CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: UM6Q

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

		PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	ENCY	F	acility ID: 00492
MEDICARE/MEDICAID PRO (L1)			3. NAME AND ADI (L3) NEW HARM (L4) 135 GERANI (L5) SAINT PAUL	ONY CARE CENUM AVENUE EA	NTER	(L6)	55117	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE (L9)	E OF OWNERSHIP		7. PROVIDER/SUF	PPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
	06/02/2016 1 TJC 3 Other	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREA	76 76 KDOWN '19 SNF	(L18) (L17)	B. Not in Com	nce With quirements		2. Tech 3. 24 H 4. 7-Da	nnical Personnel Hour RN ay RN (Rural SNF) Safety Code A* MEETS	Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12)	tor
(L37) (L37) (76 L38)	(L39)	(L42)	(L43)					
10. STATE SURVET AGENCT	`				waiver	involving]	K033 is red	commended.	
17. SURVEYOR SIGNATURE			Date :				VEY AGENCY API		Date:
Sheryl R	Reed, HFE	NE II		06/02/2016	(L19)	Kate Joh	nnsTon, Pr	ogram Specialis	06/20/2016 (L20)
	PAR	T II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY	(===)
19. DETERMINATION OF ELIC _X 1. Facility is Eligi 2. Facility is not	ble to Participate	(L21)		IPLIANCE WITH C	IVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	\-1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	В	C AGREEMI EGINNING .41)		4. LTC AGREEME ENDING DATI (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	_00		L30) ARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE:	A.	Suspension	E SANCTIONS of Admissions: pension Date:	(L44) (L45)		03-Risk of Involu- 04-Other Reason		OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:		29	. INTERMEDIARY/C			30. REMARKS			
			03001						
	(L28	3)			(L31)				
31. RO RECEIPT OF CMS-1539		32	. DETERMINATION (OF APPROVAL DAT	ΓE	Posted 06/	/24/2016 Co.		
	(L32	!)	05/12/2016		(L33)	DETERMINA	ATION APPRO	VAL	



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.

New Harmony Care Center June 20, 2016 Page 2

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



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.

New Harmony Care Center June 20, 2016 Page 2

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245381 _{Y1}	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 quali	fied State surveyor for the Medicare, Medicaid a	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).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		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)	Completed	Reg. #	483.25(I)	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. # 483.600	(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		
REVIEWE STATE AG		REVIEWED BY (INITIALS) SR/KJ	DATE 06/20/2016	SIGNATURE OF S		2581		DATE 06/02/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE
FOLLOW (4/14/2016	JP TO SURVEY CO	DMPLETED ON		ANY UNCORRECTI TED DEFICIENCIES				YES NO

POST-CERTIFICATION REVISIT REPORT

	R / SUPPLI			MULTIPLE CONS	STRUCTION	<u> </u>	TILL VIOIT ILL			DATE O	F REVISIT
245381	ATION NO	IVIDLIX	Y1	A. Building 01 - B. Wing	- BLDG 1				Y2	5/3/201	6 _{Y3}
NAME OF	FACILITY RMONY (CARE	CENTER				STREET ADDRESS, CIT 135 GERANIUM AVENUE SAINT PAUL, MN 55117		DΕ	•	
program, corrected provision	to show the	nose d late su nd the	leficiencie uch correc	es previously repo ctive action was a	orted on the CMS-25 accomplished. Each	667, Staten deficiency	and/or Clinical Laborator nent of Deficiencies and should be fully identifie 2567 (prefix codes show	Plan of Correction of Using either the	on, that have regulation o	r LSC	
ITE	VI			DATE	ITEM		DATE	ITEM			DATE
Y4				Y5	Y4		Y5	Y4			Y5
ID Prefix				Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101			Completed	Reg. #		Completed	Reg. #			Completed
LSC	K0144			04/18/2016	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
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REVIEWE CMS RO	D BY		REVIEW (INITIAL	/ED BY	DATE	TITLE				DATE	
FOLLOW (4/14/2010	JP TO SUR	VEY C	OMPLETE	D ON			RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			YES	s 🔲 no



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 /	MULTIPLE CONSTRUCTION		DATE OF REVISIT							
IDENTIFICATION NUMBER	A. Building		0/0/0040							
00492 _{Y1}	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	e surveyor to show those deficiencies previously	reported that have been corrected and the date such	1							

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).

ITE	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20570	Cor	rection	ID Prefix	21375		Correction	ID Prefix	21426		Correction
Reg. #	MN Rule 4658.04 Subp. 4	05 Cor	npleted	Reg. #	MN Rule Subp. 1	e 4658.0800	Completed	Reg. #	MN St. Statute 144 Subd. 3	A.04	Completed
LSC		05/0	05/2016	LSC			05/05/2016	LSC			05/05/2016
ID Prefix Reg. # LSC	21535 MN Rule4658.13 ⁻ Subp.1 ABCD	15 Cor	rection mpleted	ID Prefix Reg. # LSC	21540 MN Rule Subp. 2	e 4658.1315	Correction Completed 05/05/2016	ID Prefix Reg. # LSC	21620 MN Rule 4658.134	5	Correction Completed 05/05/2016
ID Prefix Reg. # LSC	21880 MN St. Statute 14 Subd. 20	4.651 Cor	rrection mpleted	ID Prefix Reg. # LSC			Correction	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			rection	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
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4/14/201	JP TO SURVEY CO	OMPLETED ON					TED DEFICIENCIES ES (CMS-2567) SEN			LIM6O12	

Page 1 of 1

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: UM6Q

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1		PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	F	acility ID: 00492
SPECIFIC PLANE CHANGE ON OVERSHIP 1	(L1) 245381 2.STATE VENDOR OR MEDICAID NO.	NO.	(L3) NEW HARM (L4) 135 GERANI	IONY CARE CEI IUM AVENUE EA	NTER	(I	.6) 55117	Initial Termination Validation	2. Recertification 4. CHOW 6. Complaint
STATE SUNYEY AGENCY REMARKS, T PART		NERSHIP				`			
A In Compliance With Program Regulements (a):	8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	` '	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	E		DATE: (L35)
I. LTC CERTIFIED BED BREAKDOWN 18 SNP 19 SNP 1CF 1IID 1861 (e) (1) or 1861 (f) (1); (L1.5) (L1.5) (L1.5) (L3.7) (L3.8) (L3.9) (L4.2) (L4.3) (L3.7) (L3.8) (L3.9) (L4.2) (L4.3) (L3.7) (L3.8) (L3.9) (L4.2) (L4.3) (L3.7) (L3.8) (L3.9) (L3.2) (L4.3) (L3.7) (L3.8) (L3.9) (L3.2) (L3.7) (L3.8) (L3.9) (L3.2) (L3.2) (L3.7) (L3.8) (L3.9) (L3.2) (L3.	From (a): To (b): 12. Total Facility Beds		A. In Complian Program Re Compliance1. A X B. Not in Com	nce With equirements Based On: Acceptable POC	n	2. T 3. 2 4. 7 X 5. I	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code	6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room	ces Limit or
Facility's request for a continuing waiver involving K033 is recommended.	18 SNF 18/19 SNF 76	19 SNF	ICF	IID	CIS.	15. FACILIT	Y MEETS		
19. DETERMINATION OF ELIGIBILITY 19. DETERMINATION OF ELIGIBILITY 10. Facility is Eligible to Participate 11. Facility is Eligible to Participate 12. Facility is not Eligible 12. Facility is not Eligible 12. ALT CAGREEMENT 12. LTC AGREEMENT 13. Both of the Above: 12. LTC AGREEMENT 14. LTC AGREEMENT 15. LTC AGREEMENT 16. LT	17. SURVEYOR SIGNATURE	Facility's	request for a c	05/03/2016	(L19)	18. STATE S Kate Jo	urvey agency apports ohns Ton, Pro	ogram Specialis	t 05/09/2016
OF PARTICIPATION 12/01/1986 (L.24) (L.41) (L.25) 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L.27) B. Rescind Suspension Date: (L.27) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. (L.28) (L.28) 30. REMARKS Posted 05/12/2016 Co. AW requested for K33 Email notification to CMS 05/12/2016 Co.	1. Facility is Eligible to Pa	Y	20. COM	MPLIANCE WITH C		21.	Statement of Financi Ownership/Control I	al Solvency (HCFA-2572)	-1513)
25. LIC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. (L28) (L28) 30. REMARKS Posted 05/12/2016 Co. AW requested for K33 Email notification to CMS 05/12/2016 Co.	12/01/1986	BEGINNING		ENDING DATI		VOLUNTAR 01-Merger, Cl 02-Dissatisfac	Y		ARY eet Health/Safety
O3001 (L28) (L28) (L31) Posted 05/12/2016 Co. AW requested for K33 Email notification to CMS 05/12/2016 Co.	25. LTC EXTENSION DATE: (L27)	A. Suspension of	of Admissions:					07-Provider	Status Change
31. RU RECEIPT OF CMS-1339 32. DETERMINATION OF APPROVAL DATE	28. TERMINATION DATE:			CARRIER NO.	(L31)				
	31. RO RECEIPT OF CMS-1539		. DETERMINATION (OF APPROVAL DA					MS 05/12/2016 Co.



