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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: I815

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00492

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245381**

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/16/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** 5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 04/28/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 04/28/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 5/3/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/23/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5381

At the time of the standard survey completed February 28, 2013, 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 was given an opportunity to correct before remedies were imposed.

On April 16, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 28, 2013, effective April 8, 2013. Therefore, the remedies outlined in our letter dated March 14, 2013, will not be imposed. See the attached CMS-2567B form for the results of the April 16, 2013 revisit.

The facility's request for a continuing waiver involving the deficiencies cited at K33 is recommended for approval.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5381

April 28, 2013

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 April 8, 2013 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 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K33.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 28, 2013

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

RE: Project Number S5381023

Dear Mr. Carlson:

On March 14, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 28, 2013. 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 April 16, 2013, 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 February 28, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 8, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 28, 2013, effective April 8, 2013 and therefore remedies outlined in our letter to you dated March 14, 2013, will not be imposed.

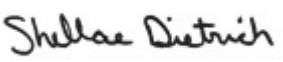
Your request for a continuing waiver involving the deficiency cited under K33 at the time of the February 28, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5381s113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245381	A. Building B. Wing	4/16/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **04/03/2013**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/15/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/08/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/sd	04/28/13	16022	04/16/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/28/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: I815

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00492

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245381**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/28/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 04/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/19/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/23/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5381

At the time of the standard survey completed February 28, 2013, 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 were 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.

The facility's request for a continuing waiver involving the deficiencies cited at K33 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3910

March 14, 2013

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

RE: Project Number S5381023

Dear Mr. Carlson:

On February 28, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss
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 April 9, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 9, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 28, 2013 (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 August 28, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

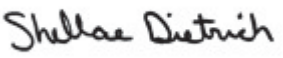
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5381s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING _____ B. WING _____	02/28/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**Disclaimer:** Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the Facility's allegation of compliance.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to make prompt efforts to resolve residents' complaints and to provide a resolution of the complaint for 5 of 5 residents (R10, R44, R69, R78, R93) in the sample who verbalized unresolved complaints. Findings include: R10, R44 complained about disrespectful treatment, staff condescending attitude and missing items. R69 complained about disrespectful treatment. R78 complained of missing items and R44 and R93 were denied an extra bath during the week. All of the individuals	F 166 3/25/13 SER	**F166 RIGHT TO RESOLVE GRIEVANCES** *It is the practice of the facility to resolve grievances the resident may have.* **Corrective action for those residents found to be affected:** Resident #10: concerns noted have been discussed with resident, documented, and addressed on 2/25/13. When social services discussed with patient regarding a staff member addressing patient with a tone of voice that was disrespectful and condescending tone, patient stated that she did not report the incident to a staff member and team reminded her that going forward, these incidents should be reported immediately to her family or a staff member. It was also discussed (and has been discussed) that patient #10 offers her roommate snacks and she does accept.	4/03/2013

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

Executive Director | 3/28/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245381	A. BUILDING _____ B. WING _____	02/28/2013

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NEW HARMONY CARE CENTER	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117

