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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1INO11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00114

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245164**

2.STATE VENDOR OR MEDICAID NO.
(L2) **296842800**

3. NAME AND ADDRESS OF FACILITY
(L3) **HEALTH AND REHABILITATION OF NEW BRIGHTON**
(L4) **825 FIRST AVENUE NORTHWEST**
(L5) **NEW BRIGHTON, MN** (L6) **55112**

4. TYPE OF ACTION: **9** (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 03/15/2016 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)

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

12.Total Facility Beds **100** (L18)

13.Total Certified Beds **100** (L17)

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 04/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION (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.
00270 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

CCN: 24-5164

On March 15, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed to verify compliance with Federal certification regulations. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Post Certification Revisit (PCR) to follow. Please refer to the CMS 2567 along with the facility's plan of correction

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 29, 2016

Ms. Carolyn Hervin, Administrator
Health And Rehabilitation Of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: Project Number S5164026

Dear Ms. Hervin:

On March 15, 2016, a Minimum Date Set (MDS) 3.0/Staffing Focused Survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 24, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 15, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 15, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST 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 A Minimum Data Set (MDS) 3.0/Staffing Focused Survey was conducted. The following deficiencies were issued. The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff, if your ePoC for the respective deficiencies (if any) is acceptable.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		4/24/16

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

Electronically Signed | 04/08/2016

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

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F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code pressure ulcers on the Minimum Data Set (MDS) for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2's discharge return anticipated MDS dated 10/16/15, was coded to indicate R2 had one pressure ulcer, an unhealed ulcer to the left buttock Stage 4 (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures e.g., tendon, joint capsule). However, a Progress Note dated 9/28/15, indicated R2 also had an open area below the coccyx that measured 2 centimeters (cm) x 4 cm. The October 2015 Treatment Record indicated there had been an order initiated to change an Allevyn dressing (moist wound healing dressings designed specifically for the management of chronic and exuding wounds) to the coccyx every three days and as needed through the days leading to the 10/16/15 MDS. In addition, a facility document, Skin Grid - Pressure/Venous Insufficiency Ulcer/other for the dates of 10/5 - 10/22/15, revealed the area on	F 278	Preparation, submission and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F278 • Resident R2's MDS ARD 10/16/16 will be modified to reflect the presence of a stage II pressure ulcer during the assessment period. • The IDT will receive the re-education on MDS accuracy standards per the RAI manual. Re-education will be conducted by the Regional Director of Revenue Integrity or designee. • The Regional Director of Revenue Integrity or designee will audit three MDS's per month for a period of three months to validate accuracy. • The facility's IDT weekly comprehensive care plan review meeting will be utilized to validate accuracy of MDS coding after the MDS has been completed. • Results of audits will be reviewed at	