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor 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

Fax: (651) 215-9697

Telephone: (651) 201-4118

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

-	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	COMPLETED	
		245381	B. WING _		04/14/2016	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	D BE COMPLÉTION	
F 000	INITIAL COMMENT	-S	F 00	00		
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 it is submission of the POC will ion 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. 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO		F 16	66	5/5/16	
	facility to resolve gr	ight to prompt efforts by the ievances the resident may se with respect to the behavior				
	by: Based on interview facility failed to ensumade to resolve resresidents (R82, R39) Findings include: During an interview complained a certain	NT is not met as evidenced and document review, the ure that prompt efforts were sident grievances for 2 of 2 e) who expressed concerns. on 4/12/16 at 10:14 a.m., R39 in department head had		F 166- Facility policy has been reby administrator with management/disciplinary team. Complaint/Grievance forms are plwall sleeves in common area on efloor for easy access. All staff in-services regarding policithe complaint/grievance process with the complaint policy and the complaint	aced in each cy and will be	
ADODATOS	electric scooter whi around the facility. I restricted the scoot	on the level of speed for the ch R39 used to transport R39 said the department head er to a level one which was	NATURE	conducted on/before May 5th. Reswere informed of the complaint/gr process and informed on how to c grievance form by the social work	ievance obtain a	

Electronically Signed

05/02/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245381	B. WING		04/14/2016		
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117			
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F 166	the lowest speed by be able to use discrete scooter. R39 end the scooter. R39 end the department hear about the speed. Refor help in resolving aware of the facility R39 insisted on der the safe use of the the bedroom the about in the hallway, the three levels of the the bedroom the about in the hallway, the three levels of the safety and indepart Resident able to sa room table, through Resident demo'd [with turning on/off sappropriate speed. I'ly [independently]. During an interview expressed concern some of the staff ar food in the evening seems to do anything familiar with a concern some (RN)-B, revergievance concern use, not aware of his source of the staff ar food in the evening seems to do anything an interview nurse (RN)-B, revergievance concern use, not aware of his source of the staff ar food in the evening seems to do anything seems to do anything an interview nurse (RN)-B, revergievance concern use, not aware of his source of the staff ar food in the evening seems to do anything seems to do anythi	at therapy had cleared R39 to retion with all three speeds of expressed being intimidated by a who was "harassing" R39 and the situation. R39 was not concern/grievance procedure. In the situation of the surveyor scooter. R39 demonstrated in sility to maneuver the scooter, R39 demonstrated the use of the scooter. If the form titled, Occupational screened resident 11/27/15, bendence with scooter. If the form titled, I [independent] the scooter was to dining the scooter and choosing Resident safe to use scooter.	F 166	Resident Council meeting held on 4/18/2016. The administrator also informed the residents of the Grievance/Complaint procedure at resident activity held on 4/29/16. Tomplaint/grievance process also reviewed at future monthly resident council meetings. Administrator postaff policy and Complaint/Grievan attached. Administrator will be responsible. R39 was re-evaluated by OT on the the scooter following State intervies afety of others, a new agreement use of the scooter was made between R39 and the OT. RT39 agreed to terms of use and signed the agree. The dietary manager followed up we regarding cold food customer servisupper meals. The most recent fol with R82 was made by the Dietary manager on 5-2-2016.	The will be t t clicy, All ce form e use of w. For on the een he ment. with R82 ice at		

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
NEW HARMONY CARE CENTER 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117 ID PROVIDER'S PLAN OF CORRECTION (XX COMPLETED STATEMENT OF CORRECTION SHOULD BE COMPLETED STATEMENT OF CORRECTION SHOULD BE COMPLETED STATEMENT OF COMPLET		245381	B. WING		04/	14/2016
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE: COMPL DATE:		ER		135 GERANIUM AVENUE EAST		
	PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
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 occumentation of resident concerns/grievances and the facility had stopped the process since mid 2015. F 280 483.20(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	A review of the face Grievance Policy a anytime you feel you an employee has regular you have a complator care in the facility concerned person following steps to oproblem." Step 3) (in a Grievance Logwork office. Writter grievances will be and will outline the eliminate the problem. When interviewed, director of social sof nursing (DON) you documentation of reand the facility had mid 2015. F 280 483.20(d)(3), 483. PARTICIPATE PLATE	lity policy dated 4/04 and titled, and Procedure, read; "If at a u are not being treated fairly, histreated you in any way, or if int about any aspect of service y, you or a family or any are encouraged to take the correct or eliminate the Grievances will be documented or file located in the social a responses to written sent within 7 days of receipt steps being taken to correct or em." on 4/13/16 at 1:00 p.m., the ervices (DSS) and the director erified there was no esident concerns/grievances stopped the process since O(k)(2) RIGHT TO NNING CARE-REVISE CP or right, unless adjudged erwise found to be remained the state, to ing care and treatment or and treatment. The plan must be developed the completion of the sessment; prepared by an arm, that includes the attending ered nurse with responsibility dother appropriate staff in remined by the resident's needs,				5/5/16

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F 280	legal representative and revised by a te- each assessment.	sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	80		
	by: Based on observat review, the facility for 1 of 1 resident (lift for all transfers. Findings include: During an observat R46 was transferre mechanical device. expressed R46 was but no one was ass transfers. F-A and F back home once Rexpressed talking voccasions as to whattempted for R46. Document review of dated 4/2/16, listed hemiparesis following cerebrovascular dispondent of the approach read; need. Assistive devicurrently Hoyer and	Family member (F)-A s supposed to pivot transfer sisting to coordinate the pivot R46 expressed a desire to go 46 is able to pivot transfer. F-A with the staff on numerous y a pivot transfer was not f the revised plan of care a diagnosis of hemiplegia and		F280: It is the intent of New Haccare Center to develop and mai current comprehensive plan of cresidents. R46 care plan has been revised current interventions. R46 care been revised to reflect the plan of transfers to a total lift transfer. It nursing staff will receive re-educe regarding revising and updating care plan by 5/4/16. DNS/Design audit 2 care plans each week x1 for current interventions and the plan each week x2 months. The be shared at the next Quality As meeting by the DNS/Designee for and further direction. Facility licinursing staff responsible for ong compliance. DNS responsible for compliance.	ntain a are for all to reflect plan has of care for cicensed ration of the nee will month in 1 care e data will surance or input ensed oing	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RMONY CARE CENTI	ER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
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F 329 SS=E	Resident Care Informassist 2 pivot. Document therapy assessment lift with nursing staff. During an interview nurse RN-B on 4/13 was not able to pivototal mechanical lift. During an interview (DON) on 4/15/16 at the plan of care and List were not accurate be updated to direct transfer. Furthermoland R46 would be in plan of care. 483.25(I) DRUG REUNNECESSARY DEACH Tesident's drug unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs us therapy is necessary in the second transfer.	ent review of the form titled, remation List, directed staff to ament review of the physical at dated 1/6/16, read, "Hoyer f." with the full time registered 8/16 at 1:00 p.m., verified R46 at transfer and was to be a continuous with the director of nursing at 11:00 a.m., the DON verified do Resident Care Information ate, and indicated both would at staff that R46 is a Hoyer are, the DON verified the F-A ancluded in the update to the EGIMEN IS FREE FROM RUGS g regimen must be free from and An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any	F 329			5/5/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
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F 329	drugs receive grad behavioral interven contraindicated, in drugs.	age 5 Ints who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 3	29			
	facility failed to ens R23, and R73) recomedications had or monitored and did (R73) who received medication, received interventions prior of Findings include:	nt review and interview, the ure 4 of 4 residents (R15, R1, eiving antipsychotic thostatic blood pressures not ensure 1 of 2 residents d an as needed antipsychotic ed non-pharmacological to medication use.			F329: It is the intent of New Harmon Care Center that residents drug residents drug residents drug residents drug residents. R15, R1, R23, R73, care plans have revised to include monitoring for additional consequences of antipsychotic drug therapy, along with specific indications the use of antipsychotic medications documented. Nursing staff are to document the use of non-pharmacon interventions prior to antipsychotic medication administration. Policy have nevised to reflect that orthostal blood pressures will be done weekly new orders and or medication incresidents.	e been verse gon for s to be blogical as tic y with	
	be awake, seated in When approached medication, Seroque notice or experience medication. R15 who behaviors. R15's face sheet we diagnoses which in disorder and deme	50 p.m., R15 was observed to in the wheelchair in her room. and interviewed regarding the uel, R15 indicated she did not be any side effects from the as observed to be relaxed with with admit date 9/6/12, R15 had cluded legal blindness, anxiety intia with behavioral ermore, R15 had an order for			1 month and monthly thereafter for Residents on antipsychotic medicat Nursing staff will receive re-educatic regarding unnecessary antipsychotic medication use. Antipsychotic medication policy will be reviewe 5/4/16. DNS/Designee will audit medication administration records or residents receiving antipsychotic medication therapy weekly for 2 mo and monthly for 1 month for complia with completion of orthostatic blood	ions. on c ication ed by of	