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F 166	Continued From page 1 stated that although their concerns were voiced, the issues had not been resolved. R10 stated in an interview on 2/25/13, at 4:40 p.m. certain staff do not ask how she is, they just come into the room and start giving her orders with a tone of voice that is disrespectful and condescending. R10 used the example of taking a walk with the walker and being told to "hurry up!" R10 talked about filling out a missing items report for snack products her son brought in and reported the situation 2/4/13, and has not heard back yet what type of investigation was completed. R44 stated in an interview on 2/26/13, at 2:02 p.m. he is not sure of the follow up and feels like he got,"The brush off." during the transition to first floor. R44 expressed he would like a second bath in the week and has told staff but has not been scheduled for a second bath. There continues to be concern about liquid creamers that he feels staff took because he stated, "There is no way I could have gone through that many." R44 further expressed having a magnetic bracelet disappear and stated, "I told anybody that would listen." Another concern is when having to wait what seems like a very long time to have the call light answered R44 stated, "Why don't the staff apologize when I have had to wait so long?."R44 does not feel there is a strong follow up in the facility and that no one gets back to him regarding the issues expressed. The most recent example according to R44 is numerous complaints by a variety of residents regarding the microwave in the dining room not working for a couple of weeks. R44 confirmed he knows maintenance was informed about the microwave	F 166	Team recommended that patient's snacks be kept with nursing but patient and her family declined. Moving forward, patient will be notified of end result of missing items form. Resident #44: concerns noted have been discussed with resident, documented, and addressed on 2/27/13 by social services. Grievance Forms have been reinstated and staff training will be completed by April 1, 2013. Grievance forms included follow up with patient and or representative. Resident #69: concerns noted have been discussed with resident, documented, and addressed. Grievance Forms have been reinstated and staff training will be completed by April 1, 2013. RECEIVED MAR 25 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 166	Continued From page 2 and it is another example of a "Brush off." R69 stated in an interview on 2/25/13, at 4:50 p.m. there were problems during a night shift where a staff member told her she was "Stupid!" R69 said she reported the situation to the nurse and the social worker but no one ever got back to her about the outcome. R69 expressed concerns about the tone of voice some staff may use towards her and her roommate. R78 stated in an interview on 2/25/13, at 6:38 p.m. a scissors, shaver, and nail trimmer are all gone. R78 says they took them away and she wants them back because she has always taken care of grooming herself. R78 roommate verified her roommate did have the property and now the situation is not clear cut as to where the items are or what happened to cause staff to take the items. R93 stated in an interview on 2/26/13, at 10:04 a.m. that another bath during the week would be great but when she asked a staff member for a second bath she was told they could only have one bath a week. During an interview on 2/27/13, at 11:00 a.m. the director of social service verified no complaint, grievance or concern forms had been completed this past year since the last survey and there were no logs taken and there was no discussion at Quality Assurance meetings regarding the grievance process. The Missing Items Report forms had been completed for R10. A Grievance Policy and Procedure dated 6/25/01, indicated residents and their families were	F 166	Resident #78: concerns noted have been discussed with resident, documented, and addressed on 2/26/2013. Call was placed to patient's family and they confirmed that patient did not have these items. Family stated that they did not bring in these items and she did not have anyone else that could have done it. Grievance Forms have been reinstated and staff training will be completed by April 1, 2013. Resident #93: concerns noted have been discussed with resident, documented, and addressed on 2/26. Social Services met with patient and she was not willing to give the staff members name. Patient was encouraged to discuss further concerns with a social worker, nursing supervisor, DON or Administrator. **Identification of other residents having the potential to be affected :** Concerns of other residents will be documented on the Resident Grievance form and given to social services for investigation and follow-up. Resident will be updated on outcome of concern.	

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F 166	Continued From page 3 "Encouraged to share concerns to correct or eliminate the problem" at the facility without "Reprisal".	F 166	**Measures put into place or systemic changes made:** To improve responses to concerns brought forth, the facility has reviewed the policy & procedure and it will be implemented. Staff will be educated on the use of the form, expectation of the policy and follow-up of resident concerns by April 1, 2013 Facility will provide follow-up to resident(s) of concerns raised. **Plans to monitor performance to make sure the solutions are sustained:** Audits will be conducted monthly x3 for resolution and follow-up with residents. Audit results, concerns/trends will be reported at QA committee quarterly. Responsible person for ongoing compliance: Becky Holmgren, LSW	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain food temperatures for 7 of 16 residents (R10, R11, R34, R44, R69, R76, R93) reviewed for food quality. Furthermore, the facility failed to date thawed, nutritional supplements according to the manufacturer recommendations affecting approximately 17 of 72 residents at the facility, receiving supplements. Findings include: The following residents were interviewed and expressed complaints regarding cold food and coffee. R10 on 2/25/13, at 4:40 p.m., R11 on 2/25/13, at 6:13 p.m., R34 on 2/26/13, at 9:16 a.m., R44 on 2/26/13, at 2:02 p.m., R69 on 2/25/13, at 4:50 p.m., R76 on 2/27/13, at 8:00 a.m., and R93 on 2/26/13, at 10:04 a.m.. All of the residents expressed they have told the staff their frequent complaints of cold food and coffee. During an observation on 2/27/13, at breakfast	F 364		

