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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: UM6Q

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 **06/02/2016** (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)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (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):
Facility's request for a continuing waiver involving K033 is recommended.

17. SURVEYOR SIGNATURE — Date :
Sheryl Reed, HFE NE II — 06/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/12/2016
(L33)

Posted 06/24/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245381
June 20, 2016

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective May 5, 2016 the above facility is certified for or recommended 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 K033 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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 these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare/Medicaid 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2016

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

RE: Project Number S5381026

Dear Mr. Carlson:

On April 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 14, 2016 that included an investigation of complaint number S5381026. 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 June 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 3, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 5, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 14, 2016, effective May 5, 2016 and therefore remedies outlined in our letter to you dated April 22, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K033 at the time of the April 14, 2016 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245381 Y1	A. Building B. Wing Y2	6/2/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0166	Correction	ID Prefix F0280	Correction	ID Prefix F0329	Correction
Reg. # 483.10(f)(2)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(l)	Completed
LSC	05/05/2016	LSC	05/05/2016	LSC	05/05/2016
ID Prefix F0428	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	05/05/2016	LSC	05/05/2016	LSC	05/05/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 06/20/2016	SIGNATURE OF SURVEYOR 22581	DATE 06/02/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245381	A. Building 01 - BLDG 1 B. Wing	5/3/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/18/2016	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
STATE AGENCY ☐	SR/KJ	06/20/2016	22581	05/03/2016
CMS RO ☐			TITLE	

FOLLOWUP TO SURVEY COMPLETED ON	
4/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2016

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

Re: Reinspection Results - Project Number S5381026

Dear Mr. Carlson:

On June 2, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 2, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00492 Y1	A. Building B. Wing Y2	6/2/2016 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20570	Correction	ID Prefix	21375	Correction	ID Prefix	21426	Correction
Reg. #	MN Rule 4658.0405 Subp. 4	Completed	Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed
LSC		05/05/2016	LSC		05/05/2016	LSC		05/05/2016
ID Prefix	21535	Correction	ID Prefix	21540	Correction	ID Prefix	21620	Correction
Reg. #	MN Rule4658.1315 Subp.1 ABCD	Completed	Reg. #	MN Rule 4658.1315 Subp. 2	Completed	Reg. #	MN Rule 4658.1345	Completed
LSC		05/05/2016	LSC		05/05/2016	LSC		05/05/2016
ID Prefix	21880	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 144.651 Subd. 20	Completed	Reg. #		Completed	Reg. #		Completed
LSC		05/05/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 06/20/2016	SIGNATURE OF SURVEYOR 22581	DATE 06/02/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: UM6Q

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 **04/14/2016** (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
X 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: **B*** (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):

Facility's request for a continuing waiver involving K033 is recommended.

17. SURVEYOR SIGNATURE — Date :
Cynthia Wentkiewicz, HFE NE II 05/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/09/2016 (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 05/12/2016 Co.

AW requested for K33 Email notification to CMS 05/12/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 22, 2016

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

RE: Project Number S5381026

Dear Mr. Carlson:

On April 14, 2016, 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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 24, 2016, 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 May 24, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 14, 2016 (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 14, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING _____ B. WING _____	04/14/2016

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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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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		
F 166 SS=D	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 ensure that prompt efforts were made to resolve resident grievances for 2 of 2 residents (R82, R39) who expressed concerns. Findings include: During an interview on 4/12/16 at 10:14 a.m., R39 complained a certain department head had placed restrictions on the level of speed for the electric scooter which R39 used to transport around the facility. R39 said the department head restricted the scooter to a level one which was	F 166	F 166- Facility policy has been reviewed by administrator with management/disciplinary team. Complaint/Grievance forms are placed in wall sleeves in common area on each floor for easy access. All staff in-services regarding policy and the complaint/grievance process will be conducted on/before May 5th. Residents were informed of the complaint/grievance process and informed on how to obtain a grievance form by the social worker at the	5/5/16

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

Electronically Signed | 05/02/2016

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F 166	Continued From page 1 the lowest speed but therapy had cleared R39 to be able to use discretion with all three speeds of the scooter. R39 expressed being intimidated by the department head who was "harassing" R39 about the speed. R39 did not know who to turn to for help in resolving the situation. R39 was not aware of the facility concern/grievance procedure. R39 insisted on demonstrating for the surveyor the safe use of the scooter. R39 demonstrated in the bedroom the ability to maneuver the scooter, and in the hallway, R39 demonstrated the use of the three levels of the scooter. Document review of the form titled, Occupational Therapy, read, "OT screened resident 11/27/15, for safety and independence with scooter. Resident able to safely maneuver way to dining room table, throughout hallways and in room. Resident demo' d [demonstrated] I [independent] with turning on/off scooter and choosing appropriate speed. Resident safe to use scooter I'ly [independently] at this time." During an interview on 4/12/16, at 1:53 p.m. R82 expressed concerns of being bossed around by some of the staff and a major concern that the food in the evening shift is often cold and no one seems to do anything about it. R82 was not familiar with a concern/grievance process at the facility. During an interview with the full time registered nurse (RN)-B, revealed not being aware of the grievance concern process, not aware of forms to use, not aware of how to locate a form and thought social service took care of resident concerns.	F 166	Resident Council meeting held on 4/18/2016. The administrator also informed the residents of the Grievance/Complaint procedure at an all resident activity held on 4/29/16. The complaint/grievance process also will be reviewed at future monthly resident council meetings. Administrator policy, All staff policy and Complaint/Grievance form attached. Administrator will be responsible. R39 was re-evaluated by OT on the use of the scooter following State interview. For safety of others, a new agreement on the use of the scooter was made between R39 and the OT. RT39 agreed to the terms of use and signed the agreement. The dietary manager followed up with R82 regarding cold food customer service at supper meals. The most recent follow up with R82 was made by the Dietary manager on 5-2-2016.	

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F 166	Continued From page 2 A review of the facility policy dated 4/04 and titled, Grievance Policy and Procedure, read; "If at anytime you feel you are not being treated fairly, an employee has mistreated you in any way, or if you have a complaint about any aspect of service or care in the facility, you or a family or any concerned person are encouraged to take the following steps to correct or eliminate the problem." Step 3) Grievances will be documented in a Grievance Log or file located in the social work office. Written responses to written grievances will be sent within 7 days of receipt and will outline the steps being taken to correct or eliminate the problem." When interviewed, on 4/13/16 at 1:00 p.m., the director of social services (DSS) and the director of nursing (DON) verified there was no documentation of resident concerns/grievances and the facility had stopped the process since mid 2015.	F 166		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		5/5/16