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F 329	which was started of R15's Minimum Darindicated R15 had a (Seroquel) X 7 days Assessment Refere R15's care plan dat Family reports convidelusional/paranoid [resident] stating gothings that have no unsafe etc. Seroque and reported helpfu 11/27/13 Keep MI non-effectiveness. effects] noted." How lacked documentation blood pressure more The MAR (Medicati January 2016, Febrapril 2016, indicate mg by mouth three 2016 indicated R15 hallucinations and compensary monitoring and stated, "My exprefusal to nurse praresident refuses more pressure monitoring "I cannot find any p	mouth three times a day, on 9/6/12. Ita Set (MDS) dated 3/14/16, an antipsychotic medication is within the last 7 days ence Date (ARD) period. It ded 4/8/16, identified, " versations of a content with resident: respond to dentist and falling etc: thappened, dreams, feeling el and Xanax used as ordered all. Seroquel increase on D updated on effectiveness or Report any adverse s/e's [side wever, R15's medical recordion of monthly orthostatic intoring. It on Administration Record) for ruary 2016, March 2016 and d R15 received Seroquel 25 times a day. MAR for April is had diagnosis of delusions, decreased appetite. a.m. registered nurse (RN)-A	F 329	pressures and documentation of interventions attempted prior to antipsychotic medication administ. The data will be shared at the nex Assurance meeting by the DNS/D for input and further direction. Facilicensed nursing staff responsible ongoing compliance. DNS respondience.	t Quality esignee cility for	

	OF DEFICIENCIES OF CORRECTION	` '		(X3) DATE SURVEY COMPLETED			
		245381	B. WING		 	04/-	14/2016
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F 329	indicated, the staff monthly orthostatic resident receiving a resident is coopera. On 4/14/16 at 11:21 pharmacist (PC) stapressure monitoring monitoring and is puthere is no reason viceommendation. In expectation is facility orthostatic blood promonthly orthostatic blood promonthly orthostatic. R1 was admitted to diagnoses of bipolar generalized anxiety disorder. The physician order included Seroquel (milligrams (mg) tabe disorder, and Seroquel (milligrams (mg) tabe disorder, and Seroquel (antipsych (antidepressant me (antianxiety medica). The care plan dated the care plan dated antianxiety medica.	a.m. director of nursing was supposed to monitor blood pressure for any antipsychotic medication if the tive and able to stand. I a.m. the consultant ated, monthly orthostatic blood g is included in the side effect art of ongoing assessment, why he should make a naddition, PC indicated, his ty staff should monitor essure monthly. I lacked documentation of blood pressures. I the facility on 1/12/15, with ar disorder, anxiety disorder, and personality I stated 4/1/16 - 4/30/16 (antipsychotic medication), 100 (alet once a day for bipolar quel (antipsychotic at bedtime. I d 4/12/16, indicated R1, with diagnosis of bipolar n, anxiety and received notic medication), Paxil (dication), and Klonopin (d 4/6/16, indicated R1 was at d to weakness, unsteadiness,	F3	329			

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F 329	all cares, mobility, a needed (prn). On 4/13/16, at 1:53 (LPN)-B stated she monitoring but does pressures.	ge 8 ug use. R1 required assist with and E-Z stand transfers as p.m. licensed practical nurse does weekly blood pressure a not monitor orthostatic blood 8 p.m. director of nursing	F3	329			
	(DON) stated she e blood pressures for meds.	expected staff to be monitoring residents taking psychotropic					
		ored for possible changes in essure due to antipsychotic					
	R23's quarterly Min	to the facility on 9/22/14 and imum Data Set (MDS) of dementia, depression, and					
		rs dated 4/1/16 - 4/30/16, ne (antipsychotic medication)					
	received Effexor (all depressive disorder	cation) for dementia,					
	required standby as ambulation, use of of one with mobility	d 4/6/16 indicated R23 ssist with transfers and rolling walker, and supervision , is fall risk for due to on, and dependence on staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 329	documentation of m pressures. On 4/13/16, at 1:53 (LPN)-B stated she monitoring but does pressures. On 4/14/16, at 12:1 (DON) stated she e blood pressures for meds. R73 was not monitor orthostatic blood pressures. Review of R73's recadmitted on 11/26/1	edical record lacked nonthly orthostatic blood p.m. licensed practical nurse does weekly blood pressure is not monitor orthostatic blood 8 p.m. director of nursing expected staff to be monitoring in residents taking psychotropic ored for possible changes in essure due to antipsychotic cord indicated R73 was 14 with diagnosis including	F 32	9		
	dementia without be unspecified dement and essential hyper Review of R73's recorders for Seroquel 25 miligrams (mg) to day, and 50 mg ond Review of R73's rec Administration Record Behavior/Intervention Treatment Record to 2016, March 2016, monitoring of orthose	ehavioral disturbances, tia with behavior disturbances, rtension (high blood pressure). cord indicated Physician (an antipsychotic medication) twice a day and 50 mg once a be a day as needed (prn). cord including Medication				

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F 329	4/14/16 at 11:30 a.r and the staff should blood pressures on antipsychotic medic blood pressures we residents. Review of the unda Protocol Statement following handwritte residents recieving therapy will have or checks done daily for medication incre R73 received as ne medication without non-pharmacologic Review of R73's Jaindicated R73 received as ne medication without non-pharmacologic Review of R73's Jaindicated R73 received as ne medication without non-pharmacologic Review of R73's Jaindicated R73 received as ne medication without non-pharmacologic Review of R73's Jaindicated R73 received as ne medication without non-pharmacologic land land land land land land land land	Director of Nursing (DON) on m., she stated it is in the policy of the completing the orthostatic any resident who receives an eation, and verified orthostatic are not being checked on those of ted "Antipsychotic Medication of House Policy" directed the en statement: "In addition, (sic) antipsychotic drug thostatic blood pressure or 1 week with new orders and ase then monthly thereafter." Deeded (prn) antipsychotic documentation of al interventions. The provided a prn dose of Seroquel on 16/16 and 3/17/16 without any ny non-pharmacological ts. Review of R73's January ior/Intervention Monthly Flow ates lacked any documentation cological interventions administration of the eation. Review of the Resident 1/10/16 at 21:40 indicated Seroquel) was given for ome what helped." No macological interventions	F 32	29		
	3/16/16 and 3/17/10 the use of the prn 5	dent Progress Notes for 6 lacked any documentation of 6eroquel, or any al interventions before the use				

