DEPARTMENT OF HEALTH					CENTERS FOR MEI	DICARE & MEDICA	AID SERVICES	
					AND TRANSMITTAL		: 22CB	
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Fa	cility ID: 00492	
1. MEDICARE/MEDICAID PROVIDER (L1) 245381	NO.	3. NAME AND AI (L3) NEW HARN	MONY CARE	CENTER		 TYPE OF ACTION Initial 	: <u>7 (L8)</u> 2. Recertification	
2.STATE VENDOR OR MEDICAID NO (L2) 602023200		(L4) 135 GERAN (L5) SAINT PAU		E EAST	(L6) 55117	3. Termination 5. Validation	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OW (L9)	VNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey After (9. Other Complaint	
6. DATE OF SURVEY 05/19/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	G DATE: (L35)	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requiremen	nts:	
To (b):			equirements e Based On:		2. Technical Personnel			
12. Total Facility Beds	76 (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN <u>X</u> 5. Life Safety Code	 7. Medical Direct NF)8. Patient Room 9. Beds/Room 		
13.Total Certified Beds	76 (L17)		npliance with Prog ents and/or Appli		* Code: A,5 *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
76 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAN	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	(APPROVAL	Date:	
Susanne Reuss, Supervisor		0	5/20/2014	(L19)	Anne Kleppe, Enforcement Specialist 06/12/2014 (L20)			
PAR	TII - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	STATE AGENCY		
 19. DETERMINATION OF ELIGIBILIT _X_ 1. Facility is Eligible to Par 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	I CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/FNT	26. TERMINATION ACTION		30)	
OF PARTICIPATION	BEGINNINC		ENDING DAT		VOLUNTARY <u>0</u>		*	
12/01/1986					01-Merger, Closure		eet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to M	eet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		Status Change	
(L27)	B. Rescind St	spension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	05/22/2014		(L33)	DETERMINATION APP	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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.



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,

Are Klegge

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



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,

Ane Klegge

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

Enclosure cc: Licensing and Certification File New Harmony Care Center May 20, 2014 Page 2

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245381	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/19/2014
Name	e of Facility		Street Address, City, State, Zip Code	
NE	W 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 Reg. # LSC	F0225 483.13(c)(1)(i		Correction Completed 05/13/2014 2) -		F0226 483.13(c)		Correction Completed 05/13/2014	Reg.	ix F0272 # 483.20(b)(1) C		Correction Completed 05/13/2014
	F0329 483.25(l)		Correction Completed 05/13/2014	ID Prefix Reg. #			Correction Completed 05/13/2014	ID Pref Reg.	ix		Correction Completed
_			Correction Completed						ix # C		
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed	Reg.	ix # C		Correction Completed
Reg. #			Correction Completed					_	ix # C		
Reviewed B State Agen Reviewed B CMS RO	су	Reviewed SR/AK Reviewed	-	Date: 05/20/20 Date:	14	re of Sur re of Sur		16	022	Date: 05/1 Date:	9/2014
Followup t	o Survey Con 4/3/2	-	:						a Summary of to the Facility?	YES	NO

DEPARTMENT OF HEALTH					CENTERS FOR MEI	DICARE & MEDICA	AID SERVICES	
					AND TRANSMITTAL		D: 22CB	
	PART I -	TO BE COMPI	LETED BY T	THE STAT	FE SURVEY AGENCY	F	acility ID: 00492	
1. MEDICARE/MEDICAID PROVIDER (L1) 245381	NO.	3. NAME AND AI (L3) NEW HARN	MONY CARE	CENTER		4. TYPE OF ACTION 1. Initial	J: <u>2 (</u> L8) 2. Recertification	
2.STATE VENDOR OR MEDICAID NO (L2) 602023200		(L4) 135 GERAN (L5) SAINT PAU		E EAST	(L6) 55117	 Termination Validation 	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OV (L9)	VNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After (9. Other Complaint	
6. DATE OF SURVEY 04/03/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L14) (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDIN 12/31	G DATE: (L35)	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirement	nts:	
To (b):			equirements e Based On:		2. Technical Personnel			
12. Total Facility Beds	76 (L18)	*	cceptable POC		$\frac{3.24 \text{ Hour RN}}{4.7 \text{-Day RN (Rural SN}}$ $\frac{\overline{X}}{5}$ 5. Life Safety Code	 7. Medical Dire 8. Patient Room 9. Beds/Room 		
13. Total Certified Beds	$76^{\ (L17)}$		npliance with Prog ents and/or Appli		* Code: B ,, 5 *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
<u>Mary Beth Lacina, HFI</u>	E-NE II		5/05/2014	(L19)	Anne Kleppe, Enforcement Specialist 05/21/2014 (L20)			
PAR	r II - TO BE (COMPLETED I	BY HCFA RE	GIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
 DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Par 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	I CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	IENT	26. TERMINATION ACTION	·	_30)	
OF PARTICIPATION	BEGINNING		ENDING DAT		VOLUNTARY _0	`	,	
12/01/1986	Dionana		LINDING DI		01-Merger, Closure		leet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		leet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		Status Change	
(L27)	B. Rescind Su	spension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001			AW LSC K33 Em	nailed CMS at RC)CHI 05/22/14	
	(L28)			(L31)			, , , , , , , , , , , , , , , , , , ,	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Wednesday, May 07, 2014 2:48 PM
То:	'rochi_lsc@cms.hhs.gov'
Cç:	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
	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

	III Avenue Last St. I adi, init Sol II	
PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAI	IC 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).	r, list the survey report form item ecific provisions of the code, if rigidly and (b) the waiver of such unmet e patients. If additional space is	
PROVISION NUMBER(S) JUS	JUSTIFICATION	
A waiver for K 033 is being requested regarding :	2	
1-the door of the north stair basement level elevator machine room,	elevator machine room ,	
2- the door of the central stair first floor elevator mach	/ator machine room,	
3- the door of the north stair first floor storage room.	ge room.	(ŝ
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.	hine room doors and the storage room door as described ange the swing of the door. It would be a financial hardshi age room.	m door as described be a financial hardship
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.	to leave the doors in the stair enclos irs. Residents primarily use the eleva t traffic, because the doors are on clo used on horizontal movement of residuated arely used option of evacuation.	ures because the tors. In emergencies, osers and these doors lents to smoke
Signage " CAUTION! OPEN DOOR SLOWLY! DO NOT PROP DOOR " are posted inside each of the doors	doors	
Surveyor (Signature) Title Office	2	Date
Fire Authority Official (Signature) Title Fire Safety Office Supervisor	State Fire Marshal	Date 5-7-14

Ł

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.



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.

New Harmony Care Center April 23, 2014 Page 2

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.