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F 280	Continued From page 3 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 1 resident (R46) to require a mechanical lift for all transfers. Findings include: During an observation on 4/13/16 at 6:56 p.m., R46 was transferred using the total lift mechanical device. Family member (F)-A expressed R46 was supposed to pivot transfer but no one was assisting to coordinate the pivot transfers. F-A and R46 expressed a desire to go back home once R46 is able to pivot transfer. F-A expressed talking with the staff on numerous occasions as to why a pivot transfer was not attempted for R46. Document review of the revised plan of care dated 4/2/16, listed a diagnosis of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left non-dominant side. The plan of care for transfers, the approach read; "Assist with transfers per need. Assistive device per PT recommendation: currently Hoyer and 2 staff- (8-13-15) has progressed to max assist of 2 pivot to Rt side (Lt sided weakness) for transfers. 9/4/15 pivot with assist 1-2 per need. Hoyer prn [whenever	F 280	F280: It is the intent of New Harmony Care Center to develop and maintain a current comprehensive plan of care for all residents. R46 care plan has been revised to reflect current interventions. R46 care plan has been revised to reflect the plan of care for transfers to a total lift transfer. Licensed nursing staff will receive re-education regarding revising and updating of the care plan by 5/4/16. DNS/Designee will audit 2 care plans each week x1 month for current interventions and then 1 care plan each week x2 months. The data will be shared at the next Quality Assurance meeting by the DNS/Designee for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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F 280	Continued From page 4 necessary] Document review of the form titled, Resident Care Information List, directed staff to assist 2 pivot. Document review of the physical therapy assessment dated 1/6/16, read, "Hoyer lift with nursing staff." During an interview with the full time registered nurse RN-B on 4/13/16 at 1:00 p.m., verified R46 was not able to pivot transfer and was to be a total mechanical lift. During an interview with the director of nursing (DON) on 4/15/16 at 11:00 a.m.,the DON verified the plan of care and Resident Care Information List were not accurate, and indicated both would be updated to direct staff that R46 is a Hoyer transfer. Furthermore, the DON verified the F-A and R46 would be included in the update to the plan of care.	F 280		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		5/5/16

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F 329	Continued From page 5 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure 4 of 4 residents (R15, R1, R23, and R73) receiving antipsychotic medications had orthostatic blood pressures monitored and did not ensure 1 of 2 residents (R73) who received an as needed antipsychotic medication, received non-pharmacological interventions prior to medication use. Findings include: R15 was not monitored for changes in orthostatic blood pressure due to antipsychotic medication use. On 4/13/16, at 12:50 p.m., R15 was observed to be awake, seated in the wheelchair in her room. When approached and interviewed regarding the medication, Seroquel, R15 indicated she did not notice or experience any side effects from the medication. R15 was observed to be relaxed with no behaviors. R15's face sheet with admit date 9/6/12, R15 had diagnoses which included legal blindness, anxiety disorder and dementia with behavioral disturbance. Furthermore, R15 had an order for	F 329	F329: It is the intent of New Harmony Care Center that residents drug regimen be free from unnecessary drugs. R15, R1, R23, R73, care plans have been revised to include monitoring for adverse consequences of antipsychotic drug therapy, along with specific indication for the use of antipsychotic medications to be documented. Nursing staff are to document the use of non-pharmacological interventions prior to antipsychotic medication administration. Policy has been revised to reflect that orthostatic blood pressures will be done weekly with new orders and or medication increase for 1 month and monthly thereafter for Residents on antipsychotic medications. Nursing staff will receive re-education regarding unnecessary antipsychotic medication use. Antipsychotic medication administration policy will be reviewed by 5/4/16. DNS/Designee will audit medication administration records of residents receiving antipsychotic medication therapy weekly for 2 months and monthly for 1 month for compliance with completion of orthostatic blood	

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F 329	Continued From page 6 Seroquel 25 mg by mouth three times a day, which was started on 9/6/12. R15's Minimum Data Set (MDS) dated 3/14/16, indicated R15 had an antipsychotic medication (Seroquel) X 7 days within the last 7 days Assessment Reference Date (ARD) period. R15's care plan dated 4/8/16, identified, "... Family reports conversations of delusional/paranoid content with resident: res [resident] stating going to dentist and falling etc: things that have not happened, dreams, feeling unsafe etc. Seroquel and Xanax used as ordered and reported helpful. Seroquel increase on 11/27/13... Keep MD updated on effectiveness or non-effectiveness. Report any adverse s/e's [side effects] noted." However, R15's medical record lacked documentation of monthly orthostatic blood pressure monitoring. The MAR (Medication Administration Record) for January 2016, February 2016, March 2016 and April 2016, indicated R15 received Seroquel 25 mg by mouth three times a day. MAR for April 2016 indicated R15 had diagnosis of delusions, hallucinations and decreased appetite. On 4/14/16, at 9:13 a.m. registered nurse (RN)-A verified R15's medical record lacked documentation of monthly orthostatic blood pressure monitoring at least in the last 6 months and stated, "My expectation is we will report refusal to nurse practitioner or medical doctor if resident refuses monthly orthostatic blood pressure monitoring." At 10:41 a.m. RN-A added, "I cannot find any physician order that indicated discontinuation of monthly orthostatic blood pressure."	F 329	pressures and documentation of interventions attempted prior to antipsychotic medication administration. The data will be shared at the next Quality Assurance meeting by the DNS/Designee for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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F 329	Continued From page 7 On 4/14/16, at 9:16 a.m. director of nursing indicated, the staff was supposed to monitor monthly orthostatic blood pressure for any resident receiving antipsychotic medication if the resident is cooperative and able to stand. On 4/14/16 at 11:21 a.m. the consultant pharmacist (PC) stated, monthly orthostatic blood pressure monitoring is included in the side effect monitoring and is part of ongoing assessment, there is no reason why he should make a recommendation. In addition, PC indicated, his expectation is facility staff should monitor orthostatic blood pressure monthly. R1's medical record lacked documentation of monthly orthostatic blood pressures. R1 was admitted to the facility on 1/12/15, with diagnoses of bipolar disorder, anxiety disorder, generalized anxiety disorder, and personality disorder. The physician orders dated 4/1/16 - 4/30/16 included Seroquel (antipsychotic medication), 100 milligrams (mg) tablet once a day for bipolar disorder, and Seroquel (antipsychotic medication), 75 mg at bedtime. The care plan dated 4/12/16, indicated R1, psychotropic drugs with diagnosis of bipolar disorder, depression, anxiety and received Seroquel (antipsychotic medication), Paxil (antidepressant medication), and Klonopin (antianxiety medication). The care plan dated 4/6/16, indicated R1 was at risk for falls, related to weakness, unsteadiness, anxiety, psychotropic, diuretic and	F 329		

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F 329	Continued From page 8	F 329		

antihypertensive drug use. R1 required assist with all cares, mobility, and E-Z stand transfers as needed (prn).

On 4/13/16, at 1:53 p.m. licensed practical nurse (LPN)-B stated she does weekly blood pressure monitoring but does not monitor orthostatic blood pressures.

On 4/14/16, at 12:18 p.m. director of nursing (DON) stated she expected staff to be monitoring blood pressures for residents taking psychotropic meds.

R23 was not monitored for possible changes in orthostatic blood pressure due to antipsychotic medication use.

R23 was admitted to the facility on 9/22/14 and R23's quarterly Minimum Data Set (MDS) included diagnoses of dementia, depression, and psychotic disorder.

The physician orders dated 4/1/16 - 4/30/16, included Risperidone (antipsychotic medication) 0.5 mg once a day.

The Care Plan dated 4/12/16, indicated R23 received Effexor (antidepressant medication) for depressive disorder and Risperidone (antipsychotic medication) for dementia, psychosis and paranoia.

The care plan dated 4/6/16 indicated R23 required standby assist with transfers and ambulation, use of rolling walker, and supervision of one with mobility, is fall risk for due to weakness, confusion, and dependence on staff for mobility safety.