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		245381	B. WING		04/	14/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	4/14/16 indicated no interventions should prn anti-psychotic a being completed. Review of New Har policy titled "Antipsy Statement of House following: It is the pencourage multidisc factors responsible behavior and to end	stered Nurse (RN)-C on	F 329			
F 428 SS=D	483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least or pharmacist. The pharmacist muthe attending physic nursing, and these This REQUIREMENT by: Based on interview facility failed to follow recommendations for the second seco	egimen review, report on on of each resident must be not a month by a licensed of the report any irregularities to cian, and the director of reports must be acted upon. In or of a review, the with a pharmacy consultant or 1 of 2 residents (R73) who ded (prn) antipsychotic	F 428	F428: Failure to follow Pharmacy Consultant Recommendations It is the intent of New Harmony Can Center that residents drug regime		5/5/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245381	B. WING			04/1	4/2016
	PROVIDER OR SUPPLIER RMONY CARE CENT	ER		13	TREET ADDRESS, CITY, STATE, ZIP CODE 35 GERANIUM AVENUE EAST 6AINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	behavioral disturbathypertension (high R73's Physician Or 4/30/16, included, 5 medication] 50 mg prn for agitation/pa R89's record included the pharm updating charting/n of non drug interve psychotropic's are locate consistent e interventions were use. Review of R73's Ja 2016 Medication Adindicated R73 had Seroquel 4 times whon-drug intervention of the medication. Interview with Regitation Adindicated R73 had Seroquel 4 times whon-drug intervention of the medication. Interview with Regitation and interventions should printer anti-psychotic abeing completed/decent Review of New Halpolicy titled "Antips	agnosis included dementia with unces, and essential blood pressure). Inder Report dated 4/1/46 - Seroquel [an antipsychotic [milligrams] oral once a day ranoia/anxiety. Ided the "Consultant Pharmacist Nursing," dated 12/15/15, nacists recommendations of monitoring to document failures nations before prnused, as he was unable to vidence that non-drug tried prior to prn medication anuary, February, and March dministration Record (MAR), been administered the prnoith no documentation of ons attempted prior to the use stered Nurse (RN)-C on non-pharmacological d be tried before the use of the and verified it was not always	F 4	128	free from unnecessary drugs. All consultant pharmacist recommendations will be reviewed I physician and/or nursing staff in a ti manner. Documentation of follow-u results will be maintained in residen charts including medication change work, or other interventions. Licens nursing staff will be re-educated in u prn antipsychotic medication, includ need to document alternate interver that were tried prior to giving a prn of an antipsychotic by 5/4/16. The DNS/Designee will monitor prn antipsychotic medication administrat for documentation of interventions attempted prior to administration. The done weekly x2 months and 1x r for 1 month. Results of audit will be reported to the QA Committee for re Facility licensed nursing staff respon for ongoing compliance. DNS respon for overall compliance.	mely up at s, lab sed use of ling the ations dose of this will month every eview.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245381	B. WING		04/	14/2016	
NAME OF PROVIDER OR SUPPLI			STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
encourage multi factors responsi behavior and to	page 13 e policy of this facility to disciplinary efforts to identify ble for changes in a resident's encourage consideration of ug) means of treating those	F 4	28			
F 431 SS=D 483.60(b), (d), (d) LABEL/STORE The facility must a licensed pharm of records of recontrolled drugs accurate reconcrecords are in or controlled drugs reconciled. Drugs and biologiabeled in according professional primappropriate accessing instructions, and applicable. In accordance with facility must stor locked compartment on trols, and permanently afficontrolled drugs Comprehensive Control Act of 18 abuse, except with a license of pharmanent with the control act of 18 abuse, except with the solution of the control act of 18 abuse, except with the solution of the control act of 18 abuse, except with the control act of 18 abuse.	employ or obtain the services of nacist who establishes a system eipt and disposition of all in sufficient detail to enable an liation; and determines that drug der and that an account of all is maintained and periodically gicals used in the facility must be lance with currently accepted ciples, and include the ssory and cautionary the expiration date when the State and Federal laws, the eall drugs and biologicals in nents under proper temperature mit only authorized personnel to the keys. provide separately locked, sed compartments for storage of listed in Schedule II of the Drug Abuse Prevention and 76 and other drugs subject to nen the facility uses single unit estribution systems in which the	F 4	31		5/5/16	

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVE COMPLETED	
	245381	B. WING		04/1	4/2016
	ER	1	35 GERANIUM AVENUE EAST		
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
quantity stored is mbe readily detected This REQUIREMEI by: Based on observareview, the facility for medications were rowed (R31 and R81) review. Findings include: During observation cart on 4/14/16, at stored: One bottle of acet (mg), approximatel expiration date of 1. One bottle of Ben capsules for R81 words.	NT is not met as evidenced tion, interview and document ailed to ensure expired emoved for 2 of 2 residents ewed for medication storage. of the first floor medication 11:21 a.m., the following were aminophen 500 milligram y 25 tablets, for R81 with an /28/16 adryl 25 mg, approximately 30 ith an expiration date of ma 8.6 mg approximately 3/4 full	F 431	F431: Drug Storage Expired med It is the intent of New Harmony Car Center to provide pharmaceutical s that will monitor drugs and biological used in the facility to ensure correct labeling and dating according to phimedication storage and expiration guidelines. Expired medication for R31, R81 wheremoved from the medicant immedial All drugs and biologicals will be rould monitored for expiration dates and removed from medication storage and disposed of in accordance with regulations. Licensed nursing staff re-educated by 5/4/16 regarding the importance of checking expiration of prior to administration of medications.	e ervices als tarmacy ere ately. tinely will be areas will be elates	
included acetamino tablets twice a day (diphenhydramine I milligrams (mg), 2 d Senna-S tablet, 8.6 every other day. Readministration recoacetaminophen wa was administered 1 was administered 1	ophen extra strength 500 mg, 2 as needed (prn), Benadryl ncl) (OTC) capsule, 25 capsules (50 mg) oral prn and 1-50 mg, 1 tablet once a day 131's January 2016 medication rd (MAR) indicated a administered 1/2/16, Senna 1/16 and 1/20/16 and Benadryl 1/21/16. The February 2016		expiration dates will be conducted to pharmacy nurse monthly for 3 monthly for security large and consumption of the formal for input & furth direction. Facility licensed nursing security licensed for formal form	ths. Ilting ality er staff	
	PROVIDER OR SUPPLIER RMONY CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa quantity stored is m be readily detected This REQUIREMENT by: Based on observation cart on 4/14/16, at stored: - One bottle of acet (mg), approximatel expiration date of 1 - One bottle of Ben capsules for R81 w 2/17/16 - One bottle of Sen for R81 with an exp R81's physician ord included acetaminot tablets twice a day (diphenhydramine I milligrams (mg), 2 of Senna-S tablet, 8.6 every other day. R8 administration reco acetaminophen wa was administered 1 was administered 1 was administered 1	PROVIDER OR SUPPLIER RMONY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	PROVIDER OR SUPPLIER RMONY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 34 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 1/216 and 1/20/16, Senna was administered 1/16 and 1/20/16. The February 2016	PROVIDER OR SUPPLIER RMONY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) 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 falled 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 Senna 8.6 mg approximately 30 capsules 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 with a can 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 with a can expiration date of 4/6/16. R81's physician orders dated 3/1/16 - 4/14/16, included acetaminophen extra strength 500 mg, 2 tablet store a day as needed (prm), 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. The February 2016	PROVIDER OR SUPPLIER RMONY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 (Part and Preceded By: Based on observation, interview and document review, the facility failed to ensure expired medications were removed for 2 of 2 residents (RS1 and R81) reviewed for medication storage. Findings include: During observation of the first floor medication card 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 Senna 8.6 mg approximately 30 capsules for R81 with an expiration date of 1/28/16. One bottle of Senna 8.6 mg approximately 30 capsules for R81 with an expiration date of 1/28/16. One bottle of Consumers of the first floor medication storage are as 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 or ecord (MAR) indicated acetaminophen was administered 1/21/16, Senna was administered 1/21/16, The February 2016 medication administration record (MAR) indicated acetaminophen was administered 1/21/16, Senna was administered 1/21/16, The February 2016 medication administration record (MAR) indicated acetaminophen was administered 1/21/16, Senna was administered 1/21/16, The February 2016

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		245381	B. WING		04/	14/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
F 431	The March 2016 May was not administered 3/7, 3/11, 3/13, 3/15 and 3/31. The April was administered 4 administered 4/5, 4. The medication carl pratropium bromide inhalation solution will vials each for R31 will record did not included Ipratropium nebulization, 3 milling needed (prn). R31's record did not included Ipratropium nebulization, 3 milling needed (prn). R31's record did not included Ipratropium nebulization, 3 milling needed (prn). R31's record did not included Ipratropium nebulization, 3 milling needed (prn). R31's record did not included Ipratropium nebulization, and the continuity of the service of the service of the service of undated Facility policy direct "10. Outdated, continuity policy direct "10. Ou	AR indicated acetaminophen ed. Senna was administered 5, 3/19, 3/21, 3/23, 3/27, 3/29 2016 MAR indicated Benadryl /13/1 and Senna was /9, 4/11 and 4/13. It also contained one box of e and albuterol sulfate with three packages of five with an expiration date of 3/16. Iters dated 3/1/16 - 4/14/16, m-albuterol solution for iters (ml) every six hours as a March 2016 medication de any administered prn dose. RN)-B verified the medications emoved them from the cart. p.m. director of nursing should not be any expired as DON further stated staff cation expiration dates before Medication Storage in the ed: aminated, or deteriorated ose in containers that are abeled, or without secure diately removed from stock, ing to facility procedures for tion, and reordered from the	F4	.31		
F 441	pharmacy if a curre 483.65 INFECTION	nt order exists." I CONTROL, PREVENT	F 4	41		5/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245381	B. WING			04/ ⁻	14/2016
	PROVIDER OR SUPPLIER RMONY CARE CENTI	ER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 441 SS=E	The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infection Control The facility must es Program under white (1) Investigates, coin the facility; (2) Decides what preshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spree (1) When the Infective determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will the (3) The facility must hands after each dinand washing is incorpressional practice. (c) Linens Personnel must hand to the present that the control of t	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective fections. I ad of Infection ion Control ch it - ntrols, and prevents infections are considered as a solution, or an individual resident; and ord of incidents and corrective fections. I ad of Infection ion Control Program resident needs isolation to of infection, the facility must as a cr infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which licated by accepted	F 4	441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245381	B. WING _		04/1	14/2016
NAME OF PROVIDER OR SUPPLIER NEW HARMONY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
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F 441	Continued From particles of the bath chair. Lice came to assist with washing hands or upair of gloves and gresser to find a bradjusting the positioning of the move and the mechanical device the bedroom doork gloves and transpo	nge 17 NT is not met as evidenced tion, interview and document ailed to implement procedures ad of infection with g resident care for R18 and ag the mechanical lift device	F 44	,	n e a The ewed s and ts of 2 the the mill be will be are at a for erculin are the	
	outside the bedroom did not perform har NA-A donned a nev	rom the room to a hamper m door, removed gloves, and hd hygiene. w pair of gloves in the tub room here were no gloves in the tub		the Medication Administration Reco Licensed nursing staff will be educa this procedure by 5/4/16. DNS/Des will audit TST results for resident admissions for induration documer for 2 months. The DNS/Designee	ated on signee station	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245381	B. WING			04/	14/2016
NAME OF PROVIDER OR SUPPLIER NEW HARMONY CARE CENTER				13	TREET ADDRESS, CITY, STATE, ZIP CODE 35 GERANIUM AVENUE EAST SAINT PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
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. NA-B took the mechanical lift into R18's room 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.		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO		rther staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 441	and NA-B verified g was no hand hygier verified the mechan between resident us. During an interview 4/13/16, at 1:00 p.m perform hand hygie Furthermore, the Dhave a policy for the sanitizing, nor did the sanitize the mechanuse. A review of the unchand hygie infectious disease, replace handwashing directions disease, replace handwashing the following condit work surfaces potentials.	on 4/13/16, at 11:58 a.m. NA-A alloves were changed but there he performed. NA-A and NA-B nical device was not sanitized se. with the director of nursing on heart to he whenever changing gloves. ON verified the facility did not be use of alcohol gel hand he facility have a policy to hical devices between resident	F 44					