New Harmony Care Center April 23, 2014 Page 4

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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:

New Harmony Care Center April 23, 2014 Page 5

> 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,

Are Klegepe

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

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

	10 T OT MEDIOATIE	A MEDICAID SERVICES			U	ND NO	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245381	B. WING	i		04/	03/2014
	PROVIDER OR SUPPLIER	ER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 35 GERANIUM AVENUE EAST AINT PAUL, MN 55117	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ſS	F (000			
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the bage of the CMS-2567 form will tion of compliance.	5/5/14 SE	¢		·	
F 225 SS=D	revisit of your facilit validate that substa	PORT	F 2	225			-0.8036 1917 - 9 - 211 - 9 - 2
	been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for	t employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a c an employee, which would or service as a nurse aide or the State nurse aide registry ies.		-	F225 It is the intent of NHCC to thoroughly investigate/report allegations/individuals.		5 13 2014
· · · · · · · · · · · · · · · · · · ·	involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce	sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the ertification agency). we evidence that all alleged					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE
Junto	=1Caller				Admministrator		212014
other safegua	y statement ending with a irds provide sufficient pro	an asterisk (*) denotes a deficiency which tection to the patients. (See instructions	on the ins	titutic	on may be excused from correcting providing nursing homes, the findings stated above are	it is deter disclosal	mined that ble 90 days

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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

CENTER	<u>AS FOR MEDICARE</u>	& MEDICAID SERVICES			U		. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				E SURVEY IPLETED
		245381	B. WING			04/	03/2014
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	ER			35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX _TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
1.15 T							
F 225	Continued From pa		F:	225		•	
u sea Legenti Dioget	prevent further pote investigation is in p The results of all in	vestigations must be reported			Corrective Plan of Action: R67 incident report was submitt to state 3/4/14. On 3/13/14 OF response to report is as follows,	IFC	5/13/2014
С. н _а	with State law (incl	r or his designated to other officials in accordance uding to the State survey and /) within 5 working days of the			the information has been review & it has been determined that n further action by this office is	ved	
	incident, and if the	alleged violation is verified ive action must be taken.			necessary at this time. Social worker interviewed residents in care group that received care fro NA-Z. No concerns noted when		
	by: Based on interviev facility failed to con	NT is not met as evidenced v and document review, the duct a thorough investigation reviewed for mistreatment, (R			interviews were completed. Tea meeting held 5/1/14 for those doing the investigations, to revie procedure for investigating allegations of abuse contained in VA Abuse/Neglect Policy. Policy	ew	<u>Orre</u>
1. 2. 1	Findings include:				was reviewed and states that during investigation, other		
ang tang tang tang tang tang tang tang t	The facility failed to allegation of mistre	thoroughly investigate an atment for R67.			residents will be interviewed to whom the alleged perpetrator provides care or services.		
1 4 1 4 1 4 5 1 4 5 1 4 5 1 4 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5	agency, dated 3/4/ reported a nursing him on the forehea He could not remen happened. A review submitted to the sta accompanying inve [statements by NA- investigating social only resident interv residents or their re	t Report submitted to the state 14, revealed "Resident assistant named [NA-Z] hit d with the palm of her hand. mber when the incident v of the Investigative Report, ate agency on 3/6/14 and estigative documents •Z, a floor nurse (FN) and the worker (LSW)] revealed the iewed was R67. No other epresentatives in NA-Z's care ewed to identify potential			Plans to monitor performance t 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 reported to QA x6 months.	t	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:22CB11

Facility ID: 00492

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

<u> </u>	15 FOR MEDICARE	& MEDICAID SERVICES			Ĺ	<u> IMB NO</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC				E SURVEY IPLETED
		245381	B. WING			04/	/03/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	ER			35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117	-	на страна
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa	uge 2	F	225			
	interviewed or aske and a FN. No other	g care. Only two staff were ed to give statements, NA-Z r nursing assistants, nurses or nit were interviewed to identify					
		regarding care provided by					· · ·
	reported R67 had e NA-Z at his care co he was hit on the fo	4/3/14 at 12:23 p.m., LSW expressed concerns regarding onference. R67 had reported orehead by NA-Z about a week					
	the day. LSW confi interviewed. LSW r residents was not p	nference but could not recall rmed no other residents were eported interviewing other part of her normal procedure egations of mistreatment. LSW					
	reported she did no the prior week to de have been on the u	ot look at NA-Z's schedule for etermine what other staff may init to interview about R67's rns regarding care provided by					
	(SSD) reported the interviewing other re investigations of all reported the facility	.m. the social service director, facility had previously been esidents as part of egations of mistreatment. SSD stopped interviewing other erviews caused them to worry.					701 (v. 14) 1
	Prohibition Policy an November 2011, dir resident abuse, neg	n Care Vulnerable Adult Abuse nd Procedure, last revised rected staff: "1. All reports of glect and injuries of unknown mptly and thoroughly					
F 226 SS=E	483.13(c) DEVELO ABUSE/NEGLECT,		F 2	26			

Facility ID: 00492

If continuation sheet Page 3 of 19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	245381	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	04	/03/2014
	RMONY CARE CENT	ER		1:	35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		· · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	policies and proced mistreatment, negl	evelop and implement written	F:	226			chaland
	by: Based on interview facility failed to follo thoroughly investige mistreatment for 1 and failed to thorou hired employees (E	NT is not met as evidenced y and document review the ow their policy regarding ating an allegation of of 3 residents reviewed, (R67) ghly pre-screen 4 of 5 newly E-A, E-B, E-C, E-D) per their he potential to impact up to 45 he facility .			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 abus of residents and misappropriation of resident property.	se	5]13/2014
	allegation of mistre A review of the Elim Prohibition Policy a November 2011, di resident abuse, neg source shall be pro investigated."	n Care Vulnerable Adult Abuse nd Procedure, last revised rected staff: "1. All reports of glect and injuries of unknown mptly and thoroughly					
1445 2445 2447 1	agency, dated 3/4/1 reported a nursing a him on the forehead He could not remen happened. A review	Report submitted to the state 4, revealed "Resident assistant named [NA-Z] hit d with the palm of her hand. nber when the incident v of the Investigative Report, ate agency on 3/6/14 and					

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11 1 Event ID:22CB11

Facility ID: 00492

If continuation sheet Page 4 of 19

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245381	B. WING	à		04	/03/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	RMONY CARE CENT	EB			135 GERANIUM AVENUE EAST		
	NINUNT CARE CENT	En			SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
			1				111, 134 1
F 226	Continued From pa	ige 4	F:	226	6		
	accompanying inve	stigative documents					
stars.		Z, a floor nurse (FN) and the					
• S		worker (LSW)] revealed the			Corrective Action Plan:		
		iewed was R67. No other			An Employee Telephone Refer		5/13/14
		epresentatives in NA-Z's care ewed to identify potential			Checking Form has been initiat		
		care. Only two staff were			beginning 5/1/2014. Departm		
		ed to give statements, NA-Z			managers will be responsible for		
		nursing assistants, nurses or			completion of the form prior to		
		nit were interviewed to identify			employee job offer. 2 current	or	
		regarding care provided by			former employers will be		
	NA-Z.				contacted in an attempt to obt		
	During interview on	4/3/14 at 12:23 p.m., LSW			information regarding potentia	1	
		expressed concerns regarding			new hires. Department head		
		inference. R67 had reported			meeting was held 4/30/14 to		
		prehead by NA-Z about a week			explain reference check procec		
		nference but could not recall			Reference checks have been do	ne	
••		rmed no other residents were			on cited employees and are		
		eported interviewing other			located in employee files.		
· · · ·		ert of her normal procedure egations of mistreatment. LSW					7
		t look at NA-Z's schedule for			Plans to monitor performance	to	
		etermine what other staff may			make sure the solutions are		
		nit to interview about R67's			sustained:		
		rns regarding care provided by			Audits of new hire personnel fi	1	
	NA-Z to other resid	ents.			will be completed monthly for a months. The Business Office	5	
	On 1/2/11 at 1.20 n	m the accial convice director					
		.m. the social service director, facility had previously been			designee/Administrator will be responsible for ongoing		
	interviewing other r				compliance. Results of audits v		
		egations of mistreatment. SSD			be reported to QA x6 months.	/111	
	reported the facility	stopped interviewing other					
	residents as the inte	erviews caused them to worry.			Refer to Exhibit A Bhana Bafar	nco	
	The feeling faile of the	there use a service of f			Refer to Exhibit A-Phone Refere Check Log form	ance a	
	newly hired employ	thoroughly pre-screen 4 of 5					
	newly mied employ					, i	i i i
	A review of the Elin	n Care Vulnerable Adult Abuse					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:22CB1	1	Fa	acility ID: 00492 If contin	Jation shee	et Page 5 of 19