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F 329	Continued From page 9 Review of R23's medical record lacked documentation of monthly orthostatic blood pressures. On 4/13/16, at 1:53 p.m. licensed practical nurse (LPN)-B stated she does weekly blood pressure monitoring but does not monitor orthostatic blood pressures. On 4/14/16, at 12:18 p.m. director of nursing (DON) stated she expected staff to be monitoring blood pressures for residents taking psychotropic meds. R73 was not monitored for possible changes in orthostatic blood pressure due to antipsychotic medication use. Review of R73's record indicated R73 was admitted on 11/26/14 with diagnosis including dementia without behavioral disturbances, unspecified dementia with behavior disturbances, and essential hypertension (high blood pressure). Review of R73's record indicated Physician orders for Seroquel (an antipsychotic medication) 25 miligrams (mg) twice a day and 50 mg once a day, and 50 mg once a day as needed (prn). Review of R73's record including Medication Administration Record (MAR), Behavior/Intervention Monthly Flow Sheet, and Treatment Record for January 2016, February 2016, March 2016, and April 2016, lacked any monitoring of orthostatic blood pressure. Review of R73's plan of care indicated "resident is at risk for falls."	F 329		

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Interview with the Director of Nursing (DON) on 4/14/16 at 11:30 a.m., she stated it is in the policy and the staff should be completing the orthostatic blood pressures on any resident who receives an antipsychotic medication, and verified orthostatic blood pressures were not being checked on those residents.

Review of the undated "Antipsychotic Medication Protocol Statement of House Policy" directed the following handwritten statement: "In addition, residents recieving (sic) antipsychotic drug therapy will have orthostatic blood pressure checks done daily for 1 week with new orders and or medication increase then monthly thereafter."

R73 received as needed (prn) antipsychotic medication without documentation of non-pharmacological interventions.

Review of R73's January and March's MAR indicated R73 received a prn dose of Seroquel on 1/10/16, 1/29/16, 3/16/16 and 3/17/16 without any documentation of any non-pharmacological intervention attempts. Review of R73's January and March's Behavior/Intervention Monthly Flow Record for those dates lacked any documentation of any non-pharmacological interventions attempted prior to administration of the antipsychotic medication. Review of the Resident Progress notes for 1/10/16 at 21:40 indicated "PRN Quetiapine (Seroquel) was given for agitation @1515. some what helped." No indication non-pharmacological interventions were attempted.
Review of the Resident Progress Notes for 3/16/16 and 3/17/16 lacked any documentation of the use of the prn Seroquel, or any non-pharmacological interventions before the use

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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 329	Continued From page 11 of Seroquel. Interview with Registered Nurse (RN)-C on 4/14/16 indicated non-pharmacological interventions should be tried before the use of the prn anti-psychotic and verified it was not always being completed. Review of New Harmony Care Center undated policy titled "Antipsychotic Medication Protocol Statement of House Policy" indicated the following : It is the policy of this facility to encourage multidisciplinary efforts to identify factors responsible for changes in a resident's behavior and to encourage consideration of alternate (non-drug) means of treating those factors.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the pharmacy consultant recommendations for 1 of 2 residents (R73) who received an as needed (prn) antipsychotic	F 428	F428: Failure to follow Pharmacy Consultant Recommendations It is the intent of New Harmony Care Center that residents□ drug regimen be	5/5/16

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F 428	Continued From page 12 medication. Findings include: R73's admitting diagnosis included dementia with behavioral disturbances, and essential hypertension (high blood pressure). R73's Physician Order Report dated 4/1/46 - 4/30/16, included, Seroquel [an antipsychotic medication] 50 mg [milligrams] oral once a day prn for agitation/paranoia/anxiety. R89's record included the "Consultant Pharmacist Communication to Nursing," dated 12/15/15, included the pharmacists recommendations of updating charting/monitoring to document failures of non drug interventions before prn psychotropic's are used, as he was unable to locate consistent evidence that non-drug interventions were tried prior to prn medication use. Review of R73's January, February, and March 2016 Medication Administration Record (MAR), indicated R73 had been administered the prn Seroquel 4 times with no documentation of non-drug interventions attempted prior to the use of the medication. Interview with Registered Nurse (RN)-C on 4/14/16 indicated non-pharmacological interventions should be tried before the use of the prn anti-psychotic and verified it was not always being completed/documented. Review of New Harmony Care Center undated policy titled "Antipsychotic Medication Protocol Statement of House Policy" indicated the	F 428	free from unnecessary drugs. All consultant pharmacist recommendations will be reviewed by physician and/or nursing staff in a timely manner. Documentation of follow-up results will be maintained in resident charts including medication changes, lab work, or other interventions. Licensed nursing staff will be re-educated in use of prn antipsychotic medication, including the need to document alternate interventions that were tried prior to giving a prn dose of an antipsychotic by 5/4/16. The DNS/Designee will monitor prn antipsychotic medication administration for documentation of interventions attempted prior to administration. This will be done weekly x2 months and 1x month for 1 month. Results of audit will be reported to the QA Committee for review. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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F 428	Continued From page 13 following : It is the policy of this facility to encourage multidisciplinary efforts to identify factors responsible for changes in a resident's behavior and to encourage consideration of alternate (non-drug) means of treating those factors.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		5/5/16

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F 431	Continued From page 14 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were removed for 2 of 2 residents (R31 and R81) reviewed for medication storage. Findings include: During observation of the first floor medication cart on 4/14/16, at 11:21 a.m., the following were stored: - One bottle of acetaminophen 500 milligram (mg), approximately 25 tablets, for R81 with an expiration date of 1/28/16 - One bottle of Benadryl 25 mg, approximately 30 capsules for R81 with an expiration date of 2/17/16 - One bottle of Senna 8.6 mg approximately ¾ full for R81 with an expiration date of 4/6/16. R81's physician orders dated 3/1/16 - 4/14/16, included acetaminophen extra strength 500 mg, 2 tablets twice a day as needed (prn), Benadryl (diphenhydramine hcl) (OTC) capsule, 25 milligrams (mg), 2 capsules (50 mg) oral prn and Senna-S tablet, 8.6-50 mg, 1 tablet once a day every other day. R81's January 2016 medication administration record (MAR) indicated acetaminophen was administered 1/2/16, Senna was administered 1/16 and 1/20/16 and Benadryl was administered 1/21/16. The February 2016 MAR indicated acetaminophen was administered 2/16 and 2/17 and Senna was administered 2/3,	F 431	F431: Drug Storage□Expired meds It is the intent of New Harmony Care Center to provide pharmaceutical services that will monitor drugs and biologicals used in the facility to ensure correct labeling and dating according to pharmacy medication storage and expiration guidelines. Expired medication for R31, R81 were removed from the med cart immediately. All drugs and biologicals will be routinely monitored for expiration dates and will be removed from medication storage areas and disposed of in accordance with regulations. Licensed nursing staff will be re-educated by 5/4/16 regarding the importance of checking expiration dates prior to administration of medication. Audits of drugs and biologicals for expiration dates will be conducted by pharmacy nurse monthly for 3 months. Results reported to DNS and consulting pharmacist to share at the next Quality Assurance Meeting for input & further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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F 431	Continued From page 15 2/8, 2/10, 2/11, 2/13, 2/17, 2/25, 2/27 and 2/29. The March 2016 MAR indicated acetaminophen was not administered. Senna was administered 3/7, 3/11, 3/13, 3/15, 3/19, 3/21, 3/23, 3/27, 3/29 and 3/31. The April 2016 MAR indicated Benadryl was administered 4/13/1 and Senna was administered 4/5, 4/9, 4/11 and 4/13. The medication cart also contained one box of Ipratropium bromide and albuterol sulfate inhalation solution with three packages of five vials each for R31 with an expiration date of 3/16. R31's physician orders dated 3/1/16 - 4/14/16, included Ipratropium-albuterol solution for nebulization, 3 milliliters (ml) every six hours as needed (prn). R31's March 2016 medication record did not include any administered prn dose. Registered nurse (RN)-B verified the medications were expired and removed them from the cart. On 4/14/16, at 1:52 p.m. director of nursing (DON) stated there should not be any expired medications in carts. DON further stated staff should check medication expiration dates before administration. Review of undated Medication Storage in the Facility policy directed: "10. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, unlabeled, or without secure closures are immediately removed from stock, disposed of according to facility procedures for medication destruction, and reordered from the pharmacy if a current order exists."	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		5/5/16