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

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - BLDG 1 245381 B. WING 04/14/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 135 GERANIUM AVENUE EAST **NEW HARMONY CARE CENTER** SAINT PAUL, MN 55117 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE 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 (X6) DATE

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

Facility ID: 00492

If continuation sheet Page 1 of 4

04/29/2016

TITLE

Electronically Signed

program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OINID IAC	. 0930-039
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR ING 01 - BLDG			E SURVEY MPLETED
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K 000	Continued From pa	· ·	K	000			
		PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defic	what has been, or will be, done iency.					
	2. The actual, or p	roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					
27	with a partial base constructed at 2 di building was const determined to be construction. Because 1976, a 3rd Floor a was determined to construction. Because 1 addition mee	re Center is a 4-story building ment. The building was fferent times. The original ructed in 1966 and was of Type II(222) construction. In addition was constructed and be of Type II(222) ause the original building and of the construction type allowed gs, the facility was surveyed as					
	throughout. The fa with smoke detect open to the corrido is monitored for au notification. The fa	omatic fire sprinkler protected acility has a fire alarm system ion in the corridors, spaces ors and all sleeping rooms that atomatic fire department acility has a capacity of 76 beds of 69 at time of the survey.					
K 033	NOT MET as evide	nt 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K	033			4/25/16

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

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G 01 - BLDG 1		E SURVEY PLETED
		245381	B. WING _		04/	14/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP C 135 GERANIUM AVENUE EAST SAINT PAUL, MN 55117	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 033 SS=F	with construction had least one hour, a continuous path of against fire or smoth building. 7.1.3.2, 8. This STANDARD is Based on observation failed to provide an protection required Sections 19.3.1.1, could affect all 76 refindings include: On facility tour betwon 04/14/2016, it with 1. The basement led elevator machine restair enclosure. 2. The first floor a onto the north stair.	ch as stairways) are enclosed aving a fire resistance rating of are arranged to provide a escape, and provide protection we from other parts of the 2.5.2, 8.2.5.4, 19.3.1.1 s not met as evidenced by: tion and interview, the facility d maintain the vertical opening by NFPA 101 - 2000 edition, 8.2.5. This deficient practice esidents. In even opened directly into the storage room opened directly enclosure. In elevator machine room to the central stair enclosure.	K 03	Waiver request for Tag K03	33 is attached	
K 144 SS=C	and FMS survey. NFPA 101 LIFE SA Generators inspectunder load for 30 n	rided granted during the last survey when the stranger of the last survey when the stranger of	K 14	.4		4/18/16

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

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES AD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BLDG 1		COMPLETED				
		245381	B. WING			04/	14/2016
	PROVIDER OR SUPPLIER	ER		135 GE	ADDRESS, CITY, STATE, ZIP CODE RANIUM AVENUE EAST PAUL, MN 55117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 144	110) This STANDARD is Based on review of facility failed to main accordance with - 1999 edition and section 3-4.1.1.2. The affect the safety of Findings include: On facility tour betwon 04/14/2016, based occumentation it will documentation for down period when	NFPA 99), Chapter 6 (NFPA s not met as evidenced by: of records and interview, the intain the emergency generator the requirements of NFPA 110 NFPA 99 - 1999 edition, This deficient practice could all patients, staff and visitors. In the emergency generator the requirements of NFPA 110 NFPA 99 - 1999 edition, This deficient practice could all patients, staff and visitors. In the emergency generator and the minimum 5 minute cool testing generator.	K 1	K1 per nov	44-The minimum 5 minute cooliod included in the generator to vincluded in the log. Revised lached.	est is	

Facility ID: 00492

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.

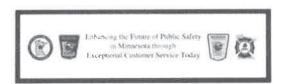
Tom Linhoff Fire Safety Supervisor

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



Name of Facility: New Harmony Care Center

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S) required, attach additional sheet(s). A waiver for K 033 is being requested regarding JUSTIFICATION

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

to relocate the elevator machine rooms and the storage room. above cannot be relocated and the owner cannot change the swing of the door. It would be a financial hardship Due to the design of the area, the two elevator machine room doors and the storage room door as described

compartments on each floor. The stairs would be a rarely used option of evacuation. rarely used. The facility's evacuation plan is focused on horizontal movement of residents to smoke the doors in the stairs will be shut and out of resident traffic. The doors are on closers and these doors are residents who reside at the facility rarely use the stairs. Residents primarily use the elevators. In emergencies This waiver does not adversely affect the residents to leave the doors in the stair enclosures because the

Signage " CAUTION! OPEN DOOR SLOWLY! DO NOT PROP DOOR " are posted inside each of the doors

Date	Office	Title	Fire Authority Official (Signature)
A	of STATE FIRE MARSHAL	FIRE SAFARY SUPERUSOR	June 1 th
Date	Office	Title	Surveyor Agnature)



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

New Harmony Care Center April 22, 2016 Page 2

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.

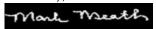
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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 guestions 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

PRINTED: 05/03/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00492	B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	FR	NIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depart					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/02/16 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 25 UM6Q11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016
_	PROVIDER OR SUPPLIER	135 GERA	DRESS, CITY, S ANIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be state Licensing federal software. The assigned to Minnesota Department be state Licensing federal software. The assigned to Minnesota Department be state of compartment of the state of the Suggested of	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 14, 2016, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting and numbers have been nota state statutes/rules for umber appears in the far left a Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute in This Rule is not met as wing the surveyors findings Method of Correction and rection. IRD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM UM6Q11 If continuation sheet 2 of 25

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE : COMPI		
		00492	B. WING		04/1	04/14/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
NEW HA	RMONY CARE CENTI	-R	NIUM AVEN				
	OLIMANA DV. OTA		UL, MN 551		N	2.5	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.						
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision		2 570			5/5/16	
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required					
	by: Based on observati review, the facility fa for 1 of 1 resident (I lift for all transfers. Findings include: During an observati R46 was transferred mechanical device. expressed R46 was but no one was ass transfers. F-A and F back home once R4	ent is not met as evidenced on, interview and document ailed to revise the plan of care R46) to require a mechanical on on 4/13/16 at 6:56 p.m., dusing the total lift Family member (F)-A supposed to pivot transfer isting to coordinate the pivot R46 expressed a desire to go 46 is able to pivot transfer. F-A vith the staff on numerous		It is the intent of New Harmony Ca Center to develop and maintain a comprehensive plan of care for all residents. R46 care plan has been revised to current interventions. R46 care plan been revised to reflect the plan of transfers to a total lift transfer. Lic nursing staff will receive re-educat regarding revising and updating of care plan by 5/4/16. DNS/Designe audit 2 care plans each week x1 m current interventions and then 1 ca each week x2 months. The data w shared at the next Quality Assurant.	o reflect an has care for ensed ion the ee will nonth for are plan will be		

