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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0UQB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00507

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245421**
2.STATE VENDOR OR MEDICAID NO.
(L2) **799342100**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEW BRIGHTON CARE CENTER**
(L4) **805 SIXTH AVENUE NORTHWEST**
(L5) **NEW BRIGHTON, MN** (L6) **55112**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/15/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 12/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS
Posted 12/23/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
12/12/2014 (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245421

December 16, 2014

Mr. Michael Chies, Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MinnesotaN 55112

Dear Mr. Chies:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program

Effective December 10, 2014 the above facility is certified for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 skilled nursing facility beds.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulations Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 16, 2014

Mr. Michael Chies, Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, Minnesota 55112

RE: Project Number S5421025

Dear Mr. Chies:

On November 11, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On December 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on October 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2014, effective December 10, 2014 and therefore remedies outlined in our letter to you dated November 11, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulations Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245421	A. Building B. Wing	12/15/2014

Name of Facility	Street Address, City, State, Zip Code
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(l** LSC	Correction Completed **12/10/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **12/10/2014**
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/10/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **12/10/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/10/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/10/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PLH/mm	12/16/2014		12/15/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/31/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245421	NEW BRIGHTON CARE CENTER

Type of Survey (select all that apply)

I	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 12835			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 3.25

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 0UQB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00507

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245421**
2.STATE VENDOR OR MEDICAID NO.
(L2) **799342100**

3. NAME AND ADDRESS OF FACILITY
(L3) **NEW BRIGHTON CARE CENTER**
(L4) **805 SIXTH AVENUE NORTHWEST**
(L5) **NEW BRIGHTON, MN** (L6) **55112**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/31/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **57** (L18)

13.Total Certified Beds **57** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 11/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6405

November 11, 2014

Mr. Michael Chies, Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, Minnesota 55112

RE: Project Number S5421025

Dear Mr. Chies:

On October 31, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

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 December 10, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

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 January 31, 2015 (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 May 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by

the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5421s15

PRINTED: 11/11/2014
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
NOV 26 2014
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Census: 53	F 000	Ok as amended per phone c DON on 11/26/14. RLH	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing	F 156	**F156 Medicare Denial Notices** It is the policy of New Brighton Care Center to inform the resident both orally and in writing in language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under s1919(e)(6) of the Act. Such notification must be	

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

Administrator — 11/24/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 156	Continued From page 1 facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and	F 156	made prior to or upon admission and during the residents stay. Receipt of such information, and any amendments to it, must be acknowledged in writing; The facility must inform each resident who is entitled to Medicaid Benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	

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F 156	Continued From page 2 advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter upon termination of all Medicare Part A skilled services for 4 of 4 residents (R78, R67, R81, R95) reviewed for liability notice and beneficiary appeal rights review. Findings include: Social Service Notes dated 5/21/14, indicated R78 was issued a Medicare denial letter that indicated Medicare coverage of current services would end on 5/23/14, when R78 would discharge	F 156	The facility must inform each resident before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924 (c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of	

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F 156	Continued From page 3 home. The facility did not provide R78 and/or their legal representative with a SNFABN/ Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter to inform them of potential liability for non-covered services and of the right to appeal the denial to Medicare. R67 discharged from the facility on 5/30/14. The facility was unable to provide evidence that R67 and/or legal representative was provided a Notice of Non-Coverage/Form CMS 10123-NOMNC or a SNFABN/ CMS-10055 or a uniform denial letter to inform them of potential liability for non-covered services and the right to appeal the denial of coverage. R81 was discharged from Medicare Part A on 6/24/14, and discharged from the facility on 6/25/14. The facility did not provide R81 and/or their legal representative with a SNFABN/ CMS-10055 or a uniform denial letter to inform them of potential liability for non-covered services and of the right to appeal the denial to Medicare. R95 was discharged from Medicare Part A on 10/29/14 and remained in the facility. The facility did not provide R95 and/or their legal representative with a SNFABN/ CMS-10055 or a uniform denial letter to inform them of potential liability for non-covered services and of the right to appeal the denial to Medicare. On 10/30/14, at 1:05 p.m. the social worker (SW) stated she was unable to find the medicare denial letters for R78 and R61. The SW stated that, since May 2014, when residents were discharged from the facility the files were cleaned out and the denial letters may have been thrown out. On 10/31/14, at 10:00 a.m. the SW stated she only	F 156	resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	

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F 156	Continued From page 4 gives residents the form (CMS 10123) Notice of Medicare Non-Coverage. The SW was unaware of any other form and verified a SNF ABN notice was not provided to R78, R67, R81, R95 and/or their legal representative .	F 156	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide bathing preferences for 1 of 3 residents (R55) reviewed for choices. Findings include: R55, interviewed on 10/28/14, at 6:57 p.m., stated she would like a tub bath, "but nobody knows how to work it". On 10/30/14, at 9:15 a.m. R55 stated she was not offered a tub bath but had a shower the previous day. R55 stated, "A bath would be nice, to just sit there and soak." R55's undated diagnosis list included a history of falls, pulmonary fibrosis, congestive heart failure, fatigue, osteoporosis, osteoarthritis, depression, Parkinson's disease, memory loss and muscle weakness.		***Resident #R67, #R78, #R81, and #R95*** -The policy and procedure for providing residents with the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) and/or a uniform denial	