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F 364	Continued From page 4 R10 complained of scrambled eggs being cold and requested they be heated in the microwave. Staff attempted to heat in the microwave which did not work at this time. R44 acknowledged numerous complaints by a variety of residents regarding the microwave in the dining room not working off and on for a couple of weeks. R44 confirmed he knows maintenance was informed about the microwave not working right. During an interview on 2/27/13, at 7:15 a.m. with dietary aide (DA1) revealed her observation of the trays on the cart waiting for the staff to pass the meal trays and communicating with each other as soon as the carts containing the meal trays are brought to the unit could be a part of the cold food issue. DA1 confirmed the base and cover for the plates are not heated units in the kitchen but the plates are warmed before the hot food is dished up on to the heated plate. Interview with maintenance (M-A) on 2/27/13 at 11:00 a.m. confirmed he knew the microwave may have had issues with heating but when he tested it there was no problem. M-A again tested the microwave during our interview and found there is a problem which created sporadic issues with the heating mechanism. On 2/28/13 at 12:00 p.m. the dietary staff were preparing lunch trays to be delivered to the 1st floor. A test tray was requested. At 12:15 p.m., the lunch trays were taken to 1st floor and passed out to residents. Four staff were available to pass trays. At 12:30 p.m. when all trays had been	F 364	**F364 Food Temperatures:** Dietary Manager/designee will complete meal audits three times per week, rotating meals and will interview residents to confirm or validate observations and to assess food palatability and temperature. Staff will offer to reheat food if needed and residents will be reminded staff is able to reheat food at meals if needed at resident council meeting. Audits will take place for six weeks or ongoing if not resolved. This will also be reported at the Quarterly Q.A. meeting. Dietary staff were re- trained by the Dietary Manager on order taking and meal /customer service the week of March 3th . Training will be included for new dietary employees and ongoing training for all staff annually.. Dietary Manager will be responsible for ongoing compliance. The microwave, located in the 1st dining area was repaired and tested by the Environmental Services Department on 2/27/13.	3/26/2013

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F 364	Continued From page 5 passed to residents, the dietary aide, (DA-Y) tested the food items on the sample tray. The results were: mashed potatoes 106 degrees Fahrenheit (F), Swedish meatballs 85 degrees F, and cooked carrots 95 degrees F. On 2/28/13 at 12:33 p.m., DA-Y verified the food tempertures were too cold and verified hearing complaints of cold food. A document review of the December 2012, November 2012 and February 2013 Resident Council minutes addressed resident concerns of cold food and coffee without a resolution. NOURISHMENTS On 2/25/13, at 4:20 p.m. observation of the first floor resident nourishment refrigerator had thawed, 5 containers of 4 ounce chocolate shake, 3 containers of 4 ounce and 4 containers of 8 ounce Mighty shake not dated when thawed. The containers read, "Good for 14 days after thawed." On 2/28/13, at 12:00 p.m. observation of the second floor resident nourishment refrigerator had thawed 2 containers of 4 ounce Mighty shake, 2 containers of 4 ounce chocolate shake, 2 containers of 4 ounce vanilla shake, 1 container of 8 ounce Protein energy drink and 7 containers of 4 ounce cranberry juice drinks all not dated when thawed and the statement, "Good for 14 days after thawed," on each container. On 2/28/13, at 12:15 p.m. observation of the third floor resident nourishment refrigerator had thawed, 6 containers of 16 ounce Protein drink, 5 containers of 4 ounce Mighty shake, 8 containers	F 364		