Minnesota Department of Health

STATE FORM 6899 UM6Q11 If continuation sheet 3 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016
	PROVIDER OR SUPPLIER	FR 135 GERA	ORESS, CITY, S INIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	occasions as to why attempted for R46. Document review o dated 4/2/16, listed hemiparesis followin cerebrovascular dis non-dominant side, the approach read; need. Assistive dev currently Hoyer and progressed to max sided weakness) fo assist 1-2 per need necessary] Docume Resident Care Infor assist 2 pivot. Docume Resident Care Information assist 2 pivot. Document with nursing staff During an interview nurse RN-B on 4/13 was not able to pivot total mechanical lift. During an interview (DON) on 4/15/16 at the plan of care and List were not accurate be updated to direct transfer. Furthermound R46 would be inplan of care. SUGGESTED MET The director of nursidevelop and implementated to care plan	y a pivot transfer was not If the revised plan of care a diagnosis of hemiplegia and ng unspecified sease affecting the left The plan of care for transfers, "Assist with transfers per rice per PT recommendation: I 2 staff- (8-13-15) has assist of 2 pivot to Rt side (Lt r transfers. 9/4/15 pivot with . Hoyer prn [whenever ent review of the form titled, rmation List, directed staff to ument review of the physical at dated 1/6/16, read, "Hoyer f." with the full time registered B/16 at 1:00 p.m., verified R46 bit transfer and was to be a	2 570	meeting by the DNS/Designee for and further direction. Facility licer nursing staff responsible for ongo compliance. DNS responsible for compliance.	nsed ing	

Minnesota Department of Health

STATE FORM 6899 UM6Q11 If continuation sheet 4 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
NEW HA	RMONY CARE CENTI	-R	NIUM AVEN UL, MN 551				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE	
2 570	Continued From pa	ge 4	2 570				
	revisions. The quali	imeliness of care plan ty assessment and assurance erform random audits to					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			5/5/16	
	home must establis	n control program. A nursing h and maintain an infection signed to provide a safe and nt.					
	by: Based on observation review, the facility for to prevent the spread handwashing during R46 and when using between resident R. Findings include: During observation at 9:09 a.m., nursing the room to assist wwash hands or alcopair of gloves to assist of the bath chair. Licel came to assist with washing hands or userview.	g resident care for R18 and g the mechanical lift device		It is the intent of New Harmony Ca Center to maintain an infection corprogram designed to provide a sat sanitary environment. Nursing staff will be re-educated or preventing the spread of infection. policy on hand hygiene will be revialong with appropriate use of glowhand hygiene following glove use. DNS/Designee will do random auch hand washing/glove use weekly formonths. The data will be shared a next quality assurance meeting by DNS/Designee for input and further direction. The mechanical lift handles will be sanitized between residents. Baga attached to lifts which will contain sanitizing wipes to be used by staf Nursing staff will be educated on the sanitation of the sanitized between the	ntrol fe & The ewed es and dits of or 2 at the othe er es will be		

Minnesota Department of Health

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Minneso	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00492	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
		135 GFRA	NIUM AVEN			
NEW HA	RMONY CARE CENT	ER SAINT PA	UL, MN 551	17		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
	Continued From particles of the messer to find a briadjusting the brief of positioning of the management of the mechanical device help of LPN-A move chair. NA-A left continued the bedroom doork gloves and transposition without performing removed the linen foutside the bedroom did not perform harmous of the terminal o	ge 5 ef. Then, LPN-A assisted with on, and assisting with the echanical lift sling under R46. ontaminated gloves, picked upice for the lift and with the ed R46 into position in the tub taminated gloves on, opened nob with the contaminated rted R46 down the hallway hand hygiene LPN-A rom the room to a hamper in door, removed gloves, and			dits will soure at a g for erculin duration cate the ented on cord. cated on will ality urther y staff ce. DNS	DATE
	mechanical sling in transfer.	to place to assist with the ice was set into the hallway				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 6 of 25 UM6Q11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016
	PROVIDER OR SUPPLIER	ER 135 GERA	ORESS, CITY, S INIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	without sanitizing the staff had contaminated. NA-B took the mec without sanitizing be not perform hand hadjust the Foley car adjusting bed linen room to assist R18 donned gloves, mo assisted with the m NA-A and NA-B roll bed to remove the position R18. When interviewed and NA-B verified gwas no hand hygier verified the mechar between resident under the perform hand hygier verified the mechar between resident under the position R18. During an interviewed 4/13/16, at 1:00 p.m perform hand hygier Furthermore, the Dhave a policy for the sanitizing, nor did the sanitize the mechanuse. A review of the unce Handwashing, directious disease, replace handwashing condit work surfaces pote	the remote control which the lated during the transfer. Thanical lift into R18's room between resident use. NA-B did ygiene and donned gloves to theter, oxygen tubing, and for R18. NA-A came to the land without hand hygiene wed catheter tubing, and echanical lift transfer into bed. ed R18 back and forth in the mechanical lift sling and lift sling and lone 4/13/16, at 11:58 a.m. NA-A gloves were changed but there he performed. NA-A and NA-B hical device was not sanitized se. With the director of nursing on land, verified the staff were to land	21375			

Minnesota Department of Health STATE FORM

6899 UM6Q11 If continuation sheet 7 of 25

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 04/1	4/2010	
NEW HA	RMONY CARE CENTI	-R	NIUM AVEN UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375 21426	SUGGESTED MET The director of nurs infection control pra and educate staff. designee, could cor delivery of care to e services are implen risk of infection. TIME PERIOD FOR (21) days.	HOD OF CORRECTION: sing or designee, could review actices during personal care The director of nursing or aduct random audits of the ensure appropriate care and mented in order to reduce the R CORRECTION: Twenty-one A.04 Subd. 3 Tuberculosis	21375 21426			5/5/16	
	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volum Health shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.					

Minnesota Department of Health STATE FORM

wiirinesc	<u>ita Department of He</u>	aith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NIEW IIA	DMONY CARE CENT	135 GERA	NIUM AVEN	IUE EAST		
NEW HA	RMONY CARE CENT	SAINT PA	UL, MN 551	17		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 8	21426			
	This MN Requirements: Based on document facility failed to document facility of document facility failed fa	ent is not met as evidenced treview and interview, the ument the induration results st (TST) for 4 of 5 residents (TST) in the facility on 3/14/16. R18's cated R18 received the first sol Solution 5 unit/0.1 milliliter in 3/16/16. There were no ate the induration of the TST urthermore, a second dose (Jution 5 unit/0.1 milliliter (ML) iven on 3/30/16, and there is to indicate the induration of		tag 1426: For all residents that have had tub skin testing done at facility, the incomposition of TST will be documented to indicate the Medication Administration Reculting Licensed nursing staff will be educated this procedure by 5/4/16. DNS/Dewill audit TST results for resident admissions for induration docume for 2 months. The DNS/Designee bring data to share at the next Quanch Assurance Meeting for input and for direction. Facility licensed nursing responsible for overall compliance	duration cate the ented on ord. cated on signee entation will ality curther staff se. DNS	
	medical record indical dose step of Tubers (ml) intradermally of documents to indicate given on 3/30/16. For step of Tubersol So intradermally was good no documents to interest to interest to interest to interest to indicate the medical record indicates and the step of Tubers intradermally on 3/1 documents to indicate given on 3/10/16. For step of Tubersol So intradermally was good to interest to indicate the step of Tubersol So intradermally was good to interest the step of Tubersol So intradermally was good to intradermally was good to intradermally was good to intradermally of tubersol So intradermally was good to intradermally was	iven on 4/8/16, and there were dicate the induration of the				

Minnesota Department of Health

STATE FORM 6899 UM6Q11 If continuation sheet 9 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
			, a solesino.				
		00492	B. WING		04/1	4/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
NEW HA	RMONY CARE CENT	FR	NIUM AVEN UL, MN 551				
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21426	Continued From pa	ge 9	21426				
	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."						
	DON or designee c screening audits, in ensure residents ar disease. The DON staff were educated induration of tubero designee could rand	THOD OF CORRECTION: The ould conduct resident terventions and monitoring to be free from communicable or designee could ensure the don the importance of ulin skin testing. The DON or domly audit resident's re adequate documentation					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one					
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			5/5/16	