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F 242	Continued From page 5 The admission Activity Evaluation dated 4/2/14, indicated it was very important for R55 to choose between a tub bath, shower, bed bath or a sponge bath. The preference of a tub bath was circled. The significant change Activity Evaluation dated 7/1/14, indicated it was very important for R55 to choose between a tub bath, shower, bed bath or a sponge bath two times a week, the assessment lacked a preference. The significant change Activity Evaluation dated 10/10/14, indicated it was very important for R55 to choose between a tub bath, shower, bed bath or a sponge bath. The preference of a shower was circled. The significant change Minimum Data Set (MDS) dated 10/12/14, indicated R55 had moderately impaired cognition. The MDS further indicated R55 had no rejection of cares and it was very important for R55 to choose between a tub bath, shower, bed bath or sponge bath. R55 needed the extensive assistance of one staff with bed mobility, transfers, ambulation, locomotion, dressing and toilet use. R55 needed the limited assistance of one staff with personal hygiene and required the physical help of one staff with bathing. The Bathing care plan dated 6/2/14, indicated R55 was independent with bathing and required limited assistance of one staff to transfer only. The Communications care plan dated 6/2/14, indicated R55 was able to express her needs. On 10/30/14, at 1:00 p.m. nursing assistant (NA)-A, stated she gave R55 a shower the previous day. NA-A further stated she does not ask residents if they want a tub bath or a shower.	7156	letter upon termination of all Medicare Part A skilled services has been reviewed and revised. -All involved staff have been in-serviced on current policy and procedures on providing residents with the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) and/or a uniform denial letter upon termination of all Medicare Part A skilled services. -An audit program to be developed related to providing residents with the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) and/or a uniform denial letter upon termination of all Medicare Part A skilled services -To be completed by 12/10/14. -Review of audit results through the facility QA committee, quarterly. The DON or designee will maintain responsibility for the continued compliance of this requirement.	

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F 156	Continued From page 4 gives residents the form (CMS 10123) Notice of Medicare Non-Coverage. The SW was unaware of any other form and verified a SNF ABN notice was not provided to R78, R67, R81, R95 and/or their legal representative .			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide bathing preferences for 1 of 3 residents (R55) reviewed for choices. Findings include: R55, interviewed on 10/28/14, at 6:57 p.m., stated she would like a tub bath, "but nobody knows how to work it". On 10/30/14, at 9:15 a.m. R55 stated she was not offered a tub bath but had a shower the previous day. R55 stated, "A bath would be nice, to just sit there and soak." R55's undated diagnosis list included a history of falls, pulmonary fibrosis, congestive heart failure, fatigue, osteoporosis, osteoarthritis, depression, Parkinson's disease, memory loss and muscle weakness.	F 242	**F242 Self-Determination and Participation** It is the policy of New Brighton Care Center to ensure that the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. ***Resident #R55*** -Resident to be interviewed and provided with choices about aspects of her life in the facility that are	

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F 242	Continued From page 5 The admission Activity Evaluation dated 4/2/14, indicated it was very important for R55 to choose between a tub bath, shower, bed bath or a sponge bath. The preference of a tub bath was circled. The significant change Activity Evaluation dated 7/1/14, indicated it was very important for R55 to choose between a tub bath, shower, bed bath or a sponge bath two times a week, the assessment lacked a preference. The significant change Activity Evaluation dated 10/10/14, indicated it was very important for R55 to choose between a tub bath, shower, bed bath or a sponge bath. The preference of a shower was circled. The significant change Minimum Data Set (MDS) dated 10/12/14, indicated R55 had moderately impaired cognition. The MDS further indicated R55 had no rejection of cares and it was very important for R55 to choose between a tub bath, shower, bed bath or sponge bath. R55 needed the extensive assistance of one staff with bed mobility, transfers, ambulation, locomotion, dressing and toilet use. R55 needed the limited assistance of one staff with personal hygiene and required the physical help of one staff with bathing. The Bathing care plan dated 6/2/14, indicated R55 was independent with bathing and required limited assistance of one staff to transfer only. The Communications care plan dated 6/2/14, indicated R55 was able to express her needs. On 10/30/14, at 1:00 p.m. nursing assistant (NA)-A, stated she gave R55 a shower the previous day. NA-A further stated she does not ask residents if they want a tub bath or a shower.	F 242	significant to the resident. -Interview assessment completed and care plan to be reviewed and revised to reflect the resident's choices. -The policy and procedure for providing resident with choices about aspects of his or her life in the facility that are significant to the resident will be reviewed and revised. -All involved staff will be in-serviced on current policy and procedures on providing the residents with choices about aspects of his or her life in the facility that are significant to the resident. -All residents will continue to be interviewed and provided with choices about aspects of her life in the facility that are significant to the resident upon admission, quarterly, annually and with significant changes. These choices will	

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F 242	Continued From page 6 "We just go in the room and tell them it's their shower day." NA-A stated there was a tub on the north side of the facility that was used a couple of times. On 10/30/14, at 1:35 p.m. the activity director (AD) stated she asked the residents if one shower a week was enough. The AD stated she did not tell residents about getting a tub bath because the tub was difficult to get in and out of. On 10/31/14, at 9:35 a.m. the director of nursing (DON) stated she was unaware of a problem with bathing. The DON stated the tubs were difficult to get in and out of, but there was a nice whirlpool tub on the north side. The DON stated staff should be asking residents if they want a tub bath, shower or bed bath and not just assuming the resident wanted a shower. The bath tub on the north side of the building was observed on 10/30/14, at 1:55 p.m.. The tub was dry, there was a wire hanger on the bottom near the drain and a large roll of clear cling type wrap on the seat. A bathing preference policy was requested but not provided.	F 242	be reflected in each residents care plan. -An audit program to will be developed for providing resident with choices about aspects of his or her life in the facility that are significant to the resident. -To be completed by 12/10/14. -Review of audit results through the facility QA committee, quarterly. -The DON or designee will maintain responsibility for the continued compliance of this requirement.	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by:	F 247	**F247 Roommate Change Notice** It is the policy of New Brighton Care Center to ensure that each resident has the right to receive	

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F 247	Continued From page 7 Based on interview and document review, the facility failed to provide prior notice of a new roommate for 1 of 1 resident (R18) reviewed for admission, transfer, discharge. Findings include: The annual Minimum Data Set (MDS) dated 9/15/14, indicated R18 had moderate cognitive impairment. On 10/28/14, at 6:29 p.m. R18 stated she was not notified before a new roommate (R30) moved into her shared room. R30's Admission Record indicated she moved into the shared room with R18 on 10/9/14. The medical records lacked evidence R18 was provided advance notice prior to the change. On 10/31/14, at 9:04 a.m. the Social Worker (SW) stated she thought R18 had been notified just prior to R30's admission on 10/9/14. SW remembered introducing the two residents when R30 arrived. SW confirmed there was no documentation in the medical records to indicate R18 was notified prior to R30 moving in. SW stated she tries to notify the residents of new roommates prior to their arrival, but was not always able to do that. SW stated she was not aware of any specific facility policy regarding changes in roommates. The Policy and Procedure for Roommate Notification (undated), indicated to comply with the Resident Bill of Rights a Roommate Notification Form would be completed, and provided to the current resident in the room. The policy further directed to document in the	F 247	notice before the resident's room or roommate in the facility is changed. ***Resident #18*** -The policy and procedure for providing prior notice of a new roommate for each resident has been reviewed and revised. -All involved staff will be in-serviced on current policy and procedures for providing prior notice of a new roommate for each resident. -An audit program will be developed in providing prior notice of a new roommate for each resident -To be completed by 12/10/14. -Review of audit results through the facility QA committee, quarterly.	