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F 441 SS=E	Continued From page 16 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections 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.	F 441		

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F 441	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection with handwashing during resident care for R18 and R46 and when using the mechanical lift device between resident R18 and R46. Findings include: During observation of morning cares on 4/13/16, at 9:09 a.m., nursing assistant (NA)-A came into the room to assist with morning cares and did not wash hands or alcohol gel hands. NA-A donned a pair of gloves to assist R46 to turn from side to side to remove a soiled brief and position the mechanical device sling under R46 to get up into the bath chair. Licensed practical nurse (LPN)-A came to assist with the transfer and without washing hands or using alcohol gel, donned a pair of gloves and proceeded to go to the resident dresser to find a brief. Then, LPN-A assisted with adjusting the brief on, and assisting with the positioning of the mechanical lift sling under R46. NA-A wearing the contaminated gloves, picked up the mechanical device for the lift and with the help of LPN-A moved R46 into position in the tub chair. NA-A left contaminated gloves on, opened the bedroom doorknob with the contaminated gloves and transported R46 down the hallway without performing hand hygiene LPN-A removed the linen from the room to a hamper outside the bedroom door, removed gloves, and did not perform hand hygiene. NA-A donned a new pair of gloves in the tub room and bathed R46. There were no gloves in the tub	F 441	F441: It is the intent of New Harmony Care Center to maintain an infection control program designed to provide a safe & sanitary environment. Nursing staff will be re-educated on preventing the spread of infection. The policy on hand hygiene will be reviewed along with appropriate use of gloves and hand hygiene following glove use. DNS/Designee will do random audits of hand washing/glove use weekly for 2 months. The data will be shared at the next quality assurance meeting by the DNS/Designee for input and further direction. The mechanical lift handles will be sanitized between residents. Bags will be attached to lifts which will contain sanitizing wipes to be used by staff. Nursing staff will be educated on this new procedure by 5/4/16. Random audits will be done weekly for 2 months to assure compliance with the new policy. DNS/Designee will bring data to share at the next Quality Assurance Meeting for input and further direction. For all residents that have had tuberculin skin testing done at facility, the induration of TST will be documented to indicate the result of TST. This will be documented on the Medication Administration Record. Licensed nursing staff will be educated on this procedure by 5/4/16. DNS/Designee will audit TST results for resident admissions for induration documentation for 2 months. The DNS/Designee will	

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F 441	Continued From page 18 room so NA-A removed the gloves used for bathing and without sanitizing hands left the tub room to get another box of gloves. Upon returning to the tub room, NA-A drained the tub and dried R46 with a bath blanket. The mechanical lift sling was saturated and remained under R46 throughout the bathing process. NA-A transported R46 back to the bedroom to transfer into the bed and remove the wet sling. LPN-A came to assist and donned gloves without performing hand hygiene. The mechanical lift was used to position R46 into bed so the wet linen could be removed. R46 moved from side to side as NA-A and LPN-A changed the linen and put on a clean brief and dressed R46. NA-A removed gloves and without hand hygiene left the room to go to another unit to find a dry sling to get R46 back up into the wheel chair using the mechanical lift. NA-A used the mechanical lift to get R46 up into the wheelchair. NA-B came to the room to assist and without hand hygiene donned gloves and moved the mechanical sling into place to assist with the transfer. the mechanical device was set into the hallway without sanitizing the remote control which the staff had contaminated during the transfer. NA-B took the mechanical lift into R18's room without sanitizing between resident use. NA-B did not perform hand hygiene and donned gloves to adjust the Foley catheter, oxygen tubing, and adjusting bed linen for R18. NA-A came to the room to assist R18 and without hand hygiene donned gloves, moved catheter tubing, and assisted with the mechanical lift transfer into bed. NA-A and NA-B rolled R18 back and forth in the bed to remove the mechanical lift sling and position R18.	F 441	bring data to share at the next Quality Assurance Meeting for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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F 441	Continued From page 19 When interviewed on 4/13/16, at 11:58 a.m. NA-A and NA-B verified gloves were changed but there was no hand hygiene performed. NA-A and NA-B verified the mechanical device was not sanitized between resident use. During an interview with the director of nursing on 4/13/16, at 1:00 p.m., verified the staff were to perform hand hygiene whenever changing gloves. Furthermore, the DON verified the facility did not have a policy for the use of alcohol gel hand sanitizing, nor did the facility have a policy to sanitize the mechanical devices between resident use. A review of the undated policy, titled, Handwashing, directed: To prevent the spread of infectious disease, the use of gloves does not replace handwashing. Appropriate thirty (30) second handwashing must be performed under the following conditions: after handling items or work surfaces potentially contaminated with a resident's blood, excretions or secretions.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF Y OUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, New Harmony Care Center was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/29/2016

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. New Harmony Care Center is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(222) construction. In 1976, a 3rd Floor addition was constructed and was determined to be of Type II(222) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 69 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 033	NFPA 101 LIFE SAFETY CODE STANDARD	K 033		4/25/16

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K 033 SS=F	Continued From page 2 Exit enclosures (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. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect all 76 residents. Findings include: On facility tour between 09:30 AM and 012:00 PM on 04/14/2016, it was observed that: 1. The basement level of the north stair the elevator machine room opened directly into the stair enclosure. 2. The first floor a storage room opened directly onto the north stair enclosure. 4. The first floor an elevator machine room opened directly onto the central stair enclosure. This deficiency was verified by facility Environment Service Director (JB). Waiver Recommended A waiver has been granted during the last survey and FMS survey.	K 033	Waiver request for Tag K033 is attached	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.	K 144		4/18/16

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K 144	Continued From page 3 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 9:30 AM and 12:30 PM on 04/14/2016, based on review of available documentation it was revealed that there was no documentation for the minimum 5 minute cool down period when testing generator. This deficient practice was verified by the Director of Environmental Services.	K 144	K144-The minimum 5 minute cool down period included in the generator test is now included in the log. Revised Log attached.	

