DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 4, 2021

Administrator
New Harmony Care And Rehab Center
135 Geranium Avenue East
Saint Paul, MN 55117

RE: CCN: 245381
Cycle Start Date: August 30, 2021

Dear Administrator:

On September 21, 2021, we notified you a remedy was imposed. On November 3, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 2, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 6, 2021 be discontinued as of November 2, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 21, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 6, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Your request for a continuing waiver involving the deficiency(ies) cited under K0311 at the time of the August 30, 2021 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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 4, 2021

Administrator
New Harmony Care And Rehab Center
135 Geranium Avenue East
Saint Paul, MN 55117

Re: Reinspection Results
Event ID: ZHGE12, CVPO12, and ZTY712

Dear Administrator:

On November 3, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on surveys completed on August 30, 2021, September 30, 2021, and October 20,2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
October 27, 2021

Administrator
New Harmony Care And Rehab Center
135 Geranium Avenue East
Saint Paul, MN 55117

RE: CCN: 245381
Cycle Start Date: August 30, 2021

Dear Administrator:

On September 21, 2021, we informed you of imposed enforcement remedies.

On October 20, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On October 20, 2021, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 6, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 6, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 6, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of September 21, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide

Training and/or Competency Evaluation Programs (NATCEP) for two years from October 6, 2021.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, New Harmony Care And Rehab Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 6, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 November 30, 2021 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245381	A. BUILDING _____ B. WING _____	C 10/20/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/18/21 to 10/20/21 a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5381038C (MN00077564). The following complaint was found to be SUBSTANTIATED: H5381037C (MN00077501) with a deficiency issued at F689. The survey resulted in an Immediate Jeopardy (IJ) at F689 when R1 successfully eloped from the facility, went off the facility grounds, and was found by community members who notified paramedics. The IJ began on 10/19/21, 3:05 p.m. and the immediacy was removed on 10/20/21, at 2:30 p.m.. In addition, an extended survey was completed on 10/20/21, related to the substandard quality of care findings.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		11/2/21

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

Electronically Signed | 10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1 by: Based on interview and document review, the facility failed to prevent an elopement and provide safety for 1 of 2 residents (R1) identified at risk for elopement. R1 successfully eloped from the building, undetected, and was found by citizens about 0.2 miles away. This deficient practice resulted in immediate jeopardy (IJ) for R1. The Immediate Jeopardy (IJ) began at 6:45 p.m. on 10/8/21, when R1 attempted to elope through the front door of the facility. R1 was redirected to her room and assisted into bed at which time the attending nurse left to assist another resident. At 7:00 p.m. the door alarms sounded to alert staff one of the doors accessing the exterior of the building had been opened. Staff responded by searching the areas adjacent to the doors which led to the exterior of the building. Finding no one, staff searched the facility to ascertain which resident was missing. At 7:29 p.m. a nurse notified the administrator via telephone R1 was missing. The administrator subsequently notified the director of nursing (DON) and the nurse notified the local police via "911." At 8:32 p.m. the facility was notified by Saint Paul Fire Department paramedics that R1 was found by community citizens about 0.2 miles from the facility. R1 was then returned to the facility by the paramedics. The director of nursing (DON) was notified of the IJ on 10/19/21, at 3:05 p.m. The IJ was removed on 10/20/21, at 2:30 p.m. but non-compliance remained at a lower scope and severity level of D, which indicated no actual harm with a potential for more than minimal harm that is not immediate jeopardy.	F 689	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. F689 It is the policy of New Harmony to comply with F689. To assure continued compliance, the following plan has been put into place. Regarding cited resident: R1 was returned to facility. Skin assessment was completed by the nurse and no injuries were noted except a small contusion to the right middle finger. New Elopement Risk Observation was completed and care plan reviewed. A GPS locating device was added to R1 ankle. Actions taken to identify other potential residents having similar occurrences: IDT met 10/27/2021 to identify any other cognitively impaired residents at risk for elopement and if Elopement Observations and/or care plan updates were needed Measures put in place to ensure deficient practice does not recur: Staff educated on where to locate and	

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F 689	Continued From page 2 Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/6/21, identified R1 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 0/15. The MDS also identified R1 had diagnoses that included epilepsy, unspecified dementia without behavioral disturbances, and dysphagia following intracerebral hemorrhage (stroke). Review of the resident's progress note and incident report records revealed R1 had a history of elopement or attempted elopement on 3/18/20, 8/25/21, 9/13/21, 10/5/21,10/8/21 and 10/11/21. R1's care plan, updated 9/17/21, indicated R1 had been wearing a Wanderguard (electronic monitoring bracelet) since 3/18/21. The care plan also indicated R1 was to have a staff member "provide supervision or visual safety checks as required." A Resident Daily Care sheet dated 10/18/21, indicated R1 should "not leave the 2nd floor or building unattended, make sure Wanderguard is on and working, and visual safety checks." During an interview on 10/18/21, at 2:29 p.m., registered nurse clinical manager (CM)-A, who served as the nursing care coordinator for the second-floor units, stated R1 attempts to go outside frequently "sometimes, several times a day." CM-A stated R1 was able to ambulate independently both with and without her walker. CM-A stated, "R1 wants to go outside. We have R1 sit in the foyer near the reception desk so R1 can be distracted by the birdcage and the activities of people coming and going. That way	F 689	how to read the alarm panel and this education has been added to new staff orientation. Elopement risk assessment was completed 10/27/21 for other resident identified at risk for elopement and care plan reviewed. Missing Resident policy was updated to include "Licensed staff or environmental services will check the emergency panel to identify door that may have been used for exit." Environmental Services Director has been in contact with a company to evaluate door options to alert staff of exit. Effective implementation of actions will be monitored by: The Administrator or designee will conduct audits to ensure that all staff know how to read the alarm panel. Audits will be completed weekly x4 weeks and then monthly x2 months to ensure that staff do know how to read the alarm panel. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring /audits are recommended. Those responsible to maintain compliance will be: The Administrator or designee is responsible for maintaining compliance. Completion date for certification purposes only is: 11/2/2021	