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F 364	Continued From page 6 of 8 ounce Mighty Plus drink, 2 containers of 4 ounce chocolate shake, 1 container of 4 ounce vanilla shake all not dated when thawed and the statement, "Good for 14 days after thawed", on each container. Interview with the dietary supervisor on 2/27/13, at 3 p.m. verified the containers of supplement needed to be dated when thawed according to the manufacturer recommendations on the containers. The facility did not have a document directing staff to date the frozen nourishments when thawed.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement cooling procedures for precooked foods which had the potential to affect approximately 71 of 72 residents residing in the facility. Findings include: During the initial kitchen tour on 2/25/13 at 12:35	F 371	**F371 Food Bourne Illness:** A policy on *Supplements* was written by the corporate dietitians on 3/13/13. Dietary staff were in-serviced by the Dietary Manager on this policy on 3/ 14 /13. Dietary staff has been re-trained the week of 3/03/13 by dietary manager on the food preparation and service policy which includes proper cooling of foods & use of the cooling log. The Dietary Manager/designee will complete audits weekly for six weeks to ensure proper use of the cooling log and proper thawing, dating & delivery of supplements is being done. The Supplement Audits will be conducted on an ongoing basis following the six week period. This will also be reported at the Quarterly QA meeting. The Dietary Manger will be responsible for ongoing compliance.	3/15/2013

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F 371	Continued From page 7 p.m. a roaster was observed in the large oven. The head cook-A (Cook-A) reported a beef roast was cooking in the oven and indicated the roast was to be served the next day at the evening meal. At 5:30 p.m. the roast beef was observed in the refrigerater and was removed to have the temperature was taken. The temperature taken by dietary aid (DA-D) was 85 degrees. DA-D indicated not being aware when the roast beef was removed from the oven, but indicated Cook -A left for the day at 2:30 p.m. At 6:30 p.m., the dietary manager (DM) removed the roast beef from the refrigerator and took the temperature in two different areas of the roast beef. Temperatures were 66 and 72 degrees in two different areas of the roast. The DM reported not knowing when the roast was removed from the oven and indicated the temperature should be 41 degrees within four hours of cooling. On 2/26/13 at approximately 10:00 a.m. the DM indicated staff were to use a form that identified when to temperature foods when cooling, however, it did not get used on the 25th. The DM also reported the roast beef was disposed of, and removed from the menu. A substitute had been put in place. A policy for cooling foods was requested but not provided.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	**F 441 INFECTION CONTROL** It is the intent of NHCC to provide an infection control program that investigates, controls, and prevents infections in the facility. The facility decides what procedures such as isolation should be applied to an individual resident and maintains a record of incidents and corrective actions related to infections.	4/08/2013

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F 441	Continued From page 8 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a system to monitor, track and trend infections, experienced by staff and residents, at the facility in a timely fashion. This had the potential to affect all 72 residents at the facility. The facility also failed to	F 441	**Corrective action for those affected and/or having the potential to be affected:** Monthly Nosocomial Infection Reports have been modified to include which "team" the resident with infections resides on. Resident infections and symptoms will be monitored for tracking and trends in a timely fashion. **Plans to monitor performance to make sure the solutions are sustained :**Audits of Nosocomial infection Reports will be completed monthly for 3 months. Resident Infection tracking and trending will be reported at Quality Assurance committee meeting quarterly. Infection Control Designee/DON will be responsible for ongoing compliance. ***Maintaining a system to monitor and potentially contagious infections experienced by employees:*** An employee infection control tracking form has been initiated beginning 4/01/2013. Supervisor/Department Manager will be responsible for completion of the form at the time the employee calls to report illness with information the employee gives. Infection control designee/DON will be responsible for reviewing the tracking	