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F 247	Continued From page 8 resident's chart that a notification of a new roommate was given.	F 247	-The DON or designee will maintain responsibility for the continued compliance of this requirement.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			

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F 247	Continued From page 8 resident's chart that a notification of a new roommate was given.			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F272 Comprehensive Assessments** It is the policy of New Brighton Care Center to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of the resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior; Psychosocial well-being;	

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F 272	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide comprehensive assessment of poor oral/dental status for 1 of 1 resident (R21) reviewed for dental. Findings include: On 10/29/14, at 9:44 a.m. R21 was observed to have several brown decayed upper teeth with one brown, broken, and jagged front tooth. R21 denied current problems with chewing, mouth pain, or issues with her teeth or gums. The Oral/Dental Status section on the Admission Assessment dated 1/3/13, indicated R21 had her own teeth; however, the section regarding the condition of the teeth was left blank. A dental provider note dated 10/4/13, indicated R21 had a prophylactic and periodic dental exam. The note indicated R21 had a history remarkable for aortic valve damage and was allergic to penicillin. Clindamycin 600 mg (an antibiotic) was administered prior to the examination and prophylaxis. The note identified "Caries as shown, Gross caries (tooth decay). Oral cancer negative. Patient does not wish restoration or extraction. Heavy calculus, moderate plaque." The annual minimum data set (MDS) dated 1/5/14, did not identify R21 had oral/dental	F 272	Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. ***Resident #R21*** -Resident is to have a Comprehensive Assessment of Oral/Dental Status completed. -Residents Care Plan to be reviewed and revised by interdisciplinary team. Care	

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F 272	Continued From page 10 problems. The last page of the care plan printed 1/9/14, indicated R21 had diagnoses which included congestive heart failure (CHF), cardiac pacemaker, and hypertension (HTN). The quarterly Minimum Data Set (MDS) dated 10/6/14, indicated R21 had no cognitive impairment; had no behaviors; and required supervision with personal hygiene. The medical records lacked evidence R21's oral/dental status had been assessed to determine individualized interventions to decrease the risk of potential complications from extensive tooth decay such as abscess, mouth pain, difficulty chewing or serious infection. On 10/31/14, at 10:20 a.m. the director of nursing (DON) stated an oral cavity exam should be completed on admission and with the annual assessment. The DON confirmed R21's oral/dental status had not been assessed. The [facility name] Resident Care Plan/Assessment Process policy (undated), indicated all resident care plans/assessments would be completed using the MDS guidelines/RAI process (resident assessment instrument) per MDS/RAI manual guidelines. The policy directed a portion of the assessment to include an observation of the resident's oral cavity and and condition of the teeth.	F 272	Plan to reflect residents individual need for oral/dental care. -The facility Oral/Dental Policy and Procedure to be reviewed and revised. -The Comprehensive Assessment of Oral/Dental Status to be reviewed and revised. -All licensed nursing staff and dietician will be in-serviced on current policy and procedures for Oral/Dental Status. -All residents will continue to be assessed for Oral /Dental Status upon admission, quarterly, annually and with significant changes. -An audit program related to Comprehensive Assessment of Oral/Dental Status will be developed. -To be completed by 12/10/14.	include visual exam of oral cavity. RLH 11/26/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.			

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F 272	Continued From page 10 problems. The last page of the care plan printed 1/9/14, indicated R21 had diagnoses which included congestive heart failure (CHF), cardiac pacemaker, and hypertension (HTN). The quarterly Minimum Data Set (MDS) dated 10/6/14, indicated R21 had no cognitive impairment; had no behaviors; and required supervision with personal hygiene. The medical records lacked evidence R21's oral/dental status had been assessed to determine individualized interventions to decrease the risk of potential complications from extensive tooth decay such as abscess, mouth pain, difficulty chewing or serious infection. On 10/31/14, at 10:20 a.m. the director of nursing (DON) stated an oral cavity exam should be completed on admission and with the annual assessment. The DON confirmed R21's oral/dental status had not been assessed. The [facility name] Resident Care Plan/Assessment Process policy (undated), indicated all resident care plans/assessments would be completed using the MDS guidelines/RAI process (resident assessment instrument) per MDS/RAI manual guidelines. The policy directed a portion of the assessment to include an observation of the resident's oral cavity and and condition of the teeth.	F 272	-Review of audit results through facility QA committee, quarterly. -The DON or designee will maintain responsibility for the continued compliance of this requirement.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	**F279 Comprehensive Care Plans** It is the policy of new Brighton Care center to use the results of the assessment to develop, review and revise the residents' comprehensive plan of care.	

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F 279	Continued From page 11 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plans were developed for 2 of 2 residents (R49, R35) reviewed for self-administration of medications (SAM); for 1 of 3 residents (R42) reviewed for nutrition with a significant weight loss; and for 1 of 3 residents (R16) reviewed for other skin conditions. Findings include: SAM: R49 self-administered a nebulizer inhalation treatment via mask after set-up by nursing staff, but the care plan did not address SAM. On 10/30/14, at 9:48 a.m. licensed practical nurse (LPN)-A set-up a nebulizer inhalation treatment for R49, and stated the resident had been	F 279	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and any services that would be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). ***Resident #R35 and #R49*** -Assessments and care plans to be reviewed and revised to reflect resident's ability to self-administer medications..	