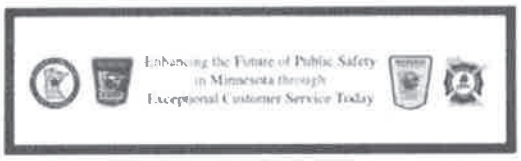
Whitney, Marian (DPS)

From: Linhoff, Tom (DPS)
Sent: Friday, April 29, 2016 1:32 PM
To: Dehler, Robert (MDH); Dietrich, Shellae (MDH); Henderson, Mary (MDH); Fiske-Downing, Kamala (MDH); Johnston, Kate (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Whitney, Marian (DPS); rochi_lsc@cms.hhs.gov
Subject: New Harmony CC - annual waiver for K-033. Previously Approved - No Changes
Attachments: WAIVER 033 4-21- 2016.docx

This is to inform you that I am accepting the annual waiver report for New Harmony Care Center regarding K-033. The exit date of the survey was 04/14/2016.

Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office phone: 651-201-7205
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.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 033 is being requested regarding : 1-the door of the north stair basement level elevator machine room , 2- the door of the central stair first floor elevator machine room, 3- the door of the north stair first floor storage room. Due to the design of the area, the two elevator machine room doors and the storage room door as described above cannot be relocated and the owner cannot change the swing of the door. It would be a financial hardship to relocate the elevator machine rooms and the storage room. This waiver does not adversely affect the residents to leave the doors in the stair enclosures because the residents who reside at the facility rarely use the stairs. Residents primarily use the elevators. In emergencies, the doors in the stairs will be shut and out of resident traffic. The doors are on closers and these doors are rarely used. The facility's evacuation plan is focused on horizontal movement of residents to smoke compartments on each floor. The stairs would be a rarely used option of evacuation. Signage " CAUTION! OPEN DOOR SLOWLY! DO NOT PROP DOOR " are posted inside each of the doors

Surveyor (Signature)	Title	Office	Date
[signature]	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	4-29-16
Fire Authority Official (Signature)	Title	Office	Date

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 22, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5381026

Dear Mr. Carlson:

The above facility was surveyed on April 11, 2016 through April 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Susanne Reuss at: (651) 201-3793 or email: susanne.reuss@state.mn.us**.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00492	A. BUILDING: _____ B. WING _____	04/14/2016

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 11, 12, 13, 14, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 1 resident (R46) to require a mechanical lift for all transfers. Findings include: During an observation on 4/13/16 at 6:56 p.m., R46 was transferred using the total lift mechanical device. Family member (F)-A expressed R46 was supposed to pivot transfer but no one was assisting to coordinate the pivot transfers. F-A and R46 expressed a desire to go back home once R46 is able to pivot transfer. F-A expressed talking with the staff on numerous	2 570	It is the intent of New Harmony Care Center to develop and maintain a current comprehensive plan of care for all residents. R46 care plan has been revised to reflect current interventions. R46 care plan has been revised to reflect the plan of care for transfers to a total lift transfer. Licensed nursing staff will receive re-education regarding revising and updating of the care plan by 5/4/16. DNS/Designee will audit 2 care plans each week x1 month for current interventions and then 1 care plan each week x2 months. The data will be shared at the next Quality Assurance	5/5/16

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2 570	Continued From page 3 occasions as to why a pivot transfer was not attempted for R46. Document review of the revised plan of care dated 4/2/16, listed a diagnosis of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left non-dominant side. The plan of care for transfers, the approach read; "Assist with transfers per need. Assistive device per PT recommendation: currently Hoyer and 2 staff- (8-13-15) has progressed to max assist of 2 pivot to Rt side (Lt sided weakness) for transfers. 9/4/15 pivot with assist 1-2 per need. Hoyer prn [whenever necessary] Document review of the form titled, Resident Care Information List, directed staff to assist 2 pivot. Document review of the physical therapy assessment dated 1/6/16, read, "Hoyer lift with nursing staff." During an interview with the full time registered nurse RN-B on 4/13/16 at 1:00 p.m., verified R46 was not able to pivot transfer and was to be a total mechanical lift. During an interview with the director of nursing (DON) on 4/15/16 at 11:00 a.m.,the DON verified the plan of care and Resident Care Information List were not accurate, and indicated both would be updated to direct staff that R46 is a Hoyer transfer. Furthermore, the DON verified the F-A and R46 would be included in the update to the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing	2 570	meeting by the DNS/Designee for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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2 570	Continued From page 4 staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection with handwashing during resident care for R18 and R46 and when using the mechanical lift device between resident R18 and R46. Findings include: During observation of morning cares on 4/13/16, at 9:09 a.m., nursing assistant (NA)-A came into the room to assist with morning cares and did not wash hands or alcohol gel hands. NA-A donned a pair of gloves to assist R46 to turn from side to side to remove a soiled brief and position the mechanical device sling under R46 to get up into the bath chair. Licensed practical nurse (LPN)-A came to assist with the transfer and without washing hands or using alcohol gel, donned a pair of gloves and proceeded to go to the resident	21375	It is the intent of New Harmony Care Center to maintain an infection control program designed to provide a safe & sanitary environment. Nursing staff will be re-educated on preventing the spread of infection. The policy on hand hygiene will be reviewed along with appropriate use of gloves and hand hygiene following glove use. DNS/Designee will do random audits of hand washing/glove use weekly for 2 months. The data will be shared at the next quality assurance meeting by the DNS/Designee for input and further direction. The mechanical lift handles will be sanitized between residents. Bags will be attached to lifts which will contain sanitizing wipes to be used by staff. Nursing staff will be educated on this new	5/5/16

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21375	Continued From page 5 dresser to find a brief. Then, LPN-A assisted with adjusting the brief on, and assisting with the positioning of the mechanical lift sling under R46. NA-A wearing the contaminated gloves, picked up the mechanical device for the lift and with the help of LPN-A moved R46 into position in the tub chair. NA-A left contaminated gloves on, opened the bedroom doorknob with the contaminated gloves and transported R46 down the hallway without performing hand hygiene LPN-A removed the linen from the room to a hamper outside the bedroom door, removed gloves, and did not perform hand hygiene. NA-A donned a new pair of gloves in the tub room and bathed R46. There were no gloves in the tub room so NA-A removed the gloves used for bathing and without sanitizing hands left the tub room to get another box of gloves. Upon returning to the tub room, NA-A drained the tub and dried R46 with a bath blanket. The mechanical lift sling was saturated and remained under R46 throughout the bathing process. NA-A transported R46 back to the bedroom to transfer into the bed and remove the wet sling. LPN-A came to assist and donned gloves without performing hand hygiene. The mechanical lift was used to position R46 into bed so the wet linen could be removed. R46 moved from side to side as NA-A and LPN-A changed the linen and put on a clean brief and dressed R46. NA-A removed gloves and without hand hygiene left the room to go to another unit to find a dry sling to get R46 back up into the wheel chair using the mechanical lift. NA-A used the mechanical lift to get R46 up into the wheelchair. NA-B came to the room to assist and without hand hygiene donned gloves and moved the mechanical sling into place to assist with the transfer. the mechanical device was set into the hallway	21375	procedure by 5/4/16. Random audits will be done weekly for 2 months to assure compliance with the new policy. DNS/Designee will bring data to share at the next Quality Assurance Meeting for input and further direction. For all residents that have had tuberculin skin testing done at facility, the induration of TST will be documented to indicate the result of TST. This will be documented on the Medication Administration Record. Licensed nursing staff will be educated on this procedure by 5/4/16. DNS/Designee will audit TST results for resident admissions for induration documentation for 2 months. The DNS/Designee will bring data to share at the next Quality Assurance Meeting for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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21375	Continued From page 6 without sanitizing the remote control which the staff had contaminated during the transfer. NA-B took the mechanical lift into R18's room without sanitizing between resident use. NA-B did not perform hand hygiene and donned gloves to adjust the Foley catheter, oxygen tubing, and adjusting bed linen for R18. NA-A came to the room to assist R18 and without hand hygiene donned gloves, moved catheter tubing, and assisted with the mechanical lift transfer into bed. NA-A and NA-B rolled R18 back and forth in the bed to remove the mechanical lift sling and position R18. When interviewed on 4/13/16, at 11:58 a.m. NA-A and NA-B verified gloves were changed but there was no hand hygiene performed. NA-A and NA-B verified the mechanical device was not sanitized between resident use. During an interview with the director of nursing on 4/13/16, at 1:00 p.m., verified the staff were to perform hand hygiene whenever changing gloves. Furthermore, the DON verified the facility did not have a policy for the use of alcohol gel hand sanitizing, nor did the facility have a policy to sanitize the mechanical devices between resident use. A review of the undated policy, titled, Handwashing, directed: To prevent the spread of infectious disease, the use of gloves does not replace handwashing. Appropriate thirty (30) second handwashing must be performed under the following conditions: after handling items or work surfaces potentially contaminated with a resident's blood, excretions or secretions.	21375		