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F 441	Continued From page 9 have clean call lights and light pull cords for 9 of 13, rooms 125, 224, 241, 313, 317, 325, 327, 332 and 334 resident rooms reviewed Findings include: The facility failed to develop a system to monitor and track potentially contagious infections experienced by facility staff. The policy on tracking potentially contagious infections of staff was requested from the DON on 2/28/13. DON provided a Policy on Excessive Absences, dated May 1st 2002. The policy did not provide guidance on tracking potentially contagious infections experienced by staff. The facility failed to maintain a system to monitor, track and trend infections experienced by residents at the facility in a timely fashion. During an interview on 2/28/13, at 10:03 a.m., the DON reported she had not completed her Monthly Nosocomial Infection Report logs for the months of January and February. The DON explained she typically completed the previous month's logs at the beginning of the next month, after getting reports from the pharmacy and lab service. Nosocomial infections are those acquired at a health care facility. The DON explained she looked at the 24 hour reports and entries of infections on the computerized medical record system on a daily basis. However, she did not record in a way that would track or trend them on a daily basis. When asked how she would track and trend current infections at the facility, DON stated "because I am the nursing director and at	F 441	form to determine if a potentially contagious infection is being experienced by staff members. Information regarding the importance of reporting the type of illness experienced by staff to Supervisor/Department Manager will be given to all employees via paycheck insert and employee posting on 3/28/13. This information was also discussed with our union representatives UFCW Local 1189 regarding the importance of illness reporting on 3/20/13. **Plans to monitor performance to make sure the solutions are sustained:** Audits of Employee Infection Control tracking forms will be completed monthly for 3 months. Infection tracking and trending will be reported at the Quarterly Quality Assurance committee quarterly. Infection Control designee/DON will be responsible for ongoing compliance.	

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F 441	Continued From page 10	F 441		

Medicare conferences I would notice if it happened. We would respond. I am here everyday. I would know if two or three people had the flu or diarrhea on one unit. My nurses would know that. There would be a trend. We would know because we are nurses." DON reported she had not noticed any patterns or trends of infections and had no outbreaks for the past year. She reported there were a lot of urinary tract infections, but believed those were from residents not voiding all of their urine from their bladder. The DON reported she would complete the logs for January and February that day.

The logs entitled, Monthly Nosocomial Infection Report, for January and February, completed after the interview with DON on 2/28/13, were reviewed, after receipt on 2/28/13, at 12:53 p.m. Nosocomial infections are those acquired at a health care facility. During January, six urinary tract infections, two respiratory infections and one skin infection were noted. During February, four urinary tract infections, one gastrointestinal and one skin infection was noted. It was not clear which unit or group the residents with infections resided on, as this was not noted on the Monthly Nosocomial Infection Report.

The Monitoring Infections In Resident Population policy, undated, directed staff "1. The Infection Control Coordinator is to monitor reports of infection and record on infection log. 2. Monthly and quarterly Infection Control reports to show the number of incidents of each infection category, and monthly rate of infections. This information is compiled and reported at QA." QA stands for quality assurance committee.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 During interview on 2/28/13, at 10:03 a.m. the director of nursing (DON) reported she had no system to track potentially contagious infections experienced by facility staff. The facility had no system of correlating potentially contagious infections of facility staff with resident infections. The DON reported she was tracking employee absences individually for each employee, for the purposes of attendance tracking, but not tracking staff infections on a facility basis. Call lights and pull cords: The facility failed to maintain cleanable surfaces for call light buttons for seven of thirteen resident rooms reviewed rooms: 125, 224, 241, 313, 325, 327 and 332. Observation on 2/28/13 between the hours of 8 a.m., and 1:30 p.m. revealed call light buttons in rooms 125, 224, 241, 313, 325, 327 and 332 had orange tape, fraying and with brown patches. During an interview on 2/28/13 at 10:19 a.m. with the DON, she explained the tape had been put there as a reminder for residents to use the call light and prevent falls. The DON verified the tape was not a cleanable surface. During an interview on 2/28/13 at 11:21 a.m., the director of maintenance, verified the call lights should be cleaned with chemical disinfectant and the tape changed if frayed, when a new resident is admitted to the room. The facility failed to maintain clean overbed light cords for five of thirteen resident rooms, rooms:	F 441	***Maintaining cleanable surfaces for call light buttons and overbed light cords:*** **Corrective action for those resident found to be affected:** Rooms: 224, 241, 313, 325, 327, & 332 – orange tape has been removed from call light buttons in all resident rooms and have been sanitized on 3/08/13. Rooms: 125, 241, 317, 332, 334 – Over bed light cords that are soiled have been replaced. All over bed light cords will be replaced with a cleanable product by 4/08/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING _____ B. WING _____	02/28/2013