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F 279	Continued From page 12 assessed as safe to self-administer the nebulizer treatment using a mask after set-up. R49 self-administered the nebulizer treatment appropriately without difficulty. The physician's orders dated 9/30/14, directed staff to administer an Albuterol nebulizer 0.083% one vial per nebulizer two times a day (BID), and every four hours as needed (PRN) for shortness of breath. The Medication Administration Record (MAR) for October 2014, indicated R49 received the nebulizer treatment BID with no PRN doses used. The Monthly Self-Administration of Medication Review indicated R49's last SAM assessment was completed on 10/1/14, and R49 was assessed as safe to SAM the nebulizer treatment. R49's care plan did not address SAM. On 10/30/14, at 1:03 p.m. the director of nursing (DON) stated residents were assessed for the ability to safely SAM; however, the facility policy/protocol did not direct to complete a SAM care plan. The DON confirmed a SAM care plan was not completed for R49 and R35. The Self-Administration of Medications by Patients policy (undated), indicated if a resident desired to SAM, an assessment would be conducted, and would be recorded in the medical record. The policy further directed SAM was also to be included as part of the resident's treatment plan. NUTRITION: R42 was hospitalized for congestive heart failure (CHF), had a change in diet, and was on a desired weight loss program related to fluid loss. The care plan did not address nutrition, diet, or	F 279	-Both of these residents to have a completed comprehensive assessment and comprehensive care plan with interventions and measurable goals to self-administer medications. ***Resident #R42*** -This resident discharged to our assisted living facility on 9/2/14. Her medical record was reviewed and it has been identified that her significant weight loss was a positive outcome for this resident as she has a diagnosis of CHF and had retained large amount of fluid. She was on a desired weight loss program with her stay in the New Brighton Care Center facility. Currently her assisted living care plan reflects her nutritional status and risk of fluid retention with a desired nutritional program. -Dietary will continue to review and monitor for weight loss with each residents	

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F 279	Continued From page 13 the plan for expected weight loss. R42 was admitted on 5/28/14, and was discharged to an assisted living facility on 9/2/14. The Medication Administration Record (MAR) for 5/28/14, identified an admission weight of 228 pounds, and the September 2014, MAR for 9/2/14, (date of discharge) identified a weight of 207.8 pounds (a 20.2 pound weight loss in approximately three months or almost a 10% weight loss in 90 days). The Pain Care Area Assessment (CAA) dated 6/10/14, indicated R42 was admitted for recovery after a fall with a lumbar fracture and had diagnoses which included bilateral pitting edema in both lower extremities. The Admission Nutrition Assessment dated 6/10/14, indicated R42 weighed 228 pounds and had diagnoses of weakness, atrial fibrillation, diabetes, depression and CHF. The assessment indicated R42 was on a cardiac no added salt diet with a weight goal to remain stable between 200-220 pounds with weight loss desirable. The physician's orders dated 6/13/14, 6/16/14, and 6/23/14, indicated R42's Lasix (diuretic-water pill) was adjusted due to increased edema. The orders dated 6/24/14, identified a diet change to a 2 gram sodium restricted diet with weights three times a week. Further Lasix adjustments were made with an additional diuretic (Zaroxolyn) added for one dose on 6/30/14, and 7/1/14. The Social Service Notes indicated R42 was hospitalized from 7/2/14, to 7/7/14, due to CHF/edema. A Dietitian Review dated 7/8/14, identified R42 returned from the hospital with a low sodium cardiac diet. The physician's orders dated 7/9/14, indicated R42's Lasix dose was increased; complete daily weights; and notify the physician of any weight	F 279	comprehensive assessment and all residents care plans will be developed to meet each residents individual needs. ***Resident #R16*** -Assessment and care plan to be reviewed and revised to reflects resident's current skin condition. -This resident to have a completed comprehensive assessment and comprehensive care plan with interventions and measurable goals to maintain her skin condition. - Comprehensive assessments and care plans to be reviewed and revised to reflect individual needs upon admission, quarterly, with any significant change and PRN. With special focus on self-administration of medications, nutritional status and skin conditions. -All licensed nursing staff to be	

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F 279	Continued From page 14 gain of 2 pounds or more in 24 hours or 5 pounds or more in one week. On 7/16/14, 7/18/14, and 8/12/14, the Lasix dose was adjusted. The 8/12/14, orders directed to continue the current Lasix dose until R42's weight was down to 204-205 pounds, and then resume the previous Lasix orders. R42 lacked a nutrition care plan to address nutritional status, weight loss goals due to CHF/edema, daily weights, or the 2 gram sodium restricted diet. On 10/31/14, at approximately 2:00 p.m. the dietary supervisor (DS) confirmed R42 did not have a nutrition care plan. The Multi-Disciplinary Committee Resident Care Plan Policy and Procedure (undated), indicated the care plan committee (Minimum Data Set (MDS) coordinator, dietary supervisor, social services director, and activities director) would meet weekly, and would develop and maintain resident care plans in coordination with all departments and individuals involved in the care of the resident, including the resident themselves. The policy indicated each resident's individual needs/problems would be identified with goals based on the needs/problems to help reach or maintain their optimal level of functioning, and approaches/interventions would be placed to help each resident meet their goals. SAM R35's admission record identified diagnoses that included diabetes, dementia, anxiety, and esophageal reflux. The quarterly Minimum Data Set (MDS) indicated R35 was cognitively intact, had adequate vision, and was independent with bed mobility, transfers, ambulation dressing and	F 279	in-serviced on current policy and procedures for the comprehensive assessment and care plan development for self-administration of medications, nutritional status and skin conditions. -An audit program to be developed to aid in monitoring of the assessment processes and developing the residents comprehensive care plans. -To be completed by 12/10/14. -Review of audit results through the facility QA committee, quarterly. -The DON or designee will maintain responsibility for the continued compliance of this requirement.	