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F 689	Continued From page 3	F 689		

the receptionist can watch R1 and redirect her as needed. The receptionist has been instructed to call for assistance if [R1] becomes agitated." CM-A further stated, "staff try to watch her constantly. Even every 15-minute checks were not always enough. [R1] will wait for an opportunity and when she thinks no one is watching, she will try to go outside."

During an interview on 10/19/21, at 9:45 a.m., registered nurse (RN)-A stated she'd been working the night of 10/8/21 when R1 eloped. RN-A stated, "At approximately 6:45 p.m., I stopped [R1] from exiting through the door in the foyer and redirected her to her room. [R1] laid down in her bed. I was going to get meds when I was called to another room to assist another patient. At 7:00 p.m. a door alarm went off, but we were not sure which door was opened." RN-A stated she and other staff members went to check all the doors on the second floor. No one was found outside of the doors. RN-A, along with other staff, proceeded to search to see which resident was missing. RN-A said R1 was not in her room and not in the facility. RN-A also stated she had notified the facility administrator by phone at 7:30 p.m. and had then called the police by calling "911." RN-A stated a paramedic called the facility and said R1 had been found at "about 8:30 p.m." and R1 was returned to facility "a short time later." RN-A stated R1 had undergone a full body check and no injuries other than a small (1.7 centimeter [cm] by 1.5 cm) contusion on the right middle finger.

During the interview on 10/19/21 at 9:45 a.m., registered nurse (RN)-A stated did not know there was a door alarm locator panel at the nurse's station. RN-A stated, "I think some of the staff

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F 689	Continued From page 4	F 689		

know about this panel, newer staff do not. It was not part of my orientation." RN-A stated the use of the door panel alarm would have been helpful and would have saved time.

During an interview on 10/19/21 at 10:03 a.m., nursing assistant (NA)-A stated she was called to assist staff in a search of all the facility doors on the evening of 10/8/21, to see if a resident was outside. NA-A confirmed staff did not know which door had been opened.

During an interview on 10/19/21 at 12:08 p.m., the DON stated, "The operation of the door alarm locator has not been part of the staff orientation curriculum." The DON stated the more senior staff would know how to read the panel, but less experienced staff had not been shown how it works. The DON indicated the facility is planning an elopement drill and in-service the week of 10/25/21 however, it had not yet been scheduled.

During an interview on 10/20/21, at 9:18 a.m., facility administrator (ADM) stated they have been seeking a new placement for R1 for the past several weeks. The ADM stated a facility with a locked dementia care unit would provide a safer environment for R1, but to date, none had been found close to R1's family. In addition, the ADM stated temporary placement away from the metropolitan area was being discussed with family. The ADM also stated R1's physician had ordered a GPS (global positioning system) tracking device which was applied to R1's ankle during the afternoon of 10/19/21. In addition, the ADM stated all licensed nursing staff have been contacted and reeducated on the use of the door alarm locator panel.

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F 689	Continued From page 5 During an observation on 10/20/21 at 9:50 a.m., large "Stop" signs had been placed across the exit doors located at the end of each unit's hallways. These signs were attached with Velcro in order not to prevent egress in the case of an emergency. The IJ that began on 10/8/21 was removed on 10/20/21, when observation, interview, and record review verified the the facility had taken appropriate steps to prevent R1 from eloping. These interventions included: Application of a GPS tracking device to R1's ankle per physician order, update to R1's care plan to include use of the GPS and continued frequent visual checks and use of a Wanderguard. In addition, the facility's policy/procedure Missing Resident Plan was reviewed and updated on 10/19/21, to include item number 7, "Licensed staff or environmental services will check the emergency panel to identify door that may have been used for exit." Licensed staff were reeducated to R1's care plan, how to locate and use the emergency panel to identify any door which may have been breached, and staff were educated to the changes to the Missing Resident Plan. Interviews with staff verified staff were educated to the removal plan interventions prior to working their next shift. Any staff who were not onsite were provided telephone education.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 27, 2021

Administrator
New Harmony Care And Rehab Center
135 Geranium Avenue East
Saint Paul, MN 55117

Re: State Nursing Home Licensing Orders
Event ID: ZTY711

Dear Administrator:

The above facility was surveyed on October 18, 2021 through October 20, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00492	A. BUILDING: _____ B. WING _____	C 10/20/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/18/21 to 10/20/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5381037C (MN00077501); with a licensing order issued. The following complaint was found to be UNSUBSTANTIATED: H5381038C (MN00077564). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to prevent an elopement and provide	2 830	Completed	11/2/21

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2 830	Continued From page 2 safety for 1 of 2 residents (R1) identified at risk for elopement. R1 successfully eloped from the building, undetected, and was found by citizens about 0.2 miles away. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/6/21, identified R1 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 0/15. The MDS also identified R1 had diagnoses that included epilepsy, unspecified dementia without behavioral disturbances, and dysphagia following intracerebral hemorrhage (stroke). Review of the resident's progress note and incident report records revealed R1 had a history of elopement or attempted elopement on 3/18/20, 8/25/21, 9/13/21, 10/5/21,10/8/21 and 10/11/21. R1's care plan, updated 9/17/21, indicated R1 had been wearing a Wanderguard (electronic monitoring bracelet) since 3/18/21. The care plan also indicated R1 was to have a staff member "provide supervision or visual safety checks as required." A Resident Daily Care sheet dated 10/18/21, indicated R1 should "not leave the 2nd floor or building unattended, make sure Wanderguard is on and working, and visual safety checks." During an interview on 10/18/21, at 2:29 p.m., registered nurse clinical manager (CM)-A, who served as the nursing care coordinator for the second-floor units, stated R1 attempts to go outside frequently "sometimes, several times a day." CM-A stated R1 was able to ambulate independently both with and without her walker.	2 830		

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2 830	Continued From page 3 CM-A stated, "R1 wants to go outside. We have R1 sit in the foyer near the reception desk so R1 can be distracted by the birdcage and the activities of people coming and going. That way the receptionist can watch R1 and redirect her as needed. The receptionist has been instructed to call for assistance if [R1] becomes agitated." CM-A further stated, "staff try to watch her constantly. Even every 15-minute checks were not always enough. [R1] will wait for an opportunity and when she thinks no one is watching, she will try to go outside." During an interview on 10/19/21, at 9:45 a.m., registered nurse (RN)-A stated she'd been working the night of 10/8/21 when R1 eloped. RN-A stated, "At approximately 6:45 p.m., I stopped [R1] from exiting through the door in the foyer and redirected her to her room. [R1] laid down in her bed. I was going to get meds when I was called to another room to assist another patient. At 7:00 p.m. a door alarm went off, but we were not sure which door was opened." RN-A stated she and other staff members went to check all the doors on the second floor. No one was found outside of the doors. RN-A, along with other staff, proceeded to search to see which resident was missing. RN-A said R1 was not in her room and not in the facility. RN-A also stated she had notified the facility administrator by phone at 7:30 p.m. and had then called the police by calling "911." RN-A stated a paramedic called the facility and said R1 had been found at "about 8:30 p.m." and R1 was returned to facility "a short time later." RN-A stated R1 had undergone a full body check and no injuries other than a small (1.7 centimetere [cm] by 1.5 cm) contusion on the right middle finger. During the interview on 10/19/21 at 9:45 a.m.,	2 830		

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2 830	Continued From page 4	2 830		

registered nurse (RN)-A stated did not know there was a door alarm locator panel at the nurse's station. RN-A stated, "I think some of the staff know about this panel, newer staff do not. It was not part of my orientation." RN-A stated the use of the door panel alarm would have been helpful and would have saved time.

During an interview on 10/19/21 at 10:03 a.m., nursing assistant (NA)-A stated she was called to assist staff in a search of all the facility doors on the evening of 10/8/21, to see if a resident was outside. NA-A confirmed staff did not know which door had been opened.

During an interview on 10/19/21 at 12:08 p.m., the director of nursing (DON) stated, "The operation of the door alarm locator has not been part of the staff orientation curriculum." The DON stated the more senior staff would know how to read the panel, but less experienced staff had not been shown how it works. The DON indicated the facility is planning an elopement drill and in-service the week of 10/25/21 however, it had not yet been scheduled.

During an interview on 10/20/21, at 9:18 a.m., facility administrator (ADM) stated they have been seeking a new placement for R1 for the past several weeks. The ADM stated a facility with a locked dementia care unit would provide a safer environment for R1, but to date, none had been found close to R1's family. In addition, the ADM stated temporary placement away from the metropolitan area was being discussed with family. The ADM also stated R1's physician had ordered a GPS (global positioning system) tracking device which was applied to R1's ankle during the afternoon of 10/19/21. In addition, the ADM stated all licensed nursing staff have been

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2 830	Continued From page 5 contacted and reeducated on the use of the door alarm locator panel. During an observation on 10/20/21 at 9:50 a.m., large "Stop" signs had been placed across the exit doors located at the end of each unit's hallways. These signs were attached with Velcro in order not to prevent egress in the case of an emergency. SUGGESTED METHOD OF CORRECTION: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize elopement potential for residents at risk to assure they are receiving the necessary treatment/services to prevent elopements. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented to ensure resident safety. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 830		