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F 278	Continued From page 2 R2's coccyx which had been identified as "shear" (met the criteria for a stage II pressure ulcer). Although documentation indicated the presence of Stage 2 pressure ulcers during the assessment period, the facility failed to identify these on the 10/16/15 MDS. On 3/15/16, at 2:45 p.m. registered nurse (RN)-C (the facility's MDS supervisor), also reviewed the resident's treatment sheets, wound document sheets and progress notes. RN-C verified the Stage 2 coccyx pressure ulcers had not been coded on the MDS. She stated, "It appears we did not code the shearing area to the coccyx which was a stage II." At 3:15 p.m. on 3/15/16, RN-B, who had completed R2's MDS, stated she'd thought the coccyx wound had healed and was a scab. RN-B stated she'd only gotten documentation for one wound so had thought R2 had only pressure ulcer at the time of the 10/16/15 MDS.	F 278	the facility's QA meeting.	
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, the facility failed to follow the care plan for 1 of 4 residents (R1) reviewed for use of psychoactive medications; and for 1 of 3 residents reviewed for pressure ulcers (R3).	F 282	F282 • R1 and R3's Care Plans were reviewed and updated as appropriate. Services that have been Care Planned for resident have been provided.	4/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 3 Findings include: R1 was interviewed on 3/14/16, at 2:08 p.m. and stated when he changed positions suddenly he felt lightheaded and dizzy which resolved when he settled down. He indicated at times when the staff came to assist him he had to remind them to slow down because of the dizziness and had to take his time prior to position changes. The Physician Orders for R1 dated 3/4/16, revealed medications including quetiapine (also known as seroquel, an antipsychotic) 25 milligram (mg) twice daily, and quetiapine 200 mg at bedtime to treat psychosis and bipolar disorder; alprazolam (also known as Xanax, an antianxiety) 0.5 mg as needed; Prozac (an antidepressant) 60 mg daily, Trazodone (an antidepressant) 100 mg at bedtime as needed for sleep/depression, as well as Amlodipine (a blood pressure medication) 5 mg daily to treat high blood pressure (BP). The care plan dated 11/5/14, identified R1 had depression and received psychoactive medications. Interventions included the use of medications, and staff were directed to monitor for side effects of the medication. No orthostatic BPs had been recorded on MARs/TARs dated from 11/1/15 through 2/29/16. All through that time period the TARs were all left blank and no documentation was completed on why they had not been checked. In addition, review of the March 2016, MAR revealed R1 had received as needed Trazodone and Xanax a total of 19 times combined however, no there was no indication non-pharmacological interventions had been attempted, and there was no documented	F 282	• All residents at Health and Rehabilitation of New Brighton have the potential to be affected by this practice. All residents who are prescribed psychoactive medications or are at risk for pressure ulcers have received a care plan review. Services that have been Care Planned for residents have been provided. • Licensed/unlicensed nursing staff and IDT team were educated on following resident's plans of care by DON/Designee. • DON/Designee will audit resident's plan of care at Comprehensive Care Plan Review meetings to ensure care plan appropriate x3 charts weekly for one month, then x1 chart weekly for an additional two months. • Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components.	

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F 282	Continued From page 4	F 282		

monitoring for the effectiveness of the medications documented.

On 3/14/16, at 3:30 p.m. registered nurse (RN)-A reviewed R1's medical record and verified orthostatic BPs had not been measured between November 2015, through February 2016. When asked if the nurses were supposed to document non-pharmacological interventions prior to using any psychotropic medications RN-A stated "Yes they are supposed to and are supposed to document the effectiveness."

On 3/14/16, at 3:56 p.m. the DON verified staff were supposed to check orthostatic blood pressures as a potential side effect of psychoactive medication use, document non-pharmacological interventions used prior to the use of as needed psychoactive medications, and/or document the effectiveness of medications used. The DON verified these components of the plan of care were not always being consistently implemented.

The facility policy TARGET BEHAVIOR/TARGET MOOD OCCURRENCE dated January 2016, included: "1. Enter the resident's target behavior/mood into CareTracker [electronic record] when antipsychotic, anti-anxiety (anxiolytic) or mood stabilizer (e.g., Depakote, etc.) medications are used to manage resident behaviors/moods after medical, environment, psychosocial causes have been ruled out as causing the behavior ... 4. Note ineffective interventions for target behavior using CareTracker Mood and Behavior Section ... 5. Address ineffective behavior interventions at the next Daily Clinical Review meeting ..."
The facility policy SLEEP ASSESSMENT dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 5	F 282		

January 2016, indicated: "8. Utilize data to assist with care PLAN DEVELOPMENT USING THE Mood and Behavior Symptom Assessment Care Plan: Sleep Disturbance. 9. File and maintain the completed Sleep Assessment in the 'Assessment' section of the resident's medical record. 10. Monitor effectiveness of sedative/hypnotic (sleep aid)."
The facility policy PSYCHOACTIVE MEDICATION dated January 2016, included: "4. Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Care Plan. 5. Document the following using the appropriate Mood and Behavior Symptom Assessment Care Plan and CareTracker (Mood and Behavior Section)."