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		AND HUMAN SERVICES			0		1 APPROVEE . 0938-039 ⁻
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DAT	E SURVEY
		245381	B. WING			04	/03/2014
	PROVIDER OR SUPPLIER	ER	1	STREET ADDRESS, CITY, STATE, Z 35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117	IP CODE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULE) BE	(X5) COMPLETION DATE
	Prohibition Policy an November 2011, dir potential employees neglect, or mistreat hiring process. Scre- limited to: Criminal I current licensure sta Verify current regist registry. Reference and/or current empl States Department Services Office of Ir excluded individuals A review of personn date of 11/26/13. No	nd Procedure, last revised rected staff: "Screen all s for a history of abuse, ment of residents during the being will consist of, but not background checks. Verify atus with the licensing board. ry status with the nurse aide checks such as from previous oyers. Inquiries into United of Health and Human hispector Generals' list of and entities."	F 226				
÷	current or former en p.m., E-A's supervis not attempt to obtair current or former en A review of personned date of 1/3/14. No ev	el file for E-B, revealed a hire vidence was found of an o obtain information from		· · ·			· · · · · ·
	date of 1/3/14. No event of the facility to event of former em A review of personned date of 12/18/13. No	el file for E-D, revealed a hire evidence was found of an o obtain information from					
		n. the director of nursing					
OBM CMS-256	7(02-99) Previous Versions O	bsolete Event ID:22CB11	Facil	ity ID: 00492	If continuati	on ohoot	

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		HAND HUMAN SERVICES			FC	TED: 04/23/201 DRM APPROVE NO. 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION) DATE SURVEY COMPLETED
		245381	B. WING_			04/03/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 135 GERANIUM AVENUE EAS SAINT PAUL, MN 55117		······
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE
F 226	document phone c employers for E-A, no form to use to c or former employe	e may have called but did not alls to current or former E-B, E-C and E-D. There was locument contact with current rs.	F 22			
SS=D	a comprehensive,	onduct initially and periodically accurate, standardized sment of each resident's	F 27	2		
	resident assessme by the State. The a least the following: Identification and d Customary routine; Cognitive patterns; Communication;	esident's needs, using the nt instrument (RAI) specified assessment must include at emographic information;				
	Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses areas triggered by t	peing; g and structural problems; and health conditions; hal status; and procedures; ; summary information regarding ssment performed on the care he completion of the Minimum				· · · · · · · · · · · · · · · · · · ·
	Data Set (MDS); ar 7(02-99) Previous Versions		F	acility ID: 00492	If continuation s	heet Page 7;of 1

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		& MEDICAID SERVICES	T		OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245381	B. WING		04/03/2014
NAME OF F	PROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
	RMONY CARE CENT	FB		135 GERANIUM AVENUE EAST	:
				SAINT PAUL, MN 55117	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLÉTIO
E 070		_			
F 272	Continued From pa	-	F 2	72	· · · · · · · · · · · · · · · · · · ·
	Documentation of p	participation in assessment.			
				F272	al la
				It is the interst of NULCO .	5/13/20
				It is the intent of NHCC to co	onduct
				initially and periodically, a comprehensive, accurate,	
		NT is not met as evidenced		standardized reproducible	
	by:	is not met as evidenced		assessment of each resident	'c
		v and document review, the		functional capacity.	
		quately assess the use of an			(1):¥
		e 1 of 5 residents reviewed for		Corrective Plan of Action:	
	antipsychotic usage	e, (N/3).		R73 is no longer in the facili	Ξ γ .
	Findings include:			In-service will be held on 5/	
	-			for staff from all departmen	
٥,		st recent physician orders		regarding non-pharmacolog	I I
		prescribed quetiapine 25 mg		interventions for residents v	14
		mes daily for paranoia and tiapine is an antipsychotic		behavior expressions. In-ser	
	medication.			will be given by Tim McNam	
				licensed psychologist. 13 sta	iff
		nost recent care area		members attended Dr Allen	"
		eted by the nurse manager		Powers "Dementia Beyond E training on 4/17/14.	orugs"
		14 indicated "Pt [patient] has ions. She takes Seroquel		training on 4/1//14.	
		ered. She takes Trazadone at		In-service will also be held for	hr i i
ē.		or insomnia. Will proceed to		licensed staff on 5/13/15 giv	
	care plan." The ass	essment did not address a		consultant pharmacist, revie	
		s paranoia or delusions, what		the importance of accurate	
		ric diagnoses may relate to		assessment and documentat	ion of
		hat triggers these behaviors, we on R73 and others and what		diagnosis, description of beh	
		al interventions have been		with common terminology to	
	effective in managir	ng R73's behavioral		used.	
	symptoms. An anal	ysis of risk versus benefit of			
	treatment by psychol	pactive medication was not			

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245381	B. WING	ì		04/03/2014	
	PROVIDER OR SUPPLIER	ER	.	1	STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 272	area was left blank The Cognitive Loss assessment compl department, dated contributing factor to considered related of paranoia and de related to] short and moderate impairmed dx [diagnosis] of Al- is a progressive dis expected." The Bel assessment compl department, dated concerns, but were hallucinations: "Alt. rejecting care due to diseaseAlso cont she has pain in her agitation." During interview on nurse manager, RN behaviors of hoardi animals, thought st and was recently su	sentative regarding the care Solution of the sentences o	F	272	 Plans to monitor performance be sure solutions are sustained. Behavior/Mood Reviews/Audit. will be done on each resident in facility receiving antipsychotic medications monthly x3 month and quarterly thereafter, using assessment tool. RN Unit Managers/DON will be respons for audit completion. DON will responsible for overall complian Results will be reported to QA > months. Refer to Exhibit B- Assessment Resident Receiving Psychotropic Medication form. 	l: s n s ible be nce. c o f	5/13/20M
F 329 SS=D	adequately address 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy);	EGIMEN IS FREE FROM	F	329	F329 It is the intent of NHCC that ea resident's drug regimen be fre from unnecessary drugs.		

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Event ID:22CB11

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PRINTED: 04/23/2014 FORM APPROVED

CENTE	RS FOR MEDICARE	: & MEDICAID SERVICES				MR NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY MPLETED
		245381	B. WING			04	/03/2014
NAME OF	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	ER			35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessal as diagnosed and o record; and resider drugs receive gradu behavioral interven	se; or in the presence of nces which indicate the dose or discontinued; or any	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" train on 4/17/14.	<u>,</u>	5/113/2014
	by: Based on interview facility failed to ade antipsychotic and c amongst the interdi use of an antipsych reviewed for antipsy Findings include: A review of the mos revealed R73 was p [milligrams] three tii hallucinations. Que medication.	NT is not met as evidenced y and document review, the quately justify the use of an oordinate behavior concerns sciplinary team related to the otic for one 1 of 5 residents ychotic usage, (R73). st recent physician orders prescribed quetiapine 25 mg mes daily for paranoia and tiapine is an antipsychotic n [MD] progress notes, dated			In-service will also be held for licensed staff on 5/13/14, giver consultant pharmacist, review of the importance of accurate assessment and documentation diagnosis, description of behavio with common terminology to be used.	of ors	