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F 279	Continued From page 15 personal hygiene. The physician's orders dated 10/23/14, directed R35 to self administer the following medications: aluminum hydroxide suspension (antacid) 20 milliliters (ml) by mouth as needed at bedtime for gastroesophygeal reflux disease (GERD); Liquitears solution one drop into each eye every four hours as needed for dry eyes; and saline mist spray 0.65% (used to treat dry or irritated nasal passages) one spray into each nostril as needed for allergies. R35's monthly MAR for October 2104, lacked documentation of when R35 self administered the aluminum hydroxide, the Liquitears and the saline mist spray. SKIN R16 was observed, on 10/29/59, at 12:53 p.m., to have an approximate 6 centimeter (cm) by 5 cm bruise on the left side of the forehead, near the hairline. R16's care plan lacked a problem for risk for bruising. R16's admission record identified diagnoses that included diabetes, peripheral vascular disease, and dementia. The annual MDS dated 7/28/14, indicated R35 had short and long term memory problems, severely impaired cognitive skills for daily decision making and physical behavioral symptoms directed at others that do not put herself or others at risk for injury. The MDS further identified R16 required total assistance of two staff for bed mobility, transfers, toileting and bathing, and total assistance of one staff for dressing and personal hygiene. R35 required	F 279		

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F 279	Continued From page 16 extensive assistance of one staff for wheelchair mobility, and R35 did not ambulate. On 10/31/14, at 10:22 a.m. the DON was interviewed and verified the lack of care planning related to the risk for bruises. The DON stated the care care plan should address R16's risk for bruising.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review bruises were not identified and monitored as directed by the plan of care for one of three residents (R56) reviewed for skin conditions. Findings include: Bruises on R56's bilateral forearms were not reported to the licensed nursing staff for assessment and monitoring. R56's careplan dated 9/8/14, indicated limited physical mobility r/t dx of dementia, impaired balance and lack of safety awareness. The care plan was updated on 9/18/14, and directed staff to check R56's skin daily with cares and report any areas of redness, bruising or open areas. The care plan directed a weekly full body skin assessment by licensed staff on bath day.	F 282	**F282 Comprehensive Care Plan** It is the policy of New Brighton Care Center to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. ***Resident #R56*** -Resident to have a comprehensive skin assessment completed. -Resident's care plan to be reviewed and revised to reflect the individual's skin condition with special focus on monitoring skin condition as directed on residents care plan.	

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F 282	Continued From page 17 On 10/28/14, at 6:04 p.m. during an interview with R56, surveyor observed one purplish colored bruise approximately 4 x 5 centimeter (cm) bruise on top of R56's right lower forearm with three other smaller bruises approximately 2 x 4 cm, and 2 x 2 cm in size. On R56's left lower forearm was a purplish colored bruise approximately 2 x 4 cm in size. On 10/29/14, at 3:56 p.m. licensed practical nurse (LPN-A) verified R56's skin Body Audit Forms dated 10/20/14, and 10/27/14, did not address bruising for R56. On 10/30/14, at 9:33 a.m. R56 was sitting in her wheelchair (w/c) in her room. R56 stated, "My arms get bumped on wheelchairs, get bumped on anything." R56 also stated that staff push her in her w/c down the hall and to different places, day room, dining room, and activities room. R56 further stated her arms hurt when bumped but the bruises did not hurt. At 1:24 p.m. registered nurse (RN-C) stated she did not remember any bruises on R56 in the last month. RN-C stated if a resident has a new bruise an incident report should be completed, DON, administrator and family would be notified. RN-C also stated any bruises should be monitored on the TAR and reported off to the next shift nurse to monitor. At 2:30 p.m. the DON stated whichever staff finds a bruise on a resident should report the bruise to the nurse, and document the bruise in the progress notes. DON also stated a bruise would be monitored on the TAR by the nurse. And if necessary the nurse would make an incident	F 282	-Facility policy and procedures related to comprehensive skin condition assessments to be reviewed and revised. -Comprehensive care plans to be reviewed and revised to reflect individual needs, quarterly and PRN. With special focus on monitoring skin conditions as directed on the care plan. -All nursing staff will be in-serviced on skin condition policy and procedures. -An audit program to be developed to aid in monitoring of assessment process and assessment tools, in formulating a comprehensive care plan with special focus on monitoring skin conditions as directed on the care plan. -To be completed by 12/10/14.	

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F 282	Continued From page 18 report and notify DON and administrator if bruise is unknown in origin. DON further added in some cases bruises are outlined on the resident's skin to know if the bruise has gotten larger. The undated Multi-Disciplinary Committee Resident Care Plan Policy and Procedure indicated each resident's individual needs/problems would be identified with goals based on the needs/problems to help reach or maintain their optimal level of functioning, and approaches/interventions would be placed to help each resident meet their goals.	F 282	-Review of audit results through facility QA committee, quarterly. -The DON or designee will maintain responsibility for the continued compliance of this requirement.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the toilet transfer bars were secure in the shared bathroom utilized by 1 of 30 resident's (R31) whose bathrooms were observed. Findings include: From 10/28/14 through 10/31/14, the transfer bars and toilet seat were observed to be loose in the bathroom utilized by R31. The transfer bars	F 323	**F323 Accident Hazards** It is the policy of New Brighton Care Center to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. ***Resident #R31*** -Resident's toilet transfer bars in shared bathroom have been repaired and are secure.	

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NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(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 323	Continued From page 19 were attached to the toilet seat and the entire unit moved approximately three to four inches side to side. On 10/31/14, at 8:35 a.m. nursing assistant (NA)F stated R31 was the only resident that used the bathroom and required only stand by assist for transfers. R31 Diagnosis List dated 6/5(no year), indicated diagnoses that included confusion, dementia, hip pain, hip fracture, type 2 diabetes and congestive heart failure. R31's Bowel and Bladder care plan revised on 6/25/14, indicated R31 was continent and used the toilet independently or with the assistance of one staff when weak. The Cognition care plan revised 6/25/14, indicated R31 had impaired cognition and thought process related to the diagnoses of dementia with behavioral disturbances. The Falls care plan revised on 6/26/14, indicated R31 was at high risk for falls due to impaired safety awareness and judgement. R31 had a history of falls which resulted in a hip and pelvic fracture prior to admission. The care plan interventions indicated R31 needed a safe environment. On 10/31/14, at 10:35 a.m. R31's bathroom was observed with the maintenance supervisor (MS). The MS was not aware the safety device and the toilet seat were loose. The MS stated he did not have a monitoring system in place to routinely check the devices for safety. The MS would expect nursing staff to write on the maintenance repair log used to inform him that the device needed repair.	F 323	-All residents utilizing toilet transfer bars in shared bathrooms have been evaluated for safety. -Environmental Safety (Free of Accidental Hazards/Supervision/Devices) Policy and Procedure to be reviewed and revised. -All involved staff (nursing, maintenance and housekeeping) will be in-serviced on policy and procedures of Environmental Safety. -An audit program to be developed to aid in continued monitoring of a safe environment (Free of Accidental Hazards/Supervision/Devices). -To be completed by 12/10/14.	