On 3/15/16, at 7:30 a.m. R3 was in the wheelchair seated on a cushion. At 9:20 a.m., R3 continued to be seated in the wheelchair. During the observations, no one was observed to assist and/or offer repositioning of any type.

During interview with nursing assistant (NA)-A at 9:40 a.m. on 3/15/16, NA-A verified R3 had been assisted with getting up for the day prior to the start of NA-As shift at 6:30 am. (NA)-A stated, "He was already up when I started my shift at 6:30." When NA-A was asked whether R3 had been repositioned or toileted since that time, NA-A stated R3 was able to reposition himself, and that she had not assisted or cued him to reposition. NA-A then reviewed the NA assignment sheet and stated there were not clear directions for reposition R3, but that she would be checking with the nurse.

At 9:42 a.m. on 3/15/16, R3 was asked by the

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HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 282	Continued From page 6	F 282		

surveyor whether he was able to reposition himself. R3 responded "yes" and stated he was able to slide back at times but staff helped him. When asked if he had slid back yet this morning R3 stated, "I'm okay so far." At 9:44 a.m. R3 was observed to propel himself in the wheelchair to the hallway. NA-A was observed to immediately go into R3's room and was observed to approach R3's roommate, but did not offer any assistance to R3. R3 was then overheard to address the licensed practical nurse (LPN)-A, "I am not going to get up at 5 o'clock again."

LPN-A was interviewed at 9:57 a.m. on 3/15/16, when asked whether the NA's had reported about any issues regarding R3 refusing cares or repositioning, LPN-A stated "No." LPN-A verified R3 did at times refuse care, but stated NA-A had not reported anything that morning. At 9:59 a.m. LPN-A reported to the surveyor that NA-A had approached her to ask how R3 was supposed to be repositioned as NA-A was unsure.

At 10:00 a.m. on 3/15/16, LPN-A was observed to have R3 "scoot" back in the wheelchair. R3 was observed to push down on the armrest and lift himself off the wheelchair seat for three seconds prior to moving back in the wheelchair. LPN-A then wheeled R3 into his room and was overheard asking R3 if he wanted to lay down, but R3 declined.

During a follow up interview with LPN-a at 10:04 a.m. on 3/15/16, LPN-A acknowledged the NA's were supposed to follow each resident's plan of care, and were supposed to offer repositioning to R3 who was not always able to remember to reposition himself, and were to report any refusal of cares to the nurse immediately. LPN-A further

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F 282	Continued From page 7 stated R3 had history of pressure sores. R3's Skin Integrity Assessment Prevention and Treatment Care Plan dated 2/18/16, identified R3 was at risk for skin issues related to dermal fragility. The care plan indicated resident refused to be repositioned and lay down between meals however directed staff to reposition every two hours and as needed, and to encourage to offload on sides. The care plan directed staff that the resident should be sitting up no more than 60 minutes. At 10:09 a.m. registered nurse (RN)-A verified these interventions from the care plan and nursing assignment sheets. Nursing assistant Group One assignment sheet dated 3/11/16, directed staff to cue resident to reposition in wheelchair every two hours side to side, to encourage to lay down, and "Should be no more than 60 minutes sitting up." On 3/15/16, at 11:58 a.m. the director of nursing stated staff were supposed to follow the plan of care and facility policies. When asked what her expectation was regarding staff providing care as directed by the care plan, the DON verified staff were expected to follow each resident's care plan. The Care Plans policy effective July 2015, directed staff "The care plan must be reviewed and revised according to the RAI [Resident Assessment Intrument] process, and services provided or arranged must be consistent with each resident's written care plan..."	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		4/24/16