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NEW HARMONY CARE CENTER	135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117

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F 441	Continued From page 12 125, 241, 317, 332 and 334. During an observation on 2/28/13, between the hours of 8a.m., and 1:30 p.m., rooms 125, 241, 317, 332 and 334 revealed white cloth cords with patches of brown stains used to turn the overhead lights on and off, above the resident beds. During an interview on 2/28/13 at 10:19 a.m. the DON verified cloth cords were not a cleanable surface. During an interview on 2/28/13, at 11:21 a.m., the director of maintenance, verified the cloth cords should be cleaned with a chemical disinfectant. The policy, Housekeepers Procedure for Daily Cleaning Rooms, undated, does not have directions for cleaning call lights or cloth cords for turning on and off overhead lights. The policy, Housekeeping Department Policies, undated, directed staff: "damp wipe curtain rod, fixtures, shelves and ledges with a germicidal solution." The policy Procedure for Cleaning Room When Patient is Discharged, undated, did not include directions for removing frayed tape from resident call light buttons.	F 441	**Measures put into place or systemic changes made** The policies: *Housekeepers Procedure for daily cleaning rooms; Housekeeping Department Policies; Procedure for cleaning room where a Patient is Discharged will be consolidated and updated by 3/28/13.The procedures will include the cleaning of the call light cords/buttons and pull cords.* Housekeeping staff will be in-serviced on the revised policy/procedures by 4/01/13. Room audits will be completed on call lights and over bed light cords monthly for 3 months to ensure compliance. Designee/Environmental services Director will be responsible for ongoing compliance.	

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

F 538102Z

PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING 01 - BLDG 1 B. WING _____	02/26/2013

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

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K 000	INITIAL COMMENTS Fire Safety THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on February 26, 2013. At the time of this survey, New Harmony Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	 POC ok w/ AW for K33, that was also accepted on 6-29-12 by CMS. PS 4-8-13 K84- CMS Form-2786R Hardship Waiver Renewal. Waiver Request for K033 has been sent to Health Care Fire Inspections - State Fire Marshal Division (Attached)	3/22/2013

DC: 04.09.2013
02.28.2013
EXIT:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Mader	Administrator	3/22/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING **01 - BLDG 1** B. WING _____	**02/26/2013**

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

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and, Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. New Harmony Care Center is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(222) construction. In 1978, a 3rd Floor addition was constructed and was determined to be of Type II(222) construction .Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 72 at time of the survey.	K 000		

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	245381	A. BUILDING **01 - BLDG 1** B. WING _____	**02/26/2013**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101-2000 edition, Sections 19.3.1.1, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.3.2.1 (d), and 7.2.2.5. This deficient practice could affect all 72 residents. Findings include: On facility tour between the hours of 9:30 AM and 12:30 PM on 02/26/2013, 1. It was observed that on the basement level of the north stair the elevator machine room opened directly onto the stair enclosure. 2. It was observed that on the first floor a storage room opened directly onto the north stair enclosure. 3. It was observed that on the first floor an elevator machine room opened directly onto the	K 033	Annual Waiver	

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K 033	Continued From page 3 central stair enclosure.	K 033		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, April 08, 2013 3:39 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Linhoff, Tom (DPS); Queen, Kerry (DPS); 'tcarlson@elimcare.org'
Subject: New Harmony Care Center (245381) K33 Annual Waiver Request

This is to inform you that New Harmony CC is requesting an annual waiver for K33, door openings from elevator rooms and a storage room into exit stair enclosures. The exit date was 2-28-13.

I am recommending that CMS approve this waiver request since this waiver item was first cited during a Fire Safety FMS, and subsequently approved by CMS. K33 was the only fire safety deficiency cited during the 2-28-13 fire inspection.

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

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

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

Surveyor *(Signature)*	Title	Office	Date
Fire ~~Authority~~ Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 4-8-13