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F 323	Continued From page 20 The facility's Maintenance policy revised and updated 2/13, indicated maintenance maintained a repair log near the South nursing station. Staff had been taught to write down repair issues they observe in the log. Maintenance staff reviewed the log each day and proceed to repair any issues. All staff had been taught to immediately bring to the attention of maintenance any problems which need immediately need attention.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently measure heart rate (pulse) as ordered by the physician to monitor the effectiveness of a blood pressure lowering medication for 1 of 5 residents (R18) whose medications were reviewed. Findings include: R18's current physician's orders dated 9/29/14, indicated diagnosis of hypertension (high blood pressure) and directed staff to administer Metroprolol Tartrate (lowers blood pressure) 50 milligrams twice a day (started 4/9/13). The orders further directed the medication held if R18's pulse was less than 60 beats per minute. The Medication Administration Records (MAR's) for August, September and October 2014, indicated R18 received the medication twice daily. R18 was observed on 10/30/14, at 7:29 a.m. in the room lying on the bed, and on 10/31/14, at 9:33 a.m. in the room sitting in the wheelchair. No signs or symptoms of possible adverse reactions to the medication were noted. Documented pulse checks on the MAR's for August, September, and October 2014, were as follows: August 2014 - there were no documented pulses for 11 of the 31 days for the morning (a.m.) medication; and for 12 of the 31 days for the evening (p.m.) medication. September 2014 - there were no documented pulses for 13 of the 30 days for the a.m.	F 329	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. ***Resident #R18*** Regarding Metroprolol Tartrate usage. -The resident's drug regime has been reviewed and evaluated for medication effectiveness and necessary treatment. It has been determined by the pharmacy consultant and the	

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F 329	Continued From page 22 medication. October 2014 - there were no documented pulses for 29 of the 29 days for the a.m. medication, and for 27 of the 29 days for the p.m. medication. Review of the documented pulses on the MAR's and on the Weekly Vital Sign records for August, September, and October 2014, indicated R18 had no documented pulses of less than 60. On 10/30/14, at 2:35 p.m. the registered nurse (RN)-B confirmed R18's medical records lacked documentation to indicate a pulse was consistently checked prior to administration of the medication. RN-A stated the staff should check R18's pulse prior to administration of the blood pressure medication as directed by the physician's orders, and to document results on the MAR. The consultant pharmacist, interviewed by phone on 11/3/14, at 1:15 p.m., (after survey exit) stated if a resident had a physician's order to hold a medication based on specific parameters (such as if the pulse was less than 60), he would expect the staff to check the pulse prior to administering the medication, and document the results in the medical records.	F 329	physician to discontinue monitoring of pulse before administration of this medication. -The policy and procedure for Unnecessary Drugs will be reviewed and revised. -All licensed nursing staff, pharmacy consultant and physicians/nurse practitioners to be in-serviced on current policy and procedures for Unnecessary Drugs. -Nursing staff, the pharmacy consultant and physicians/nurse practitioners will ensure each resident's drug regime is free from unnecessary drugs. With special focus on adequate monitoring of prescribed medications (such as monitoring pulse before administering a medication). -Each resident's drug regime will continue to be reviewed and evaluated monthly and as needed by the pharmacy	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced			

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F 329	Continued From page 22 medication. October 2014 - there were no documented pulses for 29 of the 29 days for the a.m. medication, and for 27 of the 29 days for the p.m. medication. Review of the documented pulses on the MAR's and on the Weekly Vital Sign records for August, September, and October 2014, indicated R18 had no documented pulses of less than 60. On 10/30/14, at 2:35 p.m. the registered nurse (RN)-B confirmed R18's medical records lacked documentation to indicate a pulse was consistently checked prior to administration of the medication. RN-A stated the staff should check R18's pulse prior to administration of the blood pressure medication as directed by the physician's orders, and to document results on the MAR. The consultant pharmacist, interviewed by phone on 11/3/14, at 1:15 p.m., (after survey exit) stated if a resident had a physician's order to hold a medication based on specific parameters (such as if the pulse was less than 60), he would expect the staff to check the pulse prior to administering the medication, and document the results in the medical records.	F 329	consultant. -An audit program to be developed related to evaluating resident's drug regime and the use of Unnecessary Drugs. -To be completed by 12/10/14. -Review of audit results through the facility QA committee, quarterly. -The DON or designee will maintain responsibility for the continued compliance of this requirement.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced	F 332	**F332 Medication Errors** It is the policy of New Brighton Care Center to ensure that the facility is free of medication error rates of five percent or greater.	

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F 332	Continued From page 23 by: Based on observation, interview, and document review, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents (R69, R49) who were observed for medication administration. Findings include: The facility had 4 medication errors in 27 opportunities resulting in an error rate of 14%. R69 did not have Levothyroxine, Nexium, and Calcium administered appropriately resulting in 3 medication errors. The Admission Record indicated R69 had multiple diagnoses including hypothyroidism and esophageal reflux. The physician's orders dated 10/23/14, included Levothyroxine 75 micrograms (mcg) every morning, Calcium with D 600 milligrams (mg)/400 units (u) twice a day and Nexium 40 mg one capsule every morning. The certified nurse practitioner (CNP) order dated 10/6/14, directed the Nexium dose to be administered at 10:00 a.m. and, "Should not be given with other meds for maximum effect." On 10/30/14, at 9:22 a.m. licensed practical nurse (LPN)-A was observed to administer morning medications to R69. The medications were Levothyroxine 75 mcg, Nexium 40 mg, Calcium 600 mg/400 U, plus Vitamin D, Senna, Lexapro, Metroprolol, Tylenol, and Oxycodone. At that time, R69 was finishing the breakfast meal, and stated she never used to take her Levothyroxine or Nexium with meals prior to admission to the facility. R69 stated she didn't like it when all her pills were administered together, but, "They can't find time and don't listen to me." R69 added, her	F 332	***Resident #R69 and #R49*** -Both resident's drug regime has been reviewed and evaluated. Proper scheduling and timing of medication administration for prescribed meds have been determined and set up on the Medication Administration Record (MAR). -The policy and procedure has been reviewed and revised for the medication pass, with special focus on preventing medication errors. -All licensed nursing staff to be in-serviced on policy and procedures for the medication pass, with special focus on preventing medication errors. -An audit program to be developed related to the medication pass, with special focus on preventing medication errors.	

