _____,

_____, _____, _____, _____.

* MMSE – Mini Mental State Exam BIMs – Brief Interview of Mental Status

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F 6381023

PRINTED: 04/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING 01 - BLDG 1 B. WING	04/01/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF Y OUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, New Harmony Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	**K33** A hardship waiver was approved from the last survey. A hardship waiver K 033 is being applied for this survey. **Refer to exhibit C-***Provision #84/form#CMS-2786R* POC ok w/AW for K33 5-7-14 RECEIVED MAY - 7 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	5/2/2014

DC: 5-13-14

EXIT: 4-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	5/2/2014

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. New Harmony Care Center is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(222) construction. In 1976, a 3rd Floor addition was constructed and was determined to be of Type II(222) construction .Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 72 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 033	NFPA 101 LIFE SAFETY CODE STANDARD	K 033		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 033 SS=F	Continued From page 2 Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect all 76 residents. Findings include: On facility tour between 09:00 AM and 01:00 PM on 04/01/2014, it was observed that: 1. The basement level of the north stair the elevator machine room opened directly onto the stair enclosure. 2. The first floor a storage room opened directly onto the north stair enclosure. 4. The first floor an elevator machine room opened directly onto the central stair enclosure. This deficiency was verified by facility Environment Service Director (JB). Waiver Recommended A waiver has been granted during the last survey	K 033	AW Hardship waiver attached ~~Exhibit~~ Exhibit C	5/12/2014

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K 033	Continued From page 3 and FMS survey.	K 033		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7505

April 23, 2014

Mr. Trent Carlson, Administrator
New Harmony Care Center
135 Geranium Avenue East
Saint Paul, Minnesota 55117

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5381024

Dear Mr. Carlson:

The above facility was surveyed on March 31, 2014 through April 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00492	A. BUILDING: _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HARMONY CARE CENTER	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 31, 2014 through April 3, 2014, surveyors of this department staff visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the	2 000 5/5/14 SER	RECEIVED MAY - 5 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Administrator | 5/2/2014

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2 000	Continued From page 1 original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, P.O. Box 64900, St. Paul, MN 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive	2 540		

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2 540	Continued From page 2 resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately assess the use of an antipsychotic for one 1 of 5 residents reviewed for antipsychotic usage, (R73). Findings include: A review of the most recent physician orders revealed R73 was prescribed quetiapine 25 mg [milligrams] three times daily for paranoia and hallucinations. Quetiapine is an antipsychotic medication. A review of R73's most recent care area	2 540		

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2 540	Continued From page 3 assessment completed by the nurse manager [RN]-A, dated 2/13/14 indicated "Pt [patient] has paranoia and delusions. She takes Seroquel [quetiapine] as ordered. She takes Trazadone at HS [hour of sleep] for insomnia. Will proceed to care plan." The assessment did not address a description of R73's paranoia or delusions, what medical or psychiatric diagnoses may relate to these symptoms, what triggers these behaviors, the impact they have on R73 and others and what non pharmacological interventions have been effective in managing R73's behavioral symptoms. An analysis of risk versus benefit of treatment by psychoactive medication was not addressed. The section for input from resident and/or family/representative regarding the care area was left blank. The Cognitive Loss/Dementia care area assessment completed by social services department, dated 2/13/14 revealed a potential contributing factor that should have been considered related to R73's behavioral concerns of paranoia and delusions , " Alt. r/t [altered related to] short and long term memory loss and moderate impairment with decision making due to dx [diagnosis] of Alzheimer's disease. Alzheimer's is a progressive disease so continued decline is expected." The Behavioral Symptoms care area assessment completed by social services department, dated 2/13/14, revealed behavioral concerns, but were not related to paranoia or hallucinations: "Alt. r/t resident wandering and rejecting care due to dx of Alzheimer's disease...Also continue to monitor for pain, as she has pain in her knees which could increase agitation." During interview on 4/3/14 at 10:45 a.m. the nurse manager, RN-Y explained R73 had behaviors of hoarding, talking to her stuffed animals, thought staff were taking her belongings	2 540		

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2 540	Continued From page 4 and was recently suspicious of family as she did not remember who they were. RN-Y reviewed care area assessments. RN-A confirmed R73's delusions and use of an anti-psychotic were not adequately addressed. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could monitor to assure staff adequately assess the use of an antipsychotic medications and could assure policy and procedures are up to date and that staff are trained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 540		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as	21390		