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F 314	Continued From page 8 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure timely repositioning was provided for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: On 3/15/16, at 7:30 a.m. R3 was in the wheelchair seated on a cushion. At 9:20 a.m., R3 continued to be seated in the wheelchair. During the observations, no one was observed to assist and/or offer repositioning of any type. During interview with nursing assistant (NA)-A at 9:40 a.m. on 3/15/16, NA-A verified R3 had been assisted with getting up for the day prior to the start of NA-As shift at 6:30 am. (NA)-A stated, "He was already up when I started my shift at 6:30." When NA-A was asked whether R3 had been repositioned or toileted since that time, NA-A stated R3 was able to reposition himself, and that she had not assisted or cued him to reposition. NA-A then reviewed the NA assignment sheet and stated there were not clear directions for reposition R3, but that she would be	F 314	F314 • R3 has had a Skin Integrity Assessment Prevention and Treatment Care Plan review and update. R3's plan of care has been followed to ensure timely repositioning per resident's plan of care. • All residents at Health and Rehabilitation of New Brighton who are at risk for pressure ulcers have the potential to be affected by this practice. All residents who are at risk for pressure ulcers have had a review of the Skin Integrity Assessment Prevention and Treatment Care Plan and nursing assistant care guides have been updated. • Licensed/unlicensed nursing staff and IDT team were educated on following resident's plans of care by DON/Designee. • Resident Skin Integrity Assessment Prevention and Treatment Care Plan will be reviewed quarterly and PRN at Comprehensive Care Plan Review (CCPR) meetings held weekly to assure care plan assessments are appropriate	

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F 314	Continued From page 9 checking with the nurse. At 9:42 a.m. on 3/15/16, R3 was asked by the surveyor whether he was able to reposition himself. R3 responded "yes" and stated he was able to slide back at times but staff helped him. When asked if he had slid back yet this morning R3 stated, "I'm okay so far." At 9:44 a.m. R3 was observed to propel himself in the wheelchair to the hallway. NA-A was observed to immediately go into R3's room and was observed to approach R3's roommate, but did not offer any assistance to R3. R3 was then overheard to address the licensed practical nurse (LPN)-A, "I am not going to get up at 5 o'clock again." LPN-A was interviewed at 9:57 a.m. on 3/15/16, when asked whether the NA's had reported about any issues regarding R3 refusing cares or repositioning, LPN-A stated "No." LPN-A verified R3 did at times refuse care, but stated NA-A had not reported anything that morning. At 9:59 a.m. LPN-A reported to the surveyor that NA-A had approached her to ask how R3 was supposed to be repositioned as NA-A was unsure. At 10:00 a.m. on 3/15/16, LPN-A was observed to have R3 "scoot" back in the wheelchair. R3 was observed to push down on the armrest and lift himself off the wheelchair seat for three seconds prior to moving back in the wheelchair. LPN-A then wheeled R3 into his room and was overheard asking R3 if he wanted to lay down, but R3 declined. During a follow up interview with LPN-A at 10:04 a.m. on 3/15/16, LPN-A acknowledged the NA's were supposed to follow each resident's plan of care, and were supposed to offer repositioning to	F 314	and current. DON/Designee will audit results from CCPR meetings to ensure care plan accuracy x3 charts weekly for one month, then x1 chart weekly for an additional two months. • Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components.	

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F 314	Continued From page 10	F 314		

R3 who was not always able to remember to reposition himself, and were to report any refusal of cares to the nurse immediately. LPN-A further stated R3 had history of pressure sores.

R3's diagnoses included congestive heart failure, peripheral vascular disease, diabetes mellitus, seizure disorder and schizophrenia obtained from the quarterly Minimum Data Set (MDS) dated 2/20/16. In addition, the MDS indicated R3 had moderate cognitive impairment, was not ambulatory, and required extensive physical assistance of one to two staff with bed mobility, transfers, personal hygiene and toileting. The MDS also identified R3 was at risk for developing a pressure ulcer and had one unhealed stage II pressure ulcer.