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F 332	Continued From page 24 stomach had been more upset in the facility than when she was at home. LPN-A confirmed R69's morning medications were always administered together without regard to meals. The quarterly Minimum Data Set (MDS) dated 7/21/14, indicated R69 had no cognitive impairment. Review of the October 2014, Medication Administration Record (MAR) indicated all morning medications were scheduled for "AM" with no assigned time except for the Nexium which was ordered for 10:00 a.m. per the CNP for maximum effect. The Levothyroxine manufacturer's directions for use revised 6/20/14, identified under "Important Safety Information" agents such as calcium supplements and antacids can decrease the absorption of Levothyroxine tablets and should not be administered within four hours of these agents. The directions further recommended to take the medication as a single dose preferably on an empty stomach, one-half to one hour before breakfast to increase absorption. Review of R69's last thyroid stimulating hormone (TSH) lab test dated 7/30/14, indicated the level was high at 6.88 (normal range 0.20-4.50) which indicated a possible decrease in the effect of the medication. The Nexium manufacturer's directions for use revised 4/2014, indicated Nexium should be administered at least one hour before a meal. The director of nursing (DON), interviewed on 10/30/14, at 12:44 p.m. stated it would not matter if R69's Levothyroxine, Nexium, and Calcium were administered together with the meal unless the thyroid stimulating hormone (TSH) was "out of whack." The DON stated the staff should wait	F 332	-Pharmacy nurse to complete periodic audits of medication passes. -To be completed by 12/10/14. -Review of audit results through the facility QA committee, quarterly. -The DON or designee will maintain responsibility for the continued compliance of this requirement.	

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F 332	Continued From page 25 about "one to two minutes, or maybe five minutes" between different inhalers and between puffs of the same inhaler. On 10/30/14, at 12:59 p.m. the certified nurse practitioner (CNP) was contacted and stated that, based on R69's elevated TSH level, the Levothyroxine should be administered on an empty stomach. CNP confirmed the intent for Nexium to be administered at 10:00 a.m. was so the medication was administered between meals and not with other medications. On 11/3/14, at 1:15 p.m., (after survey exit), the consultant pharmacist (CP) was interviewed by phone and stated R69's Levothyroxine and Nexium could be administered together as there was an insignificant amount of magnesium in the Nexium. CP verified both medications should be taken on an empty stomach for optimal benefit. CP stated that simultaneous administration of calcium and Levothyroxine could cause decreased absorption of Levothyroxine and change the TSH level, and require a medication dosage adjustment. R49's Symbicort inhaler was not administered appropriately resulting in 1 medication error. The physician's orders dated 9/30/14, directed staff to administer a Spiriva inhaler once daily, and Symbicort 160 mg/4.5 mcg 2 puffs twice a day. On 10/30/14, at 9:40 a.m. LPN-A was observed to administer a Spiriva inhaler to R49. LPN-A then immediately shook a Symbicort inhaler and	F 332		

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F 332	Continued From page 26 administered two consecutive puffs of the Symbicort inhaler within 7 seconds after the Spiriva inhaler had been administered. There was no wait time in between the Spiriva or Symbicort inhalers, and there was no wait time between each puff of Symbicort. LPN-A stated she was unsure if there was a wait time between the two inhalers and would check. On 10/30/14, at 12:19 p.m. LPN-A stated she had checked the facility protocol, and confirmed she should have waited 5 minutes between the Spiriva and Symbicort inhalers. The undated policy for Oral and Nasal Inhalations Administration directed pause according to manufacturer's instructions or two minutes between inhalations of the same medication. Wait approximately five minutes between inhalations of different medications. The director of nursing (DON), interviewed on 10/30/14, at 12:44 p.m. stated the staff should wait about "one to two minutes, or maybe five minutes" between different inhalers and between puffs of the same inhaler.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed	F 356	**F356 Nurse Staffing Information** It is the policy of New Brighton Care Center to ensure that the facility will post Nurse Staffing Information as follows: 1.) *Data Requirements.* The facility must post the following information on a daily basis: facility name, current date, the total number and the actual hours	

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F 356	Continued From page 27 vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure the Report of Nursing Staff displayed actual hours worked by nursing staff. Findings included: On 10/28/14, at 1:30 p.m. the facility Report of Nursing Staff was displayed in a clear binder next to the bulletin board by the East/West wing nursing station. The report listed how many nurses and nursing assistants (NARS) were working and total hours worked per shift, but did not include the actual hours of the shifts. Behind the 10/28/14, Report of Nursing staff were 10/27/14, and 10/26/14, Reports of Nursing Staff.	F 356	worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (RN's, LPN's, CNA's), and resident census. 2.) *Posting Requirements.* The facility must post the nurse staffing data (as mentioned above) on a daily basis at the beginning of each shift. The data must be posted as follows: Clear and readable format and in a prominent place readily accessible to residents and visitors. 3.) *Public access to posted nurse staffing data.* The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. 4.) *Facility data retention requirements.* The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	