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21375	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review infection control practices during personal care and educate staff. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented in order to reduce the risk of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		5/5/16

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21426	Continued From page 8 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to document the induration results of tuberculin skin test (TST) for 4 of 5 residents (R18, R62, R79 & R99) reviewed. Findings include: R18 was admitted to the facility on 3/14/16. R18's medical record indicated R18 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ml) intradermally on 3/16/16. There were no documents to indicate the induration of the TST given on 3/16/16. Furthermore, a second dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally was given on 3/30/16, and there were no documents to indicate the induration of the TST given on 3/30/16. R62 was admitted to the facility on 3/30/16. R62's medical record indicated R62 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ml) intradermally on 3/30/16. There were no documents to indicate the induration of the TST given on 3/30/16. Furthermore, a second dose step of Tubersol Solution 5 unit/0.1 ml intradermally was given on 4/8/16, and there were no documents to indicate the induration of the TST given on 4/8/16. R79 was admitted to the facility on 3/10/16. R79's medical record indicated R79 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter intradermally on 3/10/16. There were no documents to indicate the induration of the TST given on 3/10/16. Furthermore, a second dose step of Tubersol Solution 5 unit/0.1 milliliter intradermally was given on 3/24/16, and there were no documents to indicate the induration of	21426	tag 1426: For all residents that have had tuberculin skin testing done at facility, the induration of TST will be documented to indicate the result of TST. This will be documented on the Medication Administration Record. Licensed nursing staff will be educated on this procedure by 5/4/16. DNS/Designee will audit TST results for resident admissions for induration documentation for 2 months. The DNS/Designee will bring data to share at the next Quality Assurance Meeting for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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21426	Continued From page 9 the TST given on 3/24/16. R99 was admitted to the facility on 2/19/16. R99's medical record indicated R99 received the first dose step of Tubersol Solution 5 unit/0.1 milliliter (ML) intradermally on 2/19/16. There were no documents to indicate the induration of the TST given on 2/19/16. When interviewed on 4/14/16, at 1:58 p.m., registered nurse (RN)-E verified R18, R62, R79 & R99 did not have documented induration of the TST. A review of the undated facility policy, titled Policy and Procedure on Tuberculin Testing of Residents, read, "The Mantoux should be read in 48-72 hours. An induration of 10 mm or greater indicates a significant reaction. The amount of induration at the site not erythema determines the significance of the reaction." SUGGESTED METHOD OF CORRECTION: The DON or designee could conduct resident screening audits, interventions and monitoring to ensure residents are free from communicable disease. The DON or designee could ensure the staff were educated on the importance of induration of tuberculin skin testing. The DON or designee could randomly audit resident's documents to ensure adequate documentation for induration. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		5/5/16

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21535	Continued From page 10 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow the pharmacy consultant recommendations for 1 of 2 residents (R73) who received an as needed (prn) antipsychotic medication. Findings include: R73's admitting diagnosis included dementia with behavioral disturbances, and essential hypertension (high blood pressure).	21535	Failure to follow Pharmacy Consultant Recommendations: It is the intent of New Harmony Care Center that residents□ drug regimen be free from unnecessary drugs. All consultant pharmacist recommendations will be reviewed by physician and/or nursing staff in a timely manner. Documentation of follow-up results will be maintained in resident charts including medication changes, lab work, or other interventions. Licensed	

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21535	Continued From page 11 R73's Physician Order Report dated 4/1/46 - 4/30/16, included, Seroquel [an antipsychotic medication] 50 mg [milligrams] oral once a day prn for agitation/paranoia/anxiety. R89's record included the "Consultant Pharmacist Communication to Nursing," dated 12/15/15, included the pharmacists recommendations of updating charting/monitoring to document failures of non drug interventions before prn psychotropic's are used, as he was unable to locate consistent evidence that non-drug interventions were tried prior to prn medication use. Review of R73's January, February, and March 2016 Medication Administration Record (MAR), indicated R73 had been administered the prn Seroquel 4 times with no documentation of non-drug interventions attempted prior to the use of the medication. Interview with Registered Nurse (RN)-C on 4/14/16 indicated non-pharmacological interventions should be tried before the use of the prn anti-psychotic and verified it was not always being completed/documented. Review of New Harmony Care Center undated policy titled "Antipsychotic Medication Protocol Statement of House Policy" indicated the following : It is the policy of this facility to encourage multidisciplinary efforts to identify factors responsible for changes in a resident's behavior and to encourage consideration of alternate (non-drug) means of treating those factors.	21535	nursing staff will be re-educated in use of prn antipsychotic medication, including the need to document alternate interventions that were tried prior to giving a prn dose of an antipsychotic by 5/4/16. The DNS/Designee will monitor prn antipsychotic medication administration for documentation of interventions attempted prior to administration. This will be done weekly x2 months and 1x month for 1 month. Results of audit will be reported to the QA Committee for review. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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21535	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The facility could review and/or revise their policies and procedures, provide staff education pertaining to administration of as needed antipsychotic medication. The facility could then develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced	21540		5/5/16