R3's Pressure Ulcer Care Area Assessment (CAA) dated 4/24/14, identified R3 was at risk for pressure ulcers and skin breakdown complicated by a diagnosis of diabetes. The CAA indicated R3 had an ongoing open area to the left buttock related to moisture and indicated although R3 was able to assist with repositioning, staff was to assist with bed mobility and were to observe skin with cares.

R3's Skin Integrity Assessment Prevention and Treatment Care Plan dated 2/18/16, identified R3 was at risk for skin issues related to dermal fragility. The care plan indicated resident refused to be repositioned and lay down between meals however directed staff to reposition every two hours and as needed, and to encourage to offload on sides. The care plan directed staff that the resident should be sitting up no more than 60 minutes.

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F 314	Continued From page 11 At 10:09 a.m. registered nurse (RN)-A verified these interventions from the care plan and nursing assignment sheets. Nursing assistant Group One assignment sheet dated 3/11/16, directed staff to cue resident to reposition in wheelchair every two hours side to side, to encourage to lay down, and "Should be no more than 60 minutes sitting up." Review of the facility forms: Skin Grid-Pressure/Venous Insufficiency Ulcer/Other weekly assessments from 1/11/16 through 3/1/16, indicated R3 had a stage II pressure ulcer. However, a Wound Care Specialist Evaluation dated 3/14/16, indicated both the left and right medial buttock wounds had been noted as resolved on 3/14/16. On 3/15/16, at 11:58 a.m. the director of nursing stated staff were supposed to follow each resident's plan of care and facility policies.	F 314		
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	F 329		4/24/16

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F 329	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents who utilized psychoactive medications were adequately monitored for efficacy and/or medication side effects for 1 of 4 residents (R1) reviewed for psychoactive medication use. Findings include: R1 was interviewed on 3/14/16, at 2:08 p.m. and stated when he changed positions suddenly he felt lightheaded and dizzy which resolved when he settled down. He indicated at times when the staff came to assist him he had to remind them to slow down because of the dizziness and had to take his time prior to position changes. The Physician Orders for R1 dated 3/4/16, revealed medications including quetiapine (also known as seroquel, an antipsychotic) 25 milligram (mg) twice daily, and quetiapine 200 mg at bedtime to treat psychosis and bipolar disorder; alprazolam (also known as Xanax, an antianxiety)	F 329	F329 • R1 had a medication review performed by the consultant pharmacist. Side effect monitoring for a psychoactive medication has been put into place for resident R1. • All residents at Health and Rehabilitation of New Brighton on psychoactive medication have the potential to be affected by this practice. All residents receiving psychoactive medications will have a medication review by the facilities pharmacy consultant to identify unnecessary drugs. All residents receiving psychoactive medications will be accurately monitored for efficacy and/or medication side effects. • The IDT, License/unlicensed nursing staff, and social service department will receive a re-education on unnecessary drugs and appropriate monitoring of psychoactive drugs per our policy. Re-education will be conducted by the DON or designee.	

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F 329	Continued From page 13 0.5 mg as needed; Prozac (an antidepressant) 60 mg daily, Trazodone (an antidepressant) 100 mg at bedtime as needed for sleep/depression, as well as Amlodipine (a blood pressure medication) 5 mg daily to treat high blood pressure (BP). The care plan dated 11/5/14, identified R1 had depression and received psychoactive medications. Interventions included the use of medications, and staff were directed to monitor for side effects of the medication. No orthostatic BPs had been recorded on MARs/TARs dated from 11/1/15 through 2/29/16. All through that time period the TARs were all left blank and no documentation was completed on why they had not been checked. In addition, review of the March 2016, MAR revealed R1 had received as needed Trazodone and Xanax a total of 19 times combined however, no there was no indication non-pharmacological interventions had been attempted, and there was no documented monitoring for the effectiveness of the medications documented. On 3/14/16, at 3:30 p.m. registered nurse (RN)-A reviewed R1's medical record and verified orthostatic BPs had not been measured between November 2015, through February 2016. When asked if the nurses were supposed to document non-pharmacological interventions prior to using any psychotropic medications RN-A stated "Yes they are supposed to and are supposed to document the effectiveness." On 3/14/16, at 3:56 p.m. the DON verified staff were supposed to check orthostatic blood pressures as a potential side effect of psychoactive medication use, document	F 329	• DON/Designee will audit resident CareTracker documentation completion by nursing staff 1x/week per unit for one month, then 1x/month per unit for an additional two months. DON/Designee will audit resident MAR/TAR for documentation of orthostatic blood pressure monitoring, non-pharmacological interventions prior to use of PRN psychoactive medications, and effectiveness of medications used 1x/week per unit for one month, then 1x/month per unit for an additional two months. • Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components.	