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21390	Continued From page 5 defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 3 of 3 residents (R50, R82 & R103) observed who required blood glucose monitoring. Findings include: During an observation on 3/31/14, @ 4:59 p.m. licensed practical nurse (LPN)-A wearing disposable gloves, completed a blood glucose draw with a multi use blood glucose machine on R50. LPN-A cleaned the glucometer machine using an alcohol wipe, removed the disposable gloves and did not wash hands or sanitize after removing the gloves. At 5:07 p.m. with R82, and again at 5:38 p.m. with R103, registered nurse RN-D wearing disposable gloves, completed a blood glucose draw with a multi use blood glucose machine on R82, R103 and cleaned the glucometer machine using an alcohol wipe. RN-D did not wash hands after removing gloves nor did she sanitize her hands with alcohol gel. Review of the facility policy dated 2/24/10, titled "Blood Glucose Meter" directed staff to use an	21390		

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21390	Continued From page 6 EPA approved disinfectant wipe and to follow the manufacturer recommendations inbetween multi use. When interviewed on 3/31/14 at 5:05 p.m., LPN-A was not aware of the manufacturer recommendations to saturate the machine for 2 minutes before allowing it to completely dry prior to the next resident use. RN-D was interviewed at 5:40 p.m. and acknowledged she was not aware of the manufacturer recommendations for the use of the EPA wipes to disinfect multi use glucometer machines. When interviewed on 3/31/14, at 5:45 p.m. the ADON verified the multi-use glucometers were to be saturated with the facility EPA wipes which contained bleach, for 2 minutes and then thoroughly dried prior to use with another resident. The ADON verified hands are to be washed or sanitized with alcohol gel when gloves are removed. The following observations were made during medication administration in the resident activity room on second floor. On 4/2/14, at 7:59 a.m., licensed practical nurse (LPN)-A was observered to pick up her pen and document a blood sugar number of 101, in the medication administration record (MAR). LPN-A then opened the medication cart, wearing gloves, put her gloved hand in her pocket, reaching for something. LPN-A then removed one glove on the right hand, did not wash hands or sanitize, left the left glove on and drew up insulin. At 8:03 a.m., during administration of Novolog insulin for R103, LPN-A was observed to remove the needle cap with her mouth. The needle bent	21390		

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21390	Continued From page 7 and LPN-A stopped. At 8:04 a.m., LPN-A drew another dose of Novolog insulin, with the same glove on the left hand, and proceeded with administering insulin to R103. At 8:05 a.m., LPN-A was observed to remove her left hand glove, after cleaning the glucometer with Sani-cloth for approximately one minute. The glucometer was placed on the med cart for a few minutes and then put away in the medication cart. LPN-A sanitized hands, removed the medication Advair Diskus from medication cart and administered it. During an interview on 4/2/14 at 8:23 a.m., LPN-A stated she was aware of not changing her gloves in between checking the glucometer and administering medications. LPN-A stated, "I am sorry." LPN-A indicated that she normally uses two pair of gloves but was out of gloves and should have gotten another pair. LPN-A stated, "I normally do the Accu checks in their rooms and able to get gloves in the bathroom." LPN-A stated, "I feel bad because normally I have the gloves in my cart and I don't know who took it." During an interview, on 4/2/14 at 1:27 p.m., LPN-A explained she did cleanse the glucometer for minutes after, when she used it, and let it dry for 2 minutes on her cart. If she is not sure if glucometer is clean , she will clean it prior to using in the morning and will never use alcohol wipes. In addition, she stated, "As for insulin needle caps, I took the needle cap with my teeth because I am not taking the chance of poking myself and I just took it out of the wrapper and it is sterile". During interview 4/3/14, at 10:00 a.m., with the director of nursing (DON), explained they do not	21390		