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21540	Continued From page 13 by: Based on document review and interview, the facility failed to ensure 4 of 4 residents (R15, R1, R23, and R73) receiving antipsychotic medications had orthostatic blood pressures monitored and did not ensure 1 of 2 residents (R73) who received an as needed antipsychotic medication, received non-pharmacological interventions prior to medication use. Findings include: R15 was not monitored for changes in orthostatic blood pressure due to antipsychotic medication use. On 4/13/16, at 12:50 p.m., R15 was observed to be awake, seated in the wheelchair in her room. When approached and interviewed regarding the medication, Seroquel, R15 indicated she did not notice or experience any side effects from the medication. R15 was observed to be relaxed with no behaviors. R15's face sheet with admit date 9/6/12, R15 had diagnoses which included legal blindness, anxiety disorder and dementia with behavioral disturbance. Furthermore, R15 had an order for Seroquel 25 mg by mouth three times a day, which was started on 9/6/12. R15's Minimum Data Set (MDS) dated 3/14/16, indicated R15 had an antipsychotic medication (Seroquel) X 7 days within the last 7 days Assessment Reference Date (ARD) period. R15's care plan dated 4/8/16, identified, "... Family reports conversations of delusional/paranoid content with resident: res [resident] stating going to dentist and falling etc: things that have not happened, dreams, feeling	21540	F329: It is the intent of New Harmony Care Center that residents drug regimen be free from unnecessary drugs. R15, R1, R23, R73, care plans have been revised to include monitoring for adverse consequences of antipsychotic drug therapy, along with specific indication for the use of antipsychotic medications to be documented. Nursing staff are to document the use of non-pharmacological interventions prior to antipsychotic medication administration. Policy has been revised to reflect that orthostatic blood pressures will be done weekly with new orders and or medication increase for 1 month and monthly thereafter for Residents on antipsychotic medications. Nursing staff will receive re-education regarding unnecessary antipsychotic medication use. Antipsychotic medication administration policy will be reviewed by 5/4/16. DNS/Designee will audit medication administration records of residents receiving antipsychotic medication therapy weekly for 2 months and monthly for 1 month for compliance with completion of orthostatic blood pressures and documentation of interventions attempted prior to antipsychotic medication administration. The data will be shared at the next Quality Assurance meeting by the DNS/Designee for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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21540	Continued From page 14 unsafe etc. Seroquel and Xanax used as ordered and reported helpful. Seroquel increase on 11/27/13... Keep MD updated on effectiveness or non-effectiveness. Report any adverse s/e's [side effects] noted." However, R15's medical record lacked documentation of monthly orthostatic blood pressure monitoring. The MAR (Medication Administration Record) for January 2016, February 2016, March 2016 and April 2016, indicated R15 received Seroquel 25 mg by mouth three times a day. MAR for April 2016 indicated R15 had diagnosis of delusions, hallucinations and decreased appetite. On 4/14/16, at 9:13 a.m. registered nurse (RN)-A verified R15's medical record lacked documentation of monthly orthostatic blood pressure monitoring at least in the last 6 months and stated, "My expectation is we will report refusal to nurse practitioner or medical doctor if resident refuses monthly orthostatic blood pressure monitoring." At 10:41 a.m. RN-A added, "I cannot find any physician order that indicated discontinuation of monthly orthostatic blood pressure." On 4/14/16, at 9:16 a.m. director of nursing indicated, the staff was supposed to monitor monthly orthostatic blood pressure for any resident receiving antipsychotic medication if the resident is cooperative and able to stand. On 4/14/16 at 11:21 a.m. the consultant pharmacist (PC) stated, monthly orthostatic blood pressure monitoring is included in the side effect monitoring and is part of ongoing assessment, there is no reason why he should make a recommendation. In addition, PC indicated, his expectation is facility staff should monitor	21540		

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21540	Continued From page 15 orthostatic blood pressure monthly. R1's medical record lacked documentation of monthly orthostatic blood pressures. R1 was admitted to the facility on 1/12/15, with diagnoses of bipolar disorder, anxiety disorder, generalized anxiety disorder, and personality disorder. The physician orders dated 4/1/16 - 4/30/16 included Seroquel (antipsychotic medication), 100 milligrams (mg) tablet once a day for bipolar disorder, and Seroquel (antipsychotic medication), 75 mg at bedtime. The care plan dated 4/12/16, indicated R1, psychotropic drugs with diagnosis of bipolar disorder, depression, anxiety and received Seroquel (antipsychotic medication), Paxil (antidepressant medication), and Klonopin (antianxiety medication). The care plan dated 4/6/16, indicated R1 was at risk for falls, related to weakness, unsteadiness, anxiety, psychotropic, diuretic and antihypertensive drug use. R1 required assist with all cares, mobility, and E-Z stand transfers as needed (prn). On 4/13/16, at 1:53 p.m. licensed practical nurse (LPN)-B stated she does weekly blood pressure monitoring but does not monitor orthostatic blood pressures. On 4/14/16, at 12:18 p.m. director of nursing (DON) stated she expected staff to be monitoring blood pressures for residents taking psychotropic meds.	21540		

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21540	Continued From page 16 R23 was not monitored for possible changes in orthostatic blood pressure due to antipsychotic medication use. R23 was admitted to the facility on 9/22/14 and R23's quarterly Minimum Data Set (MDS) included diagnoses of dementia, depression, and psychotic disorder. The physician orders dated 4/1/16 - 4/30/16, included Risperidone (antipsychotic medication) 0.5 mg once a day. The Care Plan dated 4/12/16, indicated R23 received Effexor (antidepressant medication) for depressive disorder and Risperidone (antipsychotic medication) for dementia, psychosis and paranoia. The care plan dated 4/6/16 indicated R23 required standby assist with transfers and ambulation, use of rolling walker, and supervision of one with mobility, is fall risk for due to weakness, confusion, and dependence on staff for mobility safety. Review of R23's medical record lacked documentation of monthly orthostatic blood pressures. On 4/13/16, at 1:53 p.m. licensed practical nurse (LPN)-B stated she does weekly blood pressure monitoring but does not monitor orthostatic blood pressures. On 4/14/16, at 12:18 p.m. director of nursing (DON) stated she expected staff to be monitoring blood pressures for residents taking psychotropic meds.	21540		

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21540	Continued From page 17 R73 was not monitored for possible changes in orthostatic blood pressure due to antipsychotic medication use. Review of R73's record indicated R73 was admitted on 11/26/14 with diagnosis including dementia without behavioral disturbances, unspecified dementia with behavior disturbances, and essential hypertension (high blood pressure). Review of R73's record indicated Physician orders for Seroquel (an antipsychotic medication) 25 miligrams (mg) twice a day and 50 mg once a day, and 50 mg once a day as needed (prn). Review of R73's record including Medication Administration Record (MAR), Behavior/Intervention Monthly Flow Sheet, and Treatment Record for January 2016, February 2016, March 2016, and April 2016, lacked any monitoring of orthostatic blood pressure. Review of R73's plan of care indicated "resident is at risk for falls." Interview with the Director of Nursing (DON) on 4/14/16 at 11:30 a.m., she stated it is in the policy and the staff should be completing the orthostatic blood pressures on any resident who receives an antipsychotic medication, and verified orthostatic blood pressures were not being checked on those residents. Review of the undated "Antipsychotic Medication Protocol Statement of House Policy" directed the following handwritten statement: "In addition, residents recieving (sic) antipsychotic drug therapy will have orthostatic blood pressure checks done daily for 1 week with new orders and	21540		

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21540	Continued From page 18 or medication increase then monthly thereafter." R73 received as needed (prn) antipsychotic medication without documentation of non-pharmacological interventions. Review of R73's January and March's MAR indicated R73 received a prn dose of Seroquel on 1/10/16, 1/29/16, 3/16/16 and 3/17/16 without any documentation of any non-pharmacological intervention attempts. Review of R73's January and March's Behavior/Intervention Monthly Flow Record for those dates lacked any documentation of any non-pharmacological interventions attempted prior to administration of the antipsychotic medication. Review of the Resident Progress notes for 1/10/16 at 21:40 indicated "PRN Quetiapine (Seroquel) was given for agitation @1515. some what helped." No indication non-pharmacological interventions were attempted. Review of the Resident Progress Notes for 3/16/16 and 3/17/16 lacked any documentation of the use of the prn Seroquel, or any non-pharmacological interventions before the use of Seroquel. Interview with Registered Nurse (RN)-C on 4/14/16 indicated non-pharmacological interventions should be tried before the use of the prn anti-psychotic and verified it was not always being completed. Review of New Harmony Care Center undated policy titled "Antipsychotic Medication Protocol Statement of House Policy" indicated the following : It is the policy of this facility to encourage multidisciplinary efforts to identify factors responsible for changes in a resident's behavior and to encourage consideration of	21540		