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		AND HUMAN SERVICES				FORM	04/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245381	B. WING	Э		04/	03/2014
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	ER		1	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	is not clear if the Se significant relief. Sh hallucinations nor s of late. This certain dose of Seroquel w 1/30/14 revealed "S Seroquel at 25 [mg also helps has help anxiety-inducing ha had over time." The for 10/7/13 stated " and hallucinatory b patient considerabl doing well on 25 m daily]" Notes for 12 provided similar inf note stated "Psyche hallucinatory behav considerable distre effectively on 25 m also be benefiting f of the NP or MD no description of what delusions were, wh caused distress to A review of R73's n assessment comple [RN]-A, dated 2/13/ paranoia and delus [quetiapine] as order HS [hour of sleep] f care plan." The ass description of R73's medical or psychiat these symptoms, w the impact they have	nxiety with depressive affect. It eroquel is continuing to provide the has not been noted to have stated any particular delusion ly occurred before the lower vas started." The MD note for She has done well with] t.i.d. [three times daily]. This bed to stifle episodic dlucinations, which she has a nurse practitioner [NP] notes Psychosis NOS-delusional ehavior that do cause the e distress. She seems to be g of Seroquel BID. [twice 2/23/13, 2/3/14 and 3/3/14 ormation. On 11/4/13, the NP osis NS. Delusional and vior that do cause the patient ss. She is now managed quite g of Seroquel b.id. She may rom pain management." None thes included an actual the hallucinations and en they started or how they R73. nost recent care area eted by the nurse manager (14 indicated "Pt [patient] has ions. She takes Seroquel ered. She takes Trazadone at for insomnia. Will proceed to bessment did not address a s paranoia or delusions, what tric diagnoses may relate to what triggers these behaviors, ve on R73 and others and what al interventions have been		329 Fa	Plans to monitor performance to be sure solutions are sustained: Behavior/Mood reviews/audits of be done on each resident in facion receiving antipsychotic medications, monthly x3 months and quarterly thereafter, using assessment tool. RN Unit Managers/DON will be responsile for audit completion. DON will be responsible for overall complian Results will be reported to QA x0 months. Refer to Exhibit B-Assessment of Resident Receiving Psychotropic Medication form.	will lity s ble ce. 5 f	5-113 (2014 9-11-01-19)

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CENTER	AS FOR MEDICARE	: & MEDICAID SERVICES		Carries or -	U	MD NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245381	B. WING			04/	03/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	ER			35 GERANIUM AVENUE EAST AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa effective in managi symptoms. An ana treatment by psych addressed. The se and/or family/repre area was left blank The Cognitive Loss assessment compl department, dated contributing factor considered related of paranoia and de related to] short an moderate impairmed dx [diagnosis] of Al is a progressive dis expected." The Bel assessment compl department, dated concerns, but were hallucinations: "Alt. rejecting care due diseaseAlso cont she has pain in her agitation." A review of Behavia Record for March a behaviors of increa resistive to activitie restless/pacing, de of sleep. R73 was on 26 days for the	age 11 ng R73's behavioral lysis of risk versus benefit of oactive medication was not ction for input from resident sentative regarding the care s/Dementia care area eted by social services 2/13/14 revealed a potential that should have been to R73's behavioral concerns lusions , " Alt. r/t [altered d long term memory loss and ent with decision making due to zheimer's disease. Alzheimer's sease so continued decline is navioral Symptoms care area eted by social services 2/13/14, revealed behavioral not related to paranoia or r/t resident wandering and to dx of Alzheimer's inue to monitor for pain, as knees which could increase pr/Intervention Monthly Flow and April 2014 indicated target sed agitation, isolating self, s of daily living and cares, lusions and number of hours noted to experience delusions month of March and April 1st		329			
	agitation on 13 day living and cares 21 days for the same progress notes for corresponding des	ted as experiencing increased s, resistive to activities of daily days and restless/pacing 24 time period. Review of the same period revealed criptions of the behaviors: res 11 times, hoarding twice,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

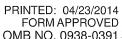
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	OMB NO. 0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245381	B. WING			04/	03/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		4999-9999-9999-9999-9999-9999-9999-999	
NEW HA	RMONY CARE CENT	ER			35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329 F 441 SS=D	note on delusions li usual" with no desc During interview on nurse manager, RN behaviors of hoardi animals, thought st and was recently su not remember who care area assessm behavior monitoring delusions were not During interview on trained medication about R73's delusio in the past R73 wor children in her room stuffed animals. TM complained about s and reported R73 of but instead "adores has taken silverwar thought they were h reported staff were by removing the silv 483.65 INFECTION SPREAD, LINENS	d delusions only once. The sted only "delusions per ription of the usual delusions. 4/3/14 at 10:45 a.m. the J-Y explained R73 had ng, talking to her stuffed aff were taking her belongings uspicious of family as she did they were. RN-Y reviewed ents, progress notes and g forms. RN-A confirmed R73's adequately addressed. 4/3/14 at 12:30 p.m., R73's aide, (TMA)-Y was asked onal behavior. TMA-Y reported uld make comments about n and would talk and tickle her IA-Y reported R73 never seeing children in her room id not fear her stuffed animals them." TMA-Y reported R73 e from the dining room as she her own silverware. TMA-Y able to manage this behavior verware on R73's bath days. I CONTROL, PREVENT	F S	329 141	F441			
du Magi Lugi Nori	safe, sanitary and c to help prevent the of disease and infer (a) Infection Contro The facility must es Program under whi	l Program tablish an Infection Control			It is the intent of NHCC to establi and maintain an Infection Contro Program designed to provide a safe, sanitary and comfortable environment, and to help prever the development and transmissio of disease and infection.	ol it	5/13/2014	

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	13 FUR MEDICARE						. 0300-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY
		245381	B. WING			04/	/03/2014
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		•••
NEW HA	RMONY CARE CENT	ER			5 GERANIUM AVENUE EAST AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what p should be applied t (3) Maintains a rec- actions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d hand washing is ind professional practic (c) Linens Personnel must ha transport linens so infection. This REQUIREMEN by: Based on observa review, the facility f to prevent the spre glucose monitoring	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective ifections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their irect resident contact for which dicated by accepted	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 b 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 fo 3 months. Results of audits will be reported to QA x6 months. Infection Control designee/DON will be responsible for ongoing compliance.	e , ed e	5-[13]2014

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245381	B. WING	i		04/	03/2014
	PROVIDER OR SUPPLIER	ER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	licensed practical n disposable gloves, draw with a multi us R50. LPN-A cleane using an alcohol wi gloves and did not removing the glove again at 5:38 p.m. v RN-D wearing disp blood glucose draw glucose machine o glucometer machin did not wash hands she sanitize her ha Review of the facilit "Blood Glucose Me EPA approved disir manufacturer recor use.	age 14 ion on 3/31/14, @ 4:59 p.m. ourse (LPN)-A wearing completed a blood glucose se blood glucose machine on d the glucometer machine pe, removed the disposable wash hands or sanitize after s. At 5:07 p.m. with R82, and with R103, registered nurse osable gloves, completed a v with a multi use blood n R82, R103 and cleaned the e using an alcohol wipe. RN-D s after removing gloves nor did nds with alcohol gel. ty policy dated 2/24/10, titled ter" directed staff to use an ifectant wipe and to follow the nmendations inbetween multi	F	441			
	minutes before allo to the next resident 5:40 p.m. and ackn of the manufacture of the EPA wipes to machines. When interviewed of ADON verified the be saturated with th	to saturate the machine for 2 wing it to completely dry prior use. RN-D was interviewed at lowledged she was not aware r recommendations for the use disinfect multi use glucometer on 3/31/14, at 5:45 p.m. the multi-use glucometers were to he facility EPA wipes which					
्र स्टब्स् स्टब्स् र	thoroughly dried pri resident. The ADO	or 2 minutes and then or to use with another N verified hands are to be d with alcohol gel when gloves					