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 10 of 25 UM6Q11

MILLINESC	nta Department of He	aim	r			,
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
	00492		B. WING		04/14	/2016
		00-102			0+/1-	72010
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	FR	NIUM AVEN			
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(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	TUALL	D/((L
21535	Continued From pa	ge 10	21535			
	Subpart 1. Genera	al. A resident's drug regimen				
		innecessary drugs. An				
		s any drug when used:				
		dose, including duplicate drug				
	therapy;					
	B. for excessiv	e duration;				
		quate indications for its use; or				
		nce of adverse consequences				
		dose should be reduced or				
	discontinued.					
		rug regimen review required in				
		e nursing home must comply				
		ne Interpretive Guidelines for				
		egulations, title 42, section				
		Appendix P of the State				
		, Guidance to Surveyors for				
		acilities, published by the				
		Ith and Human Services,				
		ring Administration, April 1992.				
		corporated by reference. It is needed to be made and the more of the corporated by reference. It is				
		te Law Library. It is not				
	subject to frequent					
	Subject to frequent	onange.				
	This MN Requireme	ent is not met as evidenced				
	by:					
		and document review, the		Failure to follow Pharmacy Consul	tant	
	facility failed to follo	w the pharmacy consultant		Recommendations:		
	recommendations for 1 of 2 residents (R73) who received an as needed (prn) antipsychotic medication.			It is the intent of New Harmony Ca		
				Center that residents drug regim	en be	
				free from unnecessary drugs.		
				All consultant pharmacist		
	Findings include:			recommendations will be reviewed		
	D701 1 1111 11			physician and/or nursing staff in a		
		gnosis included dementia with		manner. Documentation of follow-		
	behavioral disturba	*		results will be maintained in reside	-	
	hypertension (high	biooa pressure).		charts including medication chang		
				work, or other interventions. Licer	isea	

Minnesota Department of Health

STATE FORM 6899 UM6Q11 If continuation sheet 11 of 25

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0.400 0.00 0.000		LOVON DATE	01.151.751.7
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016
NAME OF PR	OVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE		
		135 GFRA	NIUM AVEN	,		
NEW HARI	MONY CARE CENTE	-R	UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535 (Continued From pa	ge 11	21535			
F Z ii S r C I Z ii K k F K S f e f k a	R73's Physician Ord 4/30/16, included, S medication] 50 mg orn for agitation/par R89's record include Communication to N ncluded the pharma updating charting/m of non drug interver osychotropic's are u ocate consistent eventerventions were to use. Review of R73's Jan 2016 Medication Ad ndicated R73 had to Seroquel 4 times with non-drug intervention of the medication. Interview with Regist 4/14/16 indicated no interventions should forn anti-psychotic a peing completed/do Review of New Hart policy titled "Antipsy Statement of House following: It is the pencourage multidisc factors responsible pehavior and to end	der Report dated 4/1/46 - Geroquel [an antipsychotic fmilligrams] oral once a day anoia/anxiety. The det the "Consultant Pharmacist Nursing," dated 12/15/15, acists recommendations of a conitoring to document failures at the final sed, as he was unable to a cridence that non-drug ried prior to prn medication The deterministration Record (MAR), been administered the prn at the no documentation of the set attempted prior to the use of the propagation of the deterministration of the set attempted prior to the use of the not verified it was not always	21303	nursing staff will be re-educated in prn antipsychotic medication, incluneed to document alternate interventhat were tried prior to giving a prn an antipsychotic by 5/4/16. The DNS/Designee will monitor prantipsychotic medication administr documentation of interventions attrict prior to administration. This will be weekly x2 months and 1x month formonth. Results of audit will be repthe QA Committee for review. Facilicensed nursing staff responsible ongoing compliance. DNS responsiverall compliance.	ding the entions dose of neation for empted endone or 1 corted to cility for	

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		L' COM		(X3) DATE	SURVEY PLETED	
ANDILAN	OF CONTILCTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COM	LLILD
		00492	B. WING		04/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	FR	NIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 12	21535			
	facility could review and procedures, pr pertaining to admin antipsychotic medi	THOD OF CORRECTION: The and/or revise their policies ovide staff education istration of as needed cation. The facility could then a system to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1318 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			5/5/16
	monitor each reside unnecessary drug to home's policies and pharmacist must regular resident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, to review to the Quality (QAA) committee regular the attending physician does not the order and if the change the order, the attending physician directly to the QAA.	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the real director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	-R	NIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	facility failed to ens R23, and R73) rece medications had or monitored and did r	t review and interview, the ure 4 of 4 residents (R15, R1, siving antipsychotic thostatic blood pressures not ensure 1 of 2 residents an as needed antipsychotic		F329: It is the intent of New Harm Care Center that residents drug be free from unnecessary drugs. R15, R1, R23, R73, care plans ha revised to include monitoring for a consequences of antipsychotic drugs.	regimen ve been dverse	
	medication, receive interventions prior t	d non-pharmacological		therapy, along with specific indicate the use of antipsychotic medication documented. Nursing staff are to document the use of non-pharmace.	ion for ns to be	
	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.			interventions prior to antipsychotic medication administration. Policy been revised to reflect that orthost blood pressures will be done week new orders and or medication incr	has atic dy with	
				1 month and monthly thereafter fo Residents on antipsychotic medical Nursing staff will receive re-educal regarding unnecessary antipsychotic medication use. Antipsychotic medication uses administration policy will be review 5/4/16. DNS/Designee will audit medication administration records	ations. tion otic edication yed by	
	diagnoses which in disorder and demendisturbance. Further	rmore, R15 had an order for mouth three times a day,		residents receiving antipsychotic medication therapy weekly for 2 m and monthly for 1 month for comp with completion of orthostatic bloo pressures and documentation of interventions attempted prior to antipsychotic medication administ	onths liance d	
	indicated R15 had a (Seroquel) X 7 days Assessment Refere R15's care plan dat Family reports conv delusional/paranoic [resident] stating go	ta Set (MDS) dated 3/14/16, an antipsychotic medication is within the last 7 days ence Date (ARD) period. led 4/8/16, identified, " versations of a content with resident: respond to dentist and falling etc: thappened, dreams, feeling		The data will be shared at the nex Assurance meeting by the DNS/D for input and further direction. Facilicensed nursing staff responsible ongoing compliance. DNS respor overall compliance.	t Quality esignee cility for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00492	B. WING		04/1	4/2016
	PROVIDER OR SUPPLIER	ER 135 GERA	DRESS, CITY, S ANIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	unsafe etc. Seroque and reported helpfu 11/27/13 Keep MI non-effectiveness. I effects] noted." How lacked documentation blood pressure more The MAR (Medication January 2016, Febrapril 2016, indicated mg by mouth three 2016 indicated R15 hallucinations and compared to the compared to	el and Xanax used as ordered al. Seroquel increase on D updated on effectiveness or Report any adverse s/e's [side vever, R15's medical record on of monthly orthostatic nitoring. on Administration Record) for tuary 2016, March 2016 and d R15 received Seroquel 25 times a day. MAR for April had diagnosis of delusions, decreased appetite. a.m. registered nurse (RN)-A	21540			

Minnesota Department of Health

STATE FORM UM6Q11 If continuation sheet 15 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00492	B. WING		04/1	4/2016
	PROVIDER OR SUPPLIER RMONY CARE CENTI	135 GER	DDRESS, CITY, S ANIUM AVEN AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa		21540			
	R1's medical record monthly orthostatic	l lacked documentation of 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).					
	(LPN)-B stated she	p.m. licensed practical nurse does weekly blood pressure a not monitor orthostatic blood				
	(DON) stated she e	8 p.m. director of nursing xpected staff to be monitoring residents taking psychotropic				

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00492	B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	FR	NIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 16	21540			
	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.					
		edical record lacked nonthly orthostatic blood				
	(LPN)-B stated she	p.m. licensed practical nurse does weekly blood pressure a not monitor orthostatic blood				
	(DON) stated she e	8 p.m. director of nursing expected staff to be monitoring residents taking psychotropic				

Minnesota Department of Health

STATE FORM UM6Q11 If continuation sheet 17 of 25

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00492	B. WING	····	04/1	4/2016
	PROVIDER OR SUPPLIER	135 GER	DRESS, CITY, S ANIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	R73 was not monitor orthostatic blood primedication use. Review of R73's readmitted on 11/26/1 dementia without be	ored for possible changes in essure due to antipsychotic cord indicated R73 was 14 with diagnosis including ehavioral disturbances,	21540			
	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.					
	Interview with the D 4/14/16 at 11:30 a.r and the staff should blood pressures on antipsychotic medic blood pressures we residents. Review of the unda Protocol Statement following handwritter residents recieving therapy will have or	Director of Nursing (DON) on m., she stated it is in the policy do be completing the orthostatic any resident who receives an eation, and verified orthostatic ere not being checked on those ted "Antipsychotic Medication of House Policy" directed the en statement: "In addition, (sic) antipsychotic drug thostatic blood pressure or 1 week with new orders and				