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F 356	Continued From page 28 The 10/27/14, Report of Nursing Staff was left blank for days, and the 10/26/14, Report of Nursing Staff was left blank for evenings. At 1:47 p.m. the health unit coordinator (HUC-H) verified the 10/27/14, Report of Nursing Staff was blank for days, and the 10/26/14, report was left blank for evenings. HUC-H also verified that none of the three Reports of Nursing Staff indicated the shift times for the nurses and NARS. HUC-H stated the East wing nurses on days and evenings and the night nurse is responsible for filling in the report. On 10/29/14, at 8:38 a.m. the Report of Nursing Staff displayed did not show the actual hours worked by the nursing staff. At 3:34 p.m. the director of nursing (DON) stated after shift report the East wing nurse checks with the North wing nurse about resident admissions and discharges, and looks at the work schedule and completes the Report of Nursing Staff for the next day. On 10/30/14, at 3:13 p.m. the DON stated the East wing nurse at the beginning of shift makes sure the staff posting is correct. DON verified that the Report of Nursing Staff did not include actual hours worked for the nurses and NARS. DON also stated, "I can correct that and will correct that." On 10/31/14, at 8:45 a.m. the Report of Nursing Staff was displayed with varying shift times for the NARS. The report did not identify how many NARS worked which hours. At 10:53 a.m. the DON stated, "I will add a spot	F 356	***Posting of Nurse Staffing Information*** -The procedure for posting nurse staffing information has been reviewed and revised. -The facility policy and procedures related to posting Nurse Staffing Information to be reviewed and revised. -All involved staff to be in-serviced on current policy and procedures on the posting of Nurse Staffing Information. –An audit program to be developed related to the posting of Nurse Staffing Information. -To be completed by 12/10/14. -Review of audit results through the facility QA committee, quarterly. -The DON or designee will maintain responsibility for the continued compliance of this requirement.	

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F 356	Continued From page 29 on the Report of Nursing Staff to add the actual number of aides working the two different shift times." At 2:25 p.m. the DON stated, "Here is the corrected Report of Nursing Staff." The corrected report included the actual hours worked for nursing staff. The facility's undated Nurse Staffing Information Policy and Procedure reads: Policy: It is the policy of New Brighton Care Center to ensure that the facility will post Nurse Staff information as follows: 1. Data Requirements: The facility must post the following information on a daily basis: facility name, current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift (RN's, LPN's, CNA's), and resident census.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	**F441 Infection Control** It is the policy of New Brighton Care Center to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 30 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review hand washing was not completed per facility policy during cares for 1 of 2 residents (R34) observed for infection control. R34's quarterly Minimum Data Set (MDS) dated 10/6/14, indicated R34 needed the extensive assistance of one staff with transfers, dressing and personal hygiene. R34 required the extensive assistance of two staff with toilet use. On 10/30/14, at 9:55 a.m. nursing assistant	F 441	**(a) Infection Control Program** The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. **(b) Preventing Spread of Infection** (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	10/31/2014

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NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 441	Continued From page 31 (NA)-B assisted R34 to ambulate from the bed to the toilet. NA-B removed R34's wet incontinent brief, washed hands and donned gloves. After R34 used the toilet, NA-B helped R34 to stand up from the toilet and washed and dried 34's peri area and buttocks. NA-B removed the gloves, pulled up R34's incontinent brief and pants, and assisted R34 to lay down. NA-B raised the head of the bed with a crank at the foot of the bed, organized the oxygen tanks, the walker and the wheelchair. NA-B picked up supplies and soiled linen from the bathroom and attached the call light to R34's shirt. NA-B gathered the bags of trash and soiled linen and stated, "I'm going to take this out before I wash my hands." NA-B left R34's room without washing or sanitizing hands, walked down the hall to the soiled utility room, pressed the buttons to unlock the door and put the bags into bins in the soiled utility room. NA-B returned to the room and washed her hands in R34's bathroom. On 10/30/14, at 10:35 a.m. NA-B stated she always left the room to go to the soiled utility room without washing or sanitizing hands and washed hands when she returned to the room. A sign outside of R34's room directed persons entering to sanitize in and sanitize out of the room. On 10/31/14, at 9:35 a.m. the director of nursing (DON) stated the NA should have washed or sanitized her hands prior to exiting the room. The DON stated that hands should also be washed after removing gloves and picking up the soiled linen and trash bags. The facility's Hand Washing and Hand Hygiene	F 441	(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. **(c) Linens** Personnel must handle, store, process and transport linens so as to prevent infection. **Resident #34** ~~Resident #21~~ plan of care reviewed. PLH 11/26/14 -The facility policy and procedure for the infection control program is to be reviewed and revised; with special focus on hand washing technique and preventing the spread of infection. -All staff will be in-serviced on proper hand washing technique and the prevention of infection. -An audit program to be developed in monitoring appropriate infection control technique with hand washing. -To be completed by 12/10/14. audit by direct care observation PLH 11/26/14	

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F 441	Continued From page 32 policy dated 2008, indicated hand hygiene must be performed after touching blood, body fluids, secretions and contaminated items. Whether or not gloves were worn, immediately after gloves were removed and otherwise indicated to avoid the transfer of microorganisms to other residents, personal equipment and or the environment. Examples included; before and after providing personal care for a resident (peri care, bathing) and after removing gloves.	F 441	-Review of audit results through facility QA committee, quarterly. -The DON or designee will maintain responsibly for the continued compliance of this requirement.	

North Cities Health Care, Inc., dba

New Brighton Care Center

805 6th Ave. NW

New Brighton, Minnesota, 55112

651-633-7200

Patricia Halverson, Unit Supervisor

Minnesota Department of Health

11 East Superior Street, Suite #290

Duluth, Minnesota 55802

November 24th, 2014

RE: Plan of Correction for the New Brighton Care Center - 2567

Project Number: S5421025

Dear Ms. Halverson,

Enclosed are the Correction Orders for the most recent survey which took place starting on October 31st, 2014. I thank your Team for their efforts during the survey process. I believe we addressed the concerns outline in our Plan of Correction and work hard to meet the intent of the Rules and Regulations that govern us. If you have any questions or concerns, please contact either myself or my Director of Nursing, Jean Kittelson.

Sincerely,

Michael R. Chies

Administrator, New Brighton Care Center.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2014**

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NEW BRIGHTON CARE CENTER	**805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, New Brighton Care Center was found to be 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. New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of construction, the building was surveyed as 1 building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. the facility has a capacity of 57 and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

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K 000	Continued From page 1 *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		