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	PROVIDER OR SUPPLIER	ER	E	-	STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa are removed.	ge 15	F	441			
		vations were made during tration in the resident activity or:					
	(LPN)-A was observed document a blood as MAR. LPN-A then of wearing gloves, put pocket reaching for removed one glove wash hands or sani	a.m., licensed practical nurse ved to pick up her pen and sugar number of 101, in the pened the medication cart her gloved right hand in her something. LPN-A then on the right hand, did not tize, left the left glove on and					840.84 840.84 810.70 10.490
	insulin for R103, LF the needle cap with and LPN-A stopped another dose of No	administration of Novolog PN-A was observed to remove her mouth. The needle bent At 8:04 a.m., LPN-A drew volog insulin, with the same nd, and proceeded with sulin to R103.					
	left hand glove, after Sani-cloth for appro- glucometer was pla minutes and then pr LPN-A sanitized han Advair Diskus from administered it. During an interview LPN-A stated she w gloves in between of administering medic sorry." LPN-A indic	was observed to remove her er cleaning the glucometer with eximately 1 minute. The ced on the med cart for a few ut away in the medication cart. nds, removed medication medication cart and on 4/2/14, at 8:23 a.m., vas aware of not changing her shecking the glucometer and cations. LPN-A stated, "I am ated that she normally uses ut was out of gloves and					

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

245381 B. WING 04/03/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NEW HARMONY CARE CENTER 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117 SUMMARY STATEMENT OF DEFICIENCIES		G	A. BUILD	IDENTIFICATION NUMBER:	OF CORRECTION	AND PLAN C
NEW HARMONY CARE CENTER 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117	245381 B. WING 04/03/		B. WING	245381		
	135 GERANIUM AVENUE EAST	135 GERANIUM AVENUE EAST		ĒR		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DA	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE C VITIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE C	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	PREFI	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC	
 F 441 Continued From page 16 should have gotten another pair. LPN-A stated, "1 normally do the Accu checks in their rooms and able to get the gloves in the bath room." LPN-A stated, "1 feel bad because normally 1 have the gloves in my cart and 1 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 with resident cares and that they treat every resident with universal precautions. In addition, DON stated her expectation was "Staff should wear gloves or use hand sanitizer. Staff should dways 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. 	her pair. LPN-A stated, " I tocks in their rooms and he bath room." LPN-A se normally I have the on't know who took it." 2/14, at 1:27 p.m., cleanse the glucometer he used it, and let it dry zart. If she is not sure if will clean it prior to using ever use alcohol wipes. As for the insulin needle ap with my teeth the chance of poking ut of the wrapper and it 3/14, at 10:00 a.m. the h, explained, they do not insulin, but do wear s and that they treat rsal precautions. In expectation was "Staff ake them off when done. I their hands before and use hand sanitizer. Staff before and after per dation." DON further cloth wipes for cleaning ne cleaning they need to The manufacturer states d let it dry for 2 weedure titled: Blood n Pen Disinfection. b; directed "Key Points: bd Glucose Meter on ssure that it has not	1		a another pair. LPN-A stated, " I cu checks in their rooms and ves in the bath room." LPN-A because normally I have the and I don't know who took it." v on 4/2/14, at 1:27 p.m., he did cleanse the glucometer when she used it, and let it dry in her cart. If she is not sure if n, she will clean it prior to using will never use alcohol wipes. Ited, "As for the insulin needle edle cap with my teeth aking the chance of poking took it out of the wrapper and it v on 4/3/14, at 10:00 a.m. the (DON), explained, they do not doing insulin, but do wear at cares and that they treat universal precautions. In ed her expectation was "Staff is and take them off when done. is wash their hands before and ves or use hand sanitizer. Staff meter before and after per mmendation." DON further Sani-cloth wipes for cleaning nen done cleaning they need to tes. "The manufacturer states ean and let it dry for 2	should have gotter normally do the Ac able to get the glov stated, "I feel bad b gloves in my cart a During an interview LPN-A explained s for minutes after, w out for 2 minutes o glucometer is clear in the morning and In addition, she sta caps, I took the new because I am not t myself and I just to is sterile." During an interview director of nursing wear gloves when gloves with resider every resident with addition, DON state should wear gloves Staff should always after taking off glov should clean gluco manufacturer recoil indicated, they use glucometer and wh let it dry for 2 minut that you have to clear minutes." The facility policy a Glucose Meter and Dated, February 24 When you first use your shift, disinfect	F 441

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION		E SURVEY IPLETED
		245381	B. WING			04/	03/2014
NAME OF PROVIDER OR SUF	PLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW HARMONY CARE	CENTE	R			135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
PREFIX (EACH DEFI	CIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
soiled, clean t isopropyl alco proceed to dis below. Blood Glucos are to be disir "3. Apply non- glucose mete the battery co test strip port. the disinfecta Meter (glucon manufacturer viruses and b glucose check Manufacturer cleaning gluco reads, "Health gloves when o Wash hands a blood present suggest clear Policy and pro hand washing "GENERAL IN GUIDELINES contact with b Policy and pro reads, "4. Nor primarily to pr employee's ha services to the contaminated removing glow	bese Me he outs hol or s sinfect f e Mete- ifected sterile r: b. Wi mpartn (If ins nt wipe neter) c s direc acteria) c." manua preter care p cleaning after tal s a pot ing the beedure dated IFECT . 5. We lood or becedure sterile event th ands whe e reside surface res. Gl	ter (glucometer) is visibly side of the meter with either soapy water and then the meter per the procedure r (glucometer) & Insulin Pens after each use." gloves. 5. Disinfect the blood pe the meter down, avoiding nent, code ship port, and the ulin pen, wipe the pen with .) c. Allow the blood Glucose fry (according to tions to mitigate HIV, other before doing the next blood divinstruction regarding MAINTENANCE, undated, rofessionals should wear g the Assure Pro meter. king off gloves. Contact with ential infection risk. We meter between patients." e for hand washing titled June 2000; reads, ION CONTROL ar gloves when coming in	F	141			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		245381	B. WING _		04	/03/2014	
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP	Construction of the Constr		
NEW HA	RMONY CARE CENT	ER		135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	When touching exc body fluids, mucou skin; 4. When hand items; 5. When it i contact with blood,	age 18 cretions, secretions, blood, is membranes or non-intact dling potentially contaminated is likely that hands will come in body fluids, or other potentially . 6. Whenever in doubt."	F 44	11			
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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
	Phone Reference Check Log	
Date:	Applicant Name:	
Name of Company:		
Spoke with:		
Employment Dates:		
Position:	Yes	No

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:	ment:					
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 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?

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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

____, ____

		AND HUMAN SERVICES	Ŧ	h [.]	78 009	FORM	04/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - BLDG 1		E SURVEY PLETED
		245381	B. WING			04/	01/2014
	PROVIDER OR SUPPLIER	ER		13	TREET ADDRESS, CITY, STATE, ZIP CODE 35 GERANIUM AVENUE EAST AINT PAUL, MN 55117		
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	FIRE SAFETY						
5-13-14	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.			K33 A hardship waiver was approve from the last survey. A hardship waiver K 033 is being applied fo	C	
De.	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO	OF AN ACCEPTABLE POC, AN OF Y OUR FACILITY MAY BE VALIDATE THAT MPLIANCE HAS BEEN ORDANCE WITH YOUR			this survey. Refer to exhibit C -Provision #84/form#CMS-2786R $\bigcirc 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0$		
-14	Minnesota Departm time of this survey, was found not in su requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			POLOK K33 WIAW for K33 VR 5-7-14		
EXIT. 43	Chapter 19 Existing PLEASE RETURN CORRECTION FO DEFICIENCIES (K- HEALTHCARE FIR STATE FIRE MARS	g Health Care. THE PLAN OF R THE FIRE SAFETY TAGS) TO: E INSPECTIONS SHAL DIVISION STREET, SUITE 145			RECEIVE MAY - 7 2014 MN DEPT. OF PUBLIC SAF STATE FIRE MARSHAL DIV		
LABORATORY	DIBECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGM	NATURE		TITLE		(X6) DATE
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Any deficience other safegua	y statement ending with a ards provide sufficient pro	an asterisk (*) denotes a deficiency whi tection to the patients. (See instruction	ich the ins s.) Excer	stitution of for	on may be excused from correcting providing i nursing homes, the findings stated above are	disclosal	ble 90 days