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non-pharmacological interventions used prior to the use of as needed psychoactive medications, and/or document the effectiveness of medications used. The DON verified these components of the plan of care were not always being consistently implemented.

The facility policy TARGET BEHAVIOR/TARGET MOOD OCCURRENCE dated January 2016, included: "1. Enter the resident's target behavior/mood into CareTracker [electronic record] when antipsychotic, anti-anxiety (anxiolytic) or mood stabilizer (e.g., Depakote, etc.) medications are used to manage resident behaviors/moods after medical, environment, psychosocial causes have been ruled out as causing the behavior ... 4. Note ineffective interventions for target behavior using CareTracker Mood and Behavior Section ... 5. Address ineffective behavior interventions at the next Daily Clinical Review meeting ..."
The facility policy SLEEP ASSESSMENT dated January 2016, indicated: "8. Utilize data to assist with care PLAN DEVELOPMENT USING THE Mood and Behavior Symptom Assessment Care Plan: Sleep Disturbance. 9. File and maintain the completed Sleep Assessment in the 'Assessment' section of the resident's medical record. 10. Monitor effectiveness of sedative/hypnotic (sleep aid)."
The facility policy PSYCHOACTIVE MEDICATION dated January 2016, included: "4. Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Care Plan. 5. Document the following using the appropriate Mood and Behavior Symptom Assessment Care Plan and CareTracker (Mood and Behavior Section)."

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F 356	Continued From page 15	F 356		
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 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 failed to post the actual hours worked for nursing staff directly responsible for	F 356	F356 • Daily nurse staff posting was immediately corrected/updated to the	4/24/16

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F 356	Continued From page 16 resident care per shift on 3/12, 3/13, and 3/14/16. This had the potential to affect visitors and all 86 residents residing in the facility. Findings include: Upon entrance to the facility on 3/14/16, at 8:00 a.m. the Daily Nurse Staffing Form was observed posted on a wall by the front desk entrance door across from the business office. The Daily Nurse Staffing Form was dated as 3/9/16, indicating a census of 90. At 8:17 a.m. on 3/14/16, the staffing coordinator (SC) verified the Daily Nurse Staffing Form currently posted was for 3/9/16. When asked what the census was the SC stated he thought the census had been 86 through the weekend. On 3/14/16, at 11:30 a.m. the SC stated he was responsible for posting the Daily Nurse Staffing Form when he was working. He said when he was out of the building, the charge/supervisor was to make sure the posting was current. On 3/15/16, at 12:30 p.m. the administrator stated she had spoken to the SC about the posting as she had also noticed the posting was for 3/9/16 when she'd arrived on 3/14/16. The administrator stated she would expect the Daily Nurse Staffing Form to be posted correctly close to shift start. The facility's Daily Nurse Staffing policy dated July 2015, indicated "Centers must post the information daily at the beginning of each shift. Any changes to be posted information must be made as soon as possible."	F 356	correct date after identification. • Staffing coordinator, facility nursing supervisors, and IDT will be educated on the facility's Daily Nurse Staffing policy by the ED or designee. • ED/Designee will audit Daily Nurse Staffing form 2x/week for one month, then 1x/week for an additional two months. • Audit results will be reviewed at monthly QAPI meetings x3 months to ensure compliance.	