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21390	Continued From page 8 wear gloves when doing insulin, but do wear gloves with resident cares and that they treat every resident with universal precautions. In addition, DON stated her expectation was, "Staff should wear gloves and take them off when done. Staff should always wash their hands before and after taking off gloves or use hand sanitizer. Staff should clean glucometer before and after per manufacturer recommendation." DON further indicated they use Sani-cloth wipes for cleaning glucometer and when done cleaning they need to let it dry for 2 minutes. "The manufacturer states that you have to clean and let it dry for 2 minutes." The facility policy and procedure titled: Blood Glucose Meter and Insulin Pen Disinfection, dated February 24, 2010, directed "Key Points": "When you first use a Blood Glucose Meter on your shift, disinfect it to assure that it has not been contaminated prior to your using it. If Blood Glucose Meter (glucometer) is visibly soiled, clean the outside of the meter with either isopropyl alacohol or soapy water and then proceed to disinfect the meter per the procedure below. Blood Glucose Meter (glucometer) & Insulin Pens are to be disinfected after each use." "3. Apply non-sterile gloves. 5. Disinfect the blood glucose meter: b. Wipe the meter down, avoiding the battery compartment, code ship port, and the test strip port. (If insulin pen, wipe the pen with the disinfectant wipe.) c. Allow the blood Glucose Meter (glucometer) dry (according to manufacturer's directions to mitigate HIV, other viruses and bacteria) before doing the next blood glucose check." Manufacturer manual/instruction regarding cleaning glucometer MAINTENANCE, undated,	21390		

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21390	Continued From page 9 reads, "Healthcare professionals should wear gloves when cleaning the Assure Pro meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning the meter between patients". Policy and procedure for hand washing titled hand washing, dated June 200, reads, "GENERAL INFECTION CONTROL GUIDELINES. 5. Wear gloves when coming in contact with blood or body fluids." Policy and procedure for, Using Gloves, undated, reads, "4. Nonsterile gloves should be used primarily to prevent the contamination of the employee's hands when provideing treatment or services to the resident and when cleaning contaminated surfaces. 5. Wash hands after removing gloves. Gloves do not replace hand washing." In addition, "Gloves should be used: When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin: 4. When handling potentially contaminated item; 5. When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious material. 6. Whenever in doubt." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that policies and procedures are up to date, staff are trained and that audits are performed to assure staff implementation of procedures and manufacturer's recommendations for cleaning blood glucose monitors, to prevent the spread of infection. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		

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21540	Continued From page 10	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately justify the use of an antipsychotic and coordinate behavior concerns amongst the interdisciplinary team related to the use of an antipsychotic for one 1 of 5 residents reviewed for antipsychotic usage, (R73). Findings include: A review of the most recent physician orders	21540		

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21540	Continued From page 11	21540		

revealed R73 was prescribed quetiapine 25 mg [milligrams] three times daily for paranoia and hallucinations. Quetiapine is an antipsychotic medication.

A review of physican [MD] progress notes, dated 9/5/13 revealed: "Anxiety with depressive affect. It is not clear if the Seroquel is continuing to provide significant relief. She has not been noted to have hallucinations nor stated any particular delusion of late. This certainly occurred before the lower dose of Seroquel was started." The MD note for 1/30/14 revealed "She has done well with Seroquel at 25 [mg] t.i.d. [three times daily]. This also helps has helped to stifle episodic anxiety-inducing hallucinations, which she has had over time." The nurse practitioner [NP] notes for 10/7/13 stated "Psychosis NOS-delusional and hallucinatory behavior that do cause the patient considerable distress. She seems to be doing well on 25 mg of Seroquel BID. [twice daily]" Notes for 12/23/13, 2/3/14 and 3/3/14 provided similar information. On 11/4/13, the NP note stated "Psychosis NS. Delusional and hallucinatory behavior that do cause the patient considerable distress. She is now managed quite effectively on 25 mg of Seroquel b.id. She may also be benefiting from pain management." None of the NP or MD notes included an actual description of what the hallucinations and delusions were, when they started or how they caused distress to R73.

A review of R73's most recent care area assessment completed by the nurse manager [RN]-A, dated 2/13/14 indicated "Pt [patient] has paranoia and delusions. She takes Seroquel [quetiapine] as ordered. She takes Trazadone at HS [hour of sleep] for insomnia. Will proceed to care plan." The assessment did not address a