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Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excluded non-concerning providing it is detentiated 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES				FORM	D: 04/23/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION 3 01 - BLDG 1	(X3) DA CO	TE SURVEY
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	DEFICIENCY MUS FOLLOWING INFO				Half Ballin		e e e e e e e e e e e e e e e e e e e
- 0- -	to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr	oposed, completion date.					
×	with a partial basen constructed at 2 dif building was constr determined to be of 1976, a 3rd Floor a was determined to .Because the origin meet the construction	e Center is a 4-story building nent. The building was ferent times. The original ucted in 1966 and was Type II(222) construction. In ddition was constructed and be of Type II(222) construction al building and the 1 addition on type allowed for existing y was surveyed as one			385		
	throughout. The fac with smoke detectic open to the corridor is monitored for aut notification. The fac	matic fire sprinkler protected ility has a fire alarm system on in the corridors, spaces s and all sleeping rooms that omatic fire department ility has a capacity of 76 beds f 72 at time of the survey.					ê
K 033	NOT MET as evide	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD	КO	33	3		20 ³ -
OBM CMS-25	67(02-99) Prevlous Verslons	Obsolete Event ID: 22CB2		Fa	acllity ID: 00492 If co	ntinuation sh	eet Page 2 of

Facility ID: 00492

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and the second sec	Based on observat failed to provide an protection required	s not met as evidenced by: ion and interview, the facility d maintain the vertical opening by NFPA 101 - 2000 edition, 8.2.5 .This deficient practice esidents.	-		Estatet Exhibit		
	on 04/01/2014, it wa 1. The basement le elevator machine ro stair enclosure.	vel of the north stair the nom opened directly onto the					
	onto the north stair 4. The first floor an opened directly onto This deficiency was Environment Servic Waiver Recommend	elevator machine room o the central stair enclosure. verified by facility e Director (JB).					
OBM CMS-25	67(02-99) Previous Versions	And a second	1	Fac	L cility ID: 00492 If continua	ation she	et Page 3 of 4

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		AND HUMAN SERVICES	1		RINTED: 04/23/2014 FORM APPROVED MB NO. 0938-0391		
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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 <u>only a suggestion</u> 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,

Are Klegepe

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 New Harmony Care Center April 23, 2014 Page 3

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:	3) DATE SURVE COMPLETED
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	NH LICENSING	CORRECTION ORDER	SER		
		Minnesota Statute, section ction order has been issued		RECHIVEL	2
	pursuant to a surve	ey. If, upon reinspection, it is			
	herein are not corre	ected, a fine for each violation		MAY - 5 2014	
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	the Minnesota Dep	artment of Health.		COMPLIANCE MONITORING DIV LICENSE AND CERTIFICATI	ON
	Determination of w corrected requires	hether a violation has been			
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	that was violated de	uring the initial inspection was			
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	INITIAL COMMEN				
		through April 3, 2014, partment staff visited the		Minnesota Department of Health is documenting the State Licensing	
	above provider and	the following correction		Correction Orders using federal softw	ware.
	orders are issued.			Tag numbers have been assigned to Minnesota state statutes/rules for Nu	rsing
		re completed, please sign and of these orders and return the		Homes.	
	epartment of Health				
30BATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DAT

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	conduct a compreh resident's needs, w capability to perforr significant impairmenursing assessmen Minnesota Statutes	ment. A nursing home must ensive assessment of each hich describes the resident's n daily life functions and ents in functional capacity. A at conducted according to s, section 148.171, subdivision s part of the comprehensive				

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revealed R73 was [milligrams] three ti	prescribed quetiapine 25 mg imes daily for paranoia and				
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Inform comprehensive resident assessme comprehensive resident assessme comprehensive resident and A. medical history; B. medical state C. physical and D. sensory and E. nutritional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental and H. discharge p I. dental conditional s F. special treat G. mental	OF CORRECTION IDENTIFICATION NUMBER: 00492 00492 PROVIDER OR SUPPLIER STREET AI RMONY CARE CENTER 135 GER SAINT P. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 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; K. rehabilitation potential; 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 tor 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	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00492 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST RMONY CARE CENTER 135 GERANIUM AVENU SAINT PAUL, MN 5511 Image: Continued From page 2 2 540 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. 2 540 Subp. 2. Information gathered. 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Findings include: A review of the most recent physician orders revealed R73 was prescribed quetiapine 25 mg [milligrams] three times d	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00492 B. WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RMONY CARE CENTER 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDERSY (EACH DEFICIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDERSY (EACH CORRECTIVE ACT (EACH CORRE	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00492 B. WING 04// PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY 135 GERANIUM AVENUE EAST YEACH DEFICIENCY MUST BE PRECIDED BY FULL ID REQUARTORY OF LSC DIENTIFYING INFORMATION) ID Requirement of DEFICIENCY MUST BE PRECIDED BY FULL PRECINCATION SHOULD BE Continued From page 2 2 540 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 status measurement; D. sensory and Physical impairments; F. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; D. sensory and physical impairments; F. special treatment is not met as evidenced by; M. reguirement 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 for an 1 of 5 residents reviewed for antipsychotic for an 1 of 5 residents reviewed for antipsychotic for an 1 of 5 residents reviewed for antipsychotic for an 1 of 5 residents reviewe

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	[RN]-A, dated 2/13, paranoia and delus [quetiapine] as order HS [hour of sleep] is care plan." The ass description of R73's medical or psychiat these symptoms, we the impact they have non pharmacologic effective in managi symptoms. An ana- treatment by psych addressed. The set and/or family/repre- area was left blank The Cognitive Loss assessment compl department, dated contributing factor is considered related of paranoia and de related to] short an moderate impairmed dx [diagnosis] of Al is a progressive dis expected." The Bel assessment compl department, dated concerns, but were hallucinations: "Alt. rejecting care due is diseaseAlso cont she has pain in her agitation." During interview or nurse manager, RN behaviors of hoard	eted by the nurse manager (14 indicated "Pt [patient] has sions. She takes Seroquel ered. She takes Trazadone at for insomnia. Will proceed to sessment did not address a s paranoia or delusions, what tric diagnoses may relate to what triggers these behaviors, we on R73 and others and what cal interventions have been ng R73's behavioral lysis of risk versus benefit of oactive medication was not ction for input from resident sentative regarding the care s/Dementia care area eted by social services 2/13/14 revealed a potential that should have been to R73's behavioral concerns lusions , " Alt. r/t [altered d long term memory loss and ent with decision making due to zheimer's disease. Alzheimer's sease so continued decline is havioral Symptoms care area eted by social services 2/13/14, revealed behavioral ent related to paranoia or r/t resident wandering and to dx of Alzheimer's inue to monitor for pain, as ' knees which could increase					