Minnesota Department of Health

STATE FORM UM6Q11 If continuation sheet 18 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00492	B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW HA	RMONY CARE CENT	FR	NIUM AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 18	21540			
	or medication incre	ase then monthly thereafter."				
	R73 received as needed (prn) antipsychotic medication without documentation of non-pharmacological interventions.					
	indicated R73 receit 1/10/16, 1/29/16, 3/4 documentation of a intervention attempt and March's Behave Record for those dof any non-pharma attempted prior to a antipsychotic medic Progress notes for "PRN Quetiapine (Sagitation @1515. Scindication non-pharwere attempted. Review of the Residual 3/16/16 and 3/17/10 the use of the prosider intervention in the second se	nuary and March's MAR ived a prn dose of Seroquel on (16/16 and 3/17/16 without any my non-pharmacological its. Review of R73's January ior/Intervention Monthly Flow ates lacked any documentation cological interventions administration of the cation. Review of the Resident 1/10/16 at 21:40 indicated Seroquel) was given for ome what helped." No macological interventions dent Progress Notes for 6 lacked any documentation of Seroquel, or any real interventions before the use				
	4/14/16 indicated n interventions should	stered Nurse (RN)-C on on-pharmacological d be tried before the use of the and verified it was not always				
	policy titled "Antips: Statement of House following: It is the pencourage multidis factors responsible	rmony Care Center undated ychotic Medication Protocol e Policy" indicated the policy of this facility to ciplinary efforts to identify for changes in a resident's courage consideration of				

Minnesota Department of Health

STATE FORM UM6Q11 If continuation sheet 19 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	
NEW HA	RMONY CARE CENT	-R	NIUM AVEN UL, MN 551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21540	Continued From pa	ge 19	21540		
	alternate (non-drug factors.) means of treating those			
	The DON or admini procedures, educat residents drug regir	THOD FOR CORRECTION: strator could establish e staff and audit to ensure that men is free of irregularities and ring is being completed.			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620		5/5/16
	Drugs used in the n in accordance with	ursing home must be labeled part 6800.6300.			
	by: Based on observation review, the facility for medications were received. Findings include: During observation cart on 4/14/16, at stored: One bottle of acet (mg), approximately expiration date of 1. One bottle of Bena capsules for R81 w 2/17/16. One bottle of Seni	ent is not met as evidenced on, interview and document ailed to ensure expired emoved for 2 of 2 residents ewed for medication storage. of the first floor medication 11:21 a.m., the following were aminophen 500 milligram y 25 tablets, for R81 with an /28/16 adryl 25 mg, approximately 30 ith an expiration date of 14.6 mg approximately 34 full iration date of 4/6/16.		It is the intent of New Harmony Care Center to maintain an infection controprogram designed to provide a safe 8 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 a hand hygiene following glove use. DNS/Designee will do random audits 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 we attached to lifts which will contain	ne ed and of le

Minnesota Department of Health STATE FORM

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			MULTIPLE CONSTRUCTION IILDING:		(X3) DATE SURVEY COMPLETED	
		00492	B. WING		04/1	4/2016
NAME OF I	IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
		135 GFRA	NIUM AVEN			
NEW HA	RMONY CARE CENT	ER SAINT PA	UL, MN 551	17	ı	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 20	21620			
	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 4/5, 4/9, 4/11 and 4/13.			sanitizing wipes to be used by state Nursing staff will be educated on the procedure by 5/4/16. Random aude be done weekly for 2 months to as compliance with the new policy. DNS/Designee will bring data to state next Quality Assurance Meeting input and further direction. For all residents that have had tube skin testing done at facility, the incompliance of TST will be documented to indicate the Medication Administration Recultions and the Medication Administration docume for 2 months. The DNS/Designee bring data to share at the next Quantication. Facility licensed nursing responsible for ongoing compliance responsible for ongoing compliance responsible for ongoing compliance.	his new dits will soure at a g for erculin duration cate the ented on cord. Cated on esignee entation will ality urther g staff ce. DNS	
	Ipratropium bromidinhalation solution v	t also contained one box of e and albuterol sulfate vith three packages of five vith an expiration date of 3/16.		responsible for overall compliance).	
	included Ipratropiur nebulization, 3 millil needed (prn). R31's	lers dated 3/1/16 - 4/14/16, n-albuterol solution for iters (ml) every six hours as a March 2016 medication de any administered prn dose.				
		RN)-B verified the medications emoved them from the cart.				
	(DON) stated there medications in carts	p.m. director of nursing should not be any expired s. DON further stated staff cation expiration dates before				

STATE FORM 6899 If continuation sheet 21 of 25 UM6Q11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		A. BUILDING.					
		00492	B. WING		04/1	4/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
I NEW HARMONY CARE CENTER			NIUM AVEN UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE		
21620	Continued From pa	ge 21	21620				
	administration.						
	Facility policy direct "10. Outdated, cont medications and th cracked, soiled, uni closures are immed disposed of accord medication destruct pharmacy if a current A SUGGESTED MI The director of nurs develop and impler to ensure that all m stored properly and develop monitoring compliance and rep Assurance Commit	caminated, or deteriorated ose in containers that are abeled, or without secure diately removed from stock, ing to facility procedures for tion, and reordered from the ent order exists." ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures edications are labeled and I educate all staff, and then systems to ensure ongoing port the findings to the Quality tee.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					
21880	Residents of HC Fa Subd. 20. Grieval shall be encourage their stay in a facilit to understand and patients, residents, residents may voice changes in policies	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff	21880			5/5/16	
	interference, coerci including threat of c grievance procedur	choice, free from restraint, on, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			7.1. 20123.110.1				
		00492	B. WING		04/1	4/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
NEW HA	RMONY CARE CENT	FR	NIUM AVEN UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21880	Continued From pa	ge 22	21880				
	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.						
	by: Based on interview facility failed to ens made to resolve res	and document review, the ure that prompt efforts were sident grievances for 2 of 2 9) who expressed concerns.		Facility policy on Complaint/Grieva been reviewed by administrator win management/disciplinary team. Complaint/Grievance forms are pl wall sleeves in common area on efloor for easy access. All staff insregarding policy and the	th aced in each		

Minnesota Department of Health

STATE FORM 6899 UM6Q11 If continuation sheet 23 of 25

Minnesc	<u>ita Department of He</u>	alth				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00492	B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, 9	STATE, ZIP CODE		
		135 GFRA	NIUM AVEN			
NEW HA	RMONY CARE CENT	ER SAINT PA	UL, MN 551	17		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 23	21880			
	During an interview complained a certa placed restrictions of electric scooter whi around the facility. I restricted the scoot the lowest speed by be able to use discribe scooter. R39 ethe department hear about the speed. Refor help in resolving aware of the facility. R39 insisted on der the safe use of the the bedroom the about in the hallway, the three levels of the safety and independent demo'd [with turning on/off sappropriate speed. I'ly [independently]. During an interview expressed concern some of the staff ar food in the evening seems to do anything.	on 4/12/16 at 10:14 a.m., R39 in department head had on the level of speed for the ch R39 used to transport R39 said the department head er to a level one which was ut therapy had cleared R39 to retion with all three speeds of expressed being intimidated by ad who was "harassing" R39 ray and in the situation. R39 was not concern/grievance procedure. The situation of the surveyor scooter. R39 demonstrated in sility to maneuver the scooter, R39 demonstrated the use of the scooter. The form titled, Occupational screened resident 11/27/15, bendence with scooter. The form titled, I [independent] cooter and choosing Resident safe to use scooter.	21000	complaint/grievance process will be conducted on/before May 5th. Reswill be informed of the complaint/grievance process and on how to obtain a grievance form group activity meetings on 4/29/16 5/02/16, and 5/03/16. The complaint/grievance process also reviewed at the monthly resident of meetings. Administrator policy, Al policy and Complaint/Grievance for attached. Administrator will be responsible.	informed through is, will be ouncil I staff	
		with the full time registered aled not being aware of the				

STATE FORM 6899 If continuation sheet 24 of 25 UM6Q11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00492	B. WING		04/1	4/2016	
NEW HARMONY CARE CENTER 135 GERA			DDRESS, CITY, STATE, ZIP CODE ANIUM AVENUE EAST AUL, MN 55117				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21880	grievance concerniuse, not aware of hithought social serviconcerns. A review of the facil Grievance Policy aranytime you feel you an employee has myou have a complai or care in the facility concerned person a following steps to coproblem." Step 3) on a Grievance Logwork office. Written grievances will be sand will outline the eliminate the problem. When interviewed, director of social see of nursing (DON) we documentation of research as a service of the service of t	process, not aware of forms to ow to locate a form and ce took care of resident ity policy dated 4/04 and titled, and Procedure, read; "If at u are not being treated fairly, histreated you in any way, or if not about any aspect of service y, you or a family or any are encouraged to take the correct or eliminate the carievances will be documented or file located in the social responses to written the ent within 7 days of receipt steps being taken to correct or em." on 4/13/16 at 1:00 p.m., the crvices (DSS) and the director	21880				
	director of nursing of requirement to addit make a good faith a grievances. Then d ensure ongoing cor findings to the Qual	THOD OF CORRECTION: The could in-service staff on the ress resident concerns and attempt to resolve the evelop monitoring systems to inpliance and report the ity Assurance Committee.					
	(21) days.	R CORRECTION: Twenty-one					

6899

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