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HARMONY CARE CENTER	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 12 description of R73's paranoia or delusions, what medical or psychiatric diagnoses may relate to these symptoms, what triggers these behaviors, the impact they have on R73 and others and what non pharmacological interventions have been effective in managing R73's behavioral symptoms. An analysis of risk versus benefit of treatment by psychoactive medication was not addressed. The section for input from resident and/or family/representative regarding the care area was left blank. The Cognitive Loss/Dementia care area assessment completed by social services department, dated 2/13/14 revealed a potential contributing factor that should have been considered related to R73's behavioral concerns of paranoia and delusions , " Alt. r/t [altered related to] short and long term memory loss and moderate impairment with decision making due to dx [diagnosis] of Alzheimer's disease. Alzheimer's is a progressive disease so continued decline is expected." The Behavioral Symptoms care area assessment completed by social services department, dated 2/13/14, revealed behavioral concerns, but were not related to paranoia or hallucinations: "Alt. r/t resident wandering and rejecting care due to dx of Alzheimer's disease...Also continue to monitor for pain, as she has pain in her knees which could increase agitation." A review of Behavior/Intervention Monthly Flow Record for March and April 2014 indicated target behaviors of increased agitation, isolating self, resistive to activities of daily living and cares, restless/pacing, delusions and number of hours of sleep. R73 was noted to experience delusions on 26 days for the month of March and April 1st to 3rd. R73 was noted as experiencing increased agitation on 13 days, resistive to activities of daily living and cares 21 days and restless/pacing 24	21540		

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21540	Continued From page 13 days for the same time period. Review of progress notes for the same period revealed corresponding descriptions of the behaviors: resistiveness to cares 11 times, hoarding twice, wandering twice and delusions only once. The note on delusions listed only "delusions per usual" with no description of the usual delusions. During interview on 4/3/14 at 10:45 a.m. the nurse manager, RN-Y explained R73 had behaviors of hoarding, talking to her stuffed animals, thought staff were taking her belongings and was recently suspicious of family as she did not remember who they were. RN-Y reviewed care area assessments, progress notes and behavior monitoring forms. RN-A confirmed R73's delusions were not adequately addressed. During interview on 4/3/14 at 12:30 p.m., R73's trained medication aide, (TMA)-Y was asked about R73's delusional behavior. TMA-Y reported in the past R73 would make comments about children in her room and would talk and tickle her stuffed animals. TMA-Y reported R73 never complained about seeing children in her room and reported R73 did not fear her stuffed animals but instead "adores them." TMA-Y reported R73 has taken silverware from the dining room as she thought they were her own silverware. TMA-Y reported staff were able to manage this behavior by removing the silverware on R73's bath days. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure policy and procedures are current that facility staff are trained and that audits are performed to assure the interdisciplinary team identify, document and monitor behaviors to assure the use of antipsychotic medications are justified.	21540		

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21540	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to	22000		

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22000	Continued From page 15 minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to conduct a thorough investigation for 1 of 3 residents reviewed for mistreatment, (R 67). Findings include: The facility failed to thoroughly investigate an allegation of mistreatment for R67. A review of Incident Report submitted to the state agency, dated 3/4/14, revealed "Resident reported a nursing assistant named [NA-Z] hit him on the forehead with the palm of her hand. He could not remember when the incident happened. A review of the Investigative Report, submitted to the state agency on 3/6/14 and accompanying investigative documents [statements by NA-Z, a floor nurse (FN) and the investigating social worker (LSW)] revealed the only resident interviewed was R67. No other residents or their representatives in NA-Z's care	22000		

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22000	Continued From page 16 group were interviewed to identify potential concerns regarding care. Only two staff were interviewed or asked to give statements, NA-Z and a FN. No other nursing assistants, nurses or other staff on the unit were interviewed to identify potential concerns regarding care provided by NA-Z. During interview on 4/3/14 at 12:23 p.m., LSW reported R67 had expressed concerns regarding NA-Z at his care conference. R67 had reported he was hit on the forehead by NA-Z about a week prior to the care conference but could not recall the day. LSW confirmed no other residents were interviewed. LSW reported interviewing other residents was not part of her normal procedure for investigating allegations of mistreatment. LSW reported she did not look at NA-Z's schedule for the prior week to determine what other staff may have been on the unit to interview about R67's allegation or concerns regarding care provided by NA-Z to other residents. On 4/3/14 at 1:30 p.m. the social service director, (SSD) reported the facility had previously been interviewing other residents as part of investigations of allegations of mistreatment. SSD reported the facility stopped interviewing other residents as the interviews caused them to worry. A review of the Elim Care Vulnerable Adult Abuse Prohibition Policy and Procedure, last revised November 2011, directed staff: "1. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could	22000		

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22000	Continued From page 17 assure that policies are followed, that staff are fully trained and that audits are performed to assure thorough reports have been written and appropriate staff, residents and family are interviewed during the process to assure all residents are free from mistreatment. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	22000		