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		00492	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
NEW HA	RMONY CARE CENT	FR	ANIUM AVENU AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 540	not remember who care area assessm delusions and use of adequately address SUGGESTED MET The director of nurs monitor to assure s of an antipsychotic	uspicious of family as she did they were. RN-Y reviewed ents. RN-A confirmed R73's of an anti-psychotic were not				
21390	(21) days.	R CORRECTION: Twenty One D Subp. 4 A-I Infection Control	21390			
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service en prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po	and procedures. The infection ust include policies and provide for the following: based on systematic data r nosocomial infections in r detection, investigation, and s of infectious diseases; d precautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		00492	B. WING		04/	04/03/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
NEW HA	RMONY CARE CENT	FR	ANIUM AVENU AUL, MN 5511				
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21390	H. a system for products which affed disinfectants, antis incontinence produ- I. methods for current standards of This MN Requirem by: Based on observat review, the facility for to prevent the spre- glucose monitoring	8.0815; or reviewing antibiotic use; or review and evaluation of ect infection control, such as eptics, gloves, and					
	During an observat licensed practical r disposable gloves, draw with a multi u R50. LPN-A cleane using an alcohol w gloves and did not removing the glove again at 5:38 p.m. RN-D wearing disp blood glucose draw glucose machine o glucometer machin did not wash hands	tion on 3/31/14, @ 4:59 p.m. nurse (LPN)-A wearing completed a blood glucose se blood glucose machine on ed the glucometer machine ipe, removed the disposable wash hands or sanitize after es. At 5:07 p.m. with R82, and with R103, registered nurse posable gloves, completed a w with a multi use blood on R82, R103 and cleaned the ne using an alcohol wipe. RN-D s after removing gloves nor did ands with alcohol gel.					
		ity policy dated 2/24/10, titled eter" directed staff to use an					

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IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	1 .	
IEW HA	RMONY CARE CENT		ANIUM AVENU AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 6	21390			
		nfectant wipe and to follow the mmendations inbetween multi				
	was not aware of the recommendations minutes before alloc to the next residen 5:40 p.m. and ackr of the manufacture	on 3/31/14 at 5:05 p.m., LPN-A he manufacturer to saturate the machine for 2 owing it to completely dry prior t use. RN-D was interviewed at nowledged she was not aware er recommendations for the use o disinfect multi use glucometer				
	ADON verified the be saturated with t contained bleach, t thoroughly dried pr resident. The ADC	on 3/31/14, at 5:45 p.m. the multi-use glucometers were to he facility EPA wipes which for 2 minutes and then for to use with another N verified hands are to be d with alcohol gel when gloves				
		ervations were made during stration in the resident activity por.				
	(LPN)-A was obser document a blood medication adminis then opened the m put her gloved han something. LPN-A	a.m., licensed practical nurse rvered to pick up her pen and sugar number of 101, in the stration record (MAR). LPN-A redication cart, wearing gloves, d in her pocket, reaching for then removed one glove on not wash hands or sanitize, left ad drew up insulin.				
	insulin for R103, Ll	g administration of Novolog PN-A was observed to remove h her mouth. The needle bent				

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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	I	
IEW HA	RMONY CARE CENT	FB	ANIUM AVENU AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21390	Continued From pa	age 7	21390			
	another dose of No	d. At 8:04 a.m., LPN-A drew ovolog insulin, with the same and, and proceeded with in to R103.				
	left hand glove, aft Sani-cloth for appr glucometer was pla minutes and then p LPN-A sanitized ha	A was observed to remove her er cleaning the glucometer with oximately one minute. The aced on the med cart for a few out away in the medication cart ands, removed the medication of medication cart and	1			
	stated she was aw in between checkir administering med sorry." LPN-A indic two pair of gloves b should have gotter normally do the Ac able to get gloves i stated, "I feel bad b	v on 4/2/14 at 8:23 a.m., LPN-A are of not changing her gloves ing the glucometer and ications. LPN-A stated, "I am cated that she normally uses but was out of gloves and in another pair. LPN-A stated, " cu checks in their rooms and in the bathroom." LPN-A because normally I have the and I don't know who took it."				
	LPN-A explained s for minutes after, w for 2 minutes on he glucometer is clear using in the mornir wipes. In addition, needle caps, I took because I am not t	v, on 4/2/14 at 1:27 p.m., he did cleanse the glucometer when she used it, and let it dry er cart. If she is not sure if n, she will clean it prior to ng and will never use alcohol she stated, "As for insulin the needle cap with my teeth aking the chance of poking bok it out of the wrapper and it				
		3/14, at 10:00 a.m., with the (DON), explained they do not				

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21390	wear gloves when a gloves with resident every resident with addition, DON state should wear gloves Staff should always after taking off glov should clean gluco manufacturer recor indicated they use glucometer and wh let it dry for 2 minut that you have to cle minutes." The facility policy a Glucose Meter and dated February 24, "When you first use your shift, disinfect been contaminated Glucose Meter (glu clean the outside o isopropyl alacohol proceed to disinfect below. Blood Glucose Met are to be disinfecter "3. Apply non-steril glucose meter: b. V the battery compar test strip port. (If in the disinfectant wip Meter (glucometer)	doing insulin, but do wear it cares and that they treat universal precautions. In ed her expectation was, "Staff s and take them off when done s wash their hands before and res or use hand sanitizer. Staff meter before and after per mmendation." DON further Sani-cloth wipes for cleaning ien done cleaning they need to tes. "The manufacturer states ean and let it dry for 2 and procedure titled: Blood I Insulin Pen Disinfection, 2010, directed "Key Points": e a Blood Glucose Meter on it to assure that it has not a prior to your using it. If Blood iccometer) is visibly soiled, f the meter with either or soapy water and then it the meter per the procedure er (glucometer) & Insulin Pens ed after each use." e gloves. 5. Disinfect the blood Vipe the meter down, avoiding tment, code ship port, and the sulin pen, wipe the pen with be.) c. Allow the blood Glucose of dry (according to				
	viruses and bacteri glucose check." Manufacturer manu	ections to mitigate HIV, other a) before doing the next blood ual/instruction regarding er MAINTENANCE, undated,				

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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	reads, "Healthcare gloves when cleani Wash hands after t blood presents a por suggest cleaning th Policy and procedu hand washing, date "GENERAL INFEC GUIDELINES. 5. W contact with blood of Policy and procedu reads, "4. Nonsteril primarily to prevent employee's hands of services to the resid contaminated surfa removing gloves. G washing." In additio When touching exc body fluids, mucous skin: 4. When hand item; 5. When it is I contact with blood, infectious material. SUGGESTED MET The director of nurs assure that policies date, staff are traine performed to assur procedures and ma recommendations f monitors, to prevent	professionals should wear ng the Assure Pro meter. aking off gloves. Contact with otential infection risk. We he meter between patients". re for hand washing titled ed June 200, reads, TION CONTROL /ear gloves when coming in or body fluids." re for, Using Gloves, undated, e gloves should be used the contamination of the when provideing treatment or dent and when cleaning .ces. 5. Wash hands after aloves do not replace hand on, "Gloves should be used: retions, secretions, blood, s membranes or non-intact lling potentially contaminated ikely that hands will come in body fluids, or other potentially 6. Whenever in doubt."				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
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21540	Continued From pa	age 10	21540			
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	unnecessary drug u home's policies and pharmacist must re- resident's attending physician does not home's recommen- adequate justification believes the reside adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, t review to the Qualiti (QAA) committee r the attending phys the consulting phar directly to the QAA					
	by: Based on interview facility failed to ade antipsychotic and c amongst the interd use of an antipsych	ent is not met as evidenced and document review, the equately justify the use of an coordinate behavior concerns isciplinary team related to the notic for one 1 of 5 residents ychotic usage, (R73).				
	Findings include:					
	A review of the mo	st recent physician orders				