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21540	Continued From page 19 alternate (non-drug) means of treating those factors. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures, educate staff and audit to ensure that residents drug regimen is free of irregularities and appropriate monitoring is being completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were removed for 2 of 2 residents (R31 and R81) reviewed for medication storage. Findings include: During observation of the first floor medication cart on 4/14/16, at 11:21 a.m., the following were stored: - One bottle of acetaminophen 500 milligram (mg), approximately 25 tablets, for R81 with an expiration date of 1/28/16 - One bottle of Benadryl 25 mg, approximately 30 capsules for R81 with an expiration date of 2/17/16 - One bottle of Senna 8.6 mg approximately ¾ full for R81 with an expiration date of 4/6/16.	21620	It is the intent of New Harmony Care Center to maintain an infection control program designed to provide a safe & sanitary environment. Nursing staff will be re-educated on preventing the spread of infection. The policy on hand hygiene will be reviewed along with appropriate use of gloves and hand hygiene following glove use. DNS/Designee will do random audits of hand washing/glove use weekly for 2 months. The data will be shared at the next quality assurance meeting by the DNS/Designee for input and further direction. The mechanical lift handles will be sanitized between residents. Bags will be attached to lifts which will contain	5/5/16

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21620	Continued From page 20 R81's physician orders dated 3/1/16 - 4/14/16, included acetaminophen extra strength 500 mg, 2 tablets twice a day as needed (prn), Benadryl (diphenhydramine hcl) (OTC) capsule, 25 milligrams (mg), 2 capsules (50 mg) oral prn and Senna-S tablet, 8.6-50 mg, 1 tablet once a day every other day. R81's January 2016 medication administration record (MAR) indicated acetaminophen was administered 1/2/16, Senna was administered 1/16 and 1/20/16 and Benadryl was administered 1/21/16. The February 2016 MAR indicated acetaminophen was administered 2/16 and 2/17 and Senna was administered 2/3, 2/8, 2/10, 2/11, 2/13, 2/17, 2/25, 2/27 and 2/29. The March 2016 MAR indicated acetaminophen was not administered. Senna was administered 3/7, 3/11, 3/13, 3/15, 3/19, 3/21, 3/23, 3/27, 3/29 and 3/31. The April 2016 MAR indicated Benadryl was administered 4/13/1 and Senna was administered 4/5, 4/9, 4/11 and 4/13. The medication cart also contained one box of Ipratropium bromide and albuterol sulfate inhalation solution with three packages of five vials each for R31 with an expiration date of 3/16. R31's physician orders dated 3/1/16 - 4/14/16, included Ipratropium-albuterol solution for nebulization, 3 milliliters (ml) every six hours as needed (prn). R31's March 2016 medication record did not include any administered prn dose. Registered nurse (RN)-B verified the medications were expired and removed them from the cart. On 4/14/16, at 1:52 p.m. director of nursing (DON) stated there should not be any expired medications in carts. DON further stated staff should check medication expiration dates before	21620	sanitizing wipes to be used by staff. Nursing staff will be educated on this new procedure by 5/4/16. Random audits will be done weekly for 2 months to assure compliance with the new policy. DNS/Designee will bring data to share at the next Quality Assurance Meeting for input and further direction. For all residents that have had tuberculin skin testing done at facility, the induration of TST will be documented to indicate the result of TST. This will be documented on the Medication Administration Record. Licensed nursing staff will be educated on this procedure by 5/4/16. DNS/Designee will audit TST results for resident admissions for induration documentation for 2 months. The DNS/Designee will bring data to share at the next Quality Assurance Meeting for input and further direction. Facility licensed nursing staff responsible for ongoing compliance. DNS responsible for overall compliance.	

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21620	Continued From page 21 administration. Review of undated Medication Storage in the Facility policy directed: "10. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, unlabeled, or without secure closures are immediately removed from stock, disposed of according to facility procedures for medication destruction, and reordered from the pharmacy if a current order exists." A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that all medications are labeled and stored properly and educate all staff, and then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the	21880		5/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00492	A. BUILDING: _____ B. WING _____	04/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 22 Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that prompt efforts were made to resolve resident grievances for 2 of 2 residents (R82, R39) who expressed concerns. Findings include:	21880	Facility policy on Complaint/Grievance has been reviewed by administrator with management/disciplinary team. Complaint/Grievance forms are placed in wall sleeves in common area on each floor for easy access. All staff in-service regarding policy and the	

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21880	Continued From page 23 During an interview on 4/12/16 at 10:14 a.m., R39 complained a certain department head had placed restrictions on the level of speed for the electric scooter which R39 used to transport around the facility. R39 said the department head restricted the scooter to a level one which was the lowest speed but therapy had cleared R39 to be able to use discretion with all three speeds of the scooter. R39 expressed being intimidated by the department head who was "harassing" R39 about the speed. R39 did not know who to turn to for help in resolving the situation. R39 was not aware of the facility concern/grievance procedure. R39 insisted on demonstrating for the surveyor the safe use of the scooter. R39 demonstrated in the bedroom the ability to maneuver the scooter, and in the hallway, R39 demonstrated the use of the three levels of the scooter. Document review of the form titled, Occupational Therapy, read, "OT screened resident 11/27/15, for safety and independence with scooter. Resident able to safely maneuver way to dining room table, throughout hallways and in room. Resident demo' d [demonstrated] I [independent] with turning on/off scooter and choosing appropriate speed. Resident safe to use scooter I'ly [independently] at this time." During an interview on 4/12/16, at 1:53 p.m. R82 expressed concerns of being bossed around by some of the staff and a major concern that the food in the evening shift is often cold and no one seems to do anything about it. R82 was not familiar with a concern/grievance process at the facility. During an interview with the full time registered nurse (RN)-B, revealed not being aware of the	21880	complaint/grievance process will be conducted on/before May 5th. Residents will be informed of the complaint/grievance process and informed on how to obtain a grievance form through group activity meetings on 4/29/16, 5/02/16,and 5/03/16. The complaint/grievance process also will be reviewed at the monthly resident council meetings. Administrator policy, All staff policy and Complaint/Grievance form attached. Administrator will be responsible.	

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21880	Continued From page 24 grievance concern process, not aware of forms to use, not aware of how to locate a form and thought social service took care of resident concerns. A review of the facility policy dated 4/04 and titled, Grievance Policy and Procedure, read; "If at anytime you feel you are not being treated fairly, an employee has mistreated you in any way, or if you have a complaint about any aspect of service or care in the facility, you or a family or any concerned person are encouraged to take the following steps to correct or eliminate the problem." Step 3) Grievances will be documented in a Grievance Log or file located in the social work office. Written responses to written grievances will be sent within 7 days of receipt and will outline the steps being taken to correct or eliminate the problem." When interviewed, on 4/13/16 at 1:00 p.m., the director of social services (DSS) and the director of nursing (DON) verified there was no documentation of resident concerns/grievances and the facility had stopped the process since mid 2015. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the requirement to address resident concerns and make a good faith attempt to resolve the grievances. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		