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NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
NEW HA	RMONY CARE CENT	FR	ANIUM AVENU AUL, MN 5511			
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21540	Continued From pa	age 11	21540			
	[milligrams] three t	prescribed quetiapine 25 mg imes daily for paranoia and etiapine is an antipsychotic				
	9/5/13 revealed: "A is not clear if the S significant relief. SI hallucinations nor s of late. This certain dose of Seroquel w 1/30/14 revealed "S Seroquel at 25 [mg also helps has help anxiety-inducing ha had over time." The for 10/7/13 stated ' and hallucinatory b patient considerable doing well on 25 m daily]" Notes for 12 provided similar inf note stated "Psych hallucinatory behav considerable distret effectively on 25 m also be benefiting for of the NP or MD no description of what	an [MD] progress notes, dated Anxiety with depressive affect. It eroquel is continuing to provide he has not been noted to have stated any particular delusion hly occurred before the lower vas started." The MD note for She has done well with g] t.i.d. [three times daily]. This bed to stifle episodic allucinations, which she has e nurse practitioner [NP] notes "Psychosis NOS-delusional behavior that do cause the le distress. She seems to be ig of Seroquel BID. [twice 2/23/13, 2/3/14 and 3/3/14 formation. On 11/4/13, the NP losis NS. Delusional and vior that do cause the patient ess. She is now managed quite ig of Seroquel b.id. She may from pain management." None otes included an actual t the hallucinations and hen they started or how they R73.				
	assessment compl [RN]-A, dated 2/13 paranoia and delus [quetiapine] as ord HS [hour of sleep]	nost recent care area leted by the nurse manager /14 indicated "Pt [patient] has sions. She takes Seroquel ered. She takes Trazadone at for insomnia. Will proceed to sessment did not address a				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
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JAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
		135 GEB	ANIUM AVENU			
IEW HA	RMONY CARE CENT	FR	AUL, MN 5511			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21540	Continued From pa	ge 12	21540			
	description of R73's	s paranoia or delusions, what				
		ric diagnoses may relate to				
	these symptoms, w	hat triggers these behaviors,				
		e on R73 and others and what	t l			
		al interventions have been				
		ng R73's behavioral				
		ysis of risk versus benefit of				
		oactive medication was not				
		ction for input from resident				
	and/or family/representative regarding the care area was left blank.					
		/Dementia care area				
		eted by social services				
		2/13/14 revealed a potential				
		hat should have been				
	considered related	to R73's behavioral concerns				
	of paranoia and del	usions, " Alt. r/t [altered				
		d long term memory loss and				
		ent with decision making due to				
		zheimer's disease. Alzheimer's	5			
		ease so continued decline is				
		navioral Symptoms care area				
		eted by social services				
		2/13/14, revealed behavioral not related to paranoia or				
	-	r/t resident wandering and				
	rejecting care due t					
		inue to monitor for pain, as				
		knees which could increase				
	agitation."					
		pr/Intervention Monthly Flow				
		nd April 2014 indicated target				
		sed agitation, isolating self,				
		s of daily living and cares,				
		usions and number of hours				
		noted to experience delusions				
		month of March and April 1st				
		ted as experiencing increased s, resistive to activities of daily				
	aultation off to udv					1

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	S, CITY, STATE, ZIP CODE		
IEW HA	RMONY CARE CENT	ER 135 GER	ANIUM AVENU	JE EAST		
		SAINT P/	AUL, MN 5511	7		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	ge 13	21540			
	progress notes for a corresponding desc resistiveness to car wandering twice an note on delusions li usual" with no desc During interview on nurse manager, RN behaviors of hoardi animals, thought st and was recently su not remember who care area assessm behavior monitoring delusions were not During interview on trained medication about R73's delusio in the past R73 woo children in her room stuffed animals. TN complained about s and reported R73 d but instead "adores has taken silverwar thought they were h reported staff were by removing the silv SUGGESTED MET The director of nurs assure policy and p facility staff are train performed to assur- identify, document	ime period. Review of the same period revealed criptions of the behaviors: res 11 times, hoarding twice, d delusions only once. The sted only "delusions per ription of the usual delusions. 4/3/14 at 10:45 a.m. the J-Y explained R73 had ng, talking to her stuffed aff were taking her belongings uspicious of family as she did they were. RN-Y reviewed ents, progress notes and g forms. RN-A confirmed R73's adequately addressed. 4/3/14 at 12:30 p.m., R73's aide, (TMA)-Y was asked onal behavior. TMA-Y reported uld make comments about n and would talk and tickle her MA-Y reported R73 never seeing children in her room lid not fear her stuffed animals them." TMA-Y reported R73 re from the dining room as she her own silverware. TMA-Y able to manage this behavior verware on R73's bath days.				

Minneso	ota Department of He	alth			FURIN	APPROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00492	B. WING		04/0	03/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW HA		FR	NIUM AVEN			
		SAINT PA	UL, MN 551 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21540	Continued From pa	ige 14	21540			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
22000		6.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			
	facility, except hom personal care atten establish and enfor- prevention plan. The assessment of the environment, and it factors which may early and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or rea The plan shall conta assessment of: (1) abuse by other indivi- vulnerable adults; (1) other vulnerable ad specific measures to risk of abuse to that adults. For the purp term "abuse" include (c) If the facility, early and personal care as knows that the vuln violent crime or an toward others, the i	s population identifying encourage or permit abuse, specific measures to be taken a of abuse. The plan shall es governing the plan licensing agency. including a home health care al care attendant services relop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing fults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the				

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		135 GER	ANIUM AVENU	JE EAST		
NEW HA	RMONY CARE CENT	ER SAINT P/	AUL, MN 5511	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 15	22000			
22000	minimize the risk the reasonably be expe- facility and persons unsupervised. Unco of a vulnerable adu misconduct or phy such information fre authority or through another facility, and	hat the vulnerable adult might ected to pose to visitors to the soutside the facility, if der this section, a facility knows lit's history of criminal sical aggression if it receives om a law enforcement in a medical record prepared by other health care provider, or g assessments of the	8			
	by: Based on interview facility failed to con for 1 of 3 residents 67).	ent is not met as evidenced and document review, the duct a thorough investigation reviewed for mistreatment, (R				
	Findings include: The facility failed to allegation of mistre	o thoroughly investigate an atment for R67.				
	agency, dated 3/4/1 reported a nursing him on the forehead He could not remer happened. A review submitted to the sta accompanying inve [statements by NA- investigating social only resident intervi	t Report submitted to the state 14, revealed "Resident assistant named [NA-Z] hit d with the palm of her hand. mber when the incident v of the Investigative Report, ate agency on 3/6/14 and estigative documents -Z, a floor nurse (FN) and the worker (LSW)] revealed the iewed was R67. No other epresentatives in NA-Z's care				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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22000	Continued From pa	age 16	22000			
	concerns regarding interviewed or aske and a FN. No other other staff on the u potential concerns NA-Z.	ewed to identify potential g care. Only two staff were ed to give statements, NA-Z r nursing assistants, nurses or nit were interviewed to identify regarding care provided by				
	reported R67 had e NA-Z at his care co he was hit on the for prior to the care co the day. LSW conf interviewed. LSW or residents was not p for investigating all reported she did not the prior week to d have been on the c	n 4/3/14 at 12:23 p.m., LSW expressed concerns regarding onference. R67 had reported orehead by NA-Z about a week inference but could not recall irmed no other residents were reported interviewing other oart of her normal procedure egations of mistreatment. LSW ot look at NA-Z's schedule for etermine what other staff may unit to interview about R67's erns regarding care provided by lents.	/			
	(SSD) reported the interviewing other r investigations of al reported the facility	b.m. the social service director, a facility had previously been residents as part of legations of mistreatment. SSE of stopped interviewing other terviews caused them to worry.)			
	Prohibition Policy a November 2011, di resident abuse, ne	n Care Vulnerable Adult Abuse and Procedure, last revised irected staff: "1. All reports of glect and injuries of unknown omptly and thoroughly				
		THOD OF CORRECTION: sing and/or designee could				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		00492	B. WING		04/	03/2014
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
EW HA	RMONY CARE CENT	FR	ANIUM AVENU AUL, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
22000	Continued From pa	200 17	22000	DEFICIENC	(Y)	
22000	assure that policies fully trained and the assure thorough re appropriate staff, re	s are followed, that staff are at audits are performed to eports have been written and esidents and family are the process to assure all	22000			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One	•			