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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GW4C

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: **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 **09/18/2015** (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 **100** (L18)

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

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Thomas Linhoff, HFE NE II — 09/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/09/1968
(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.
00452
(L31)

30. REMARKS
Posted 10/23/2015 Co.
DETERMINATION APPROVAL

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/07/2015
(L33)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245164	HEALTH AND REHAB NEW BRIGHTON

Type of Survey (select all that apply):

D					

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

Extent of Survey (Select all that apply):

D					

A Routine/Standard (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 information 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)
1. Team Leader 16022			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

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

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245164	HEALTH AND REHAB NEW BRIGHTON

Type of Survey (select all that apply):

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 Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (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 information 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)
1. Team Leader 12424			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5164
CHOW page #2 Item #16

The change of ownership for Health and Rehab of New Brighton is recommended effective July 1, 2015. The legal entity of the seller was Extendicare Home Inc. The legal entity of the buyer is FMG First Avenue Northwest Minnesota, LLC. Refer to the attached documents: CMS-1561 Health Insurance Benefit Agreement; CMS-671; the CMS-855A for both buyer and seller, approval letters from National Government Services dated July 6, 2015; Office of Civil Rights materials including the HHS-690, and; CHOW closing documents.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245164
October 1, 2015

Ms. Carolyn Hervin, Administrator
Health and Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, Minnesota 55112

Dear Ms. Hervin:

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 August 10, 2015 the above facility is certified for or recommended for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 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.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Electronically delivered
October 1, 2015

Ms. Carolyn Hervin, Administrator
Health and Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, Minnesota 55112

RE: Project Number S5164024

Dear Ms. Hervin:

On September 10, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 2, 2015, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our September 10, 2015 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 September 18, 2015, the Minnesota Department of Public Safety 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 survey, completed on July 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 2, 2015, as of August 10, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our

letter of September 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 2, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 2, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 2, 2015, is to be rescinded.

In our letter of September 10, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 10, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245164	A. Building B. Wing	8/19/2015

Name of Facility	Street Address, City, State, Zip Code
HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST 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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/10/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **08/10/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/10/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/10/2015**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **08/10/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/10/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/KJ	08/25/2015	16022	08/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/2/2015			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245164	A. Building / B. Wing: 01 - MAIN BUILDING 01	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**08/10/2015**	ID Prefix Reg. # **NFPA 101** LSC K0050	**08/10/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/KJ	10/01/2015	12424	09/18/2015
CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/30/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GW4C

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: **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 **07/02/2015** (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 **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

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
	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):

17. SURVEYOR SIGNATURE — Date :
Susan Miller HFE NE II — 07/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/09/1968
(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.
00452
(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

Electronically delivered
July 16, 2015

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

RE: Project Number S5164024

Dear Ms. Hervin:

On July 2, 2015, 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 11, 2015, 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 October 2, 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 January 2, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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 _____	07/02/2015

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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. 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).	F 279		8/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/24/2015

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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a plan of care related to locomotion for 2 of 2 residents (R6 and R34) in the sample; and failed to develop the care plan for 1 of 3 residents (R81) dependent on staff for repositioning. Findings include: R6 and R34's care plans lacked interventions regarding locomotion. R6 was observed to self-propel wheel chair and also received assist from staff for locomotion on the unit on 7/1/15, during an observation from 8:19 a.m. to 8:33 a.m. A Care Area Assessment (CAA) dated 1/21/15, read, "Res. (resident) requires ext (extensive) assist of 1-2 with most ADL (activities of daily living) and mobility needs, able to feed self indep. (independent) after set-up. Uses EZ stand (mechanical lift) for transfers. Res has dx (diagnosis) of old CVA (cardiovascular accident) with residual hemiparesis and lower back pain ....." While the care plan dated 6/2/15, addressed some of the areas identified on the CAA, locomotion was not addressed. The care plan indicated the following: "Potential or actual ADL/ mobility deficit, poor oral hygiene, oral infection r/t arthritis, CVA L (left) hemiplegia. Interventions personal hygiene/grooming/dressing/undressing assist/encourage/ provide per resident preference ...."	F 279	F 000 This Plan of Correction is not a submission of guilt on behalf of the provider. This plan of correction is being submitted because it is required by law. Alleged date of compliance is August 10, 2015. R6 and R34¿s care plans were immediately developed to include interventions for locomotion. This was completed prior to the MDH exit. Resident R81¿s care plan was immediately revised to Reflect her repositioning needs prior to the MDH exit. All resident care plans were reviewed and updated regarding their positioning and locomotion needs by 8/10/15. All Licensed staff received education regarding The development of plan of care process with emphasis on positioning and locomotion by 8/10/15. DON or designee will audit 4charts per week through the next quarter. Results of the audits will be reviewed at QAPI.	

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F 279	Continued From page 2 During an interview with R6 on 7/01/2015 at 8:12 a.m., R6 explained staff normally help him at least once a day in the dining area for wheelchair positioning, otherwise he could self-propel on the unit. Nursing assistant (NA)-D on 7/1/15, at 8:27 a.m., stated, R6 required assist with locomotion at times from staff, but mostly R6 self-propelled in the hallway. During an interview on 7/1/15 at 9:20 a.m., registered nurse (RN)-C acknowledged being unable to find information regarding R6's locomotion in the care plan. During an interview with RN-A on 7/2/15 at 10:10 a.m., RN-A stated, "I don't see it in the care plan, but he is someone who is independent with wheel chair propelling and will ask for help if needed. It is not specifically in this care plan". R34 was observed to self-propel wheel chair and also received assist from staff for locomotion on the unit on 7/1/15, at 9:15 a.m. and on 7/2/15, at 10:21 a.m. A CAA, dated 1/21/15, read, "Res. is LTC (long term care) requires ext assist of 1-2 with most ADL and mobility needs. Has dx of paranoid schizophrenia, morbid obesity..... able to locomote about facility indep. Once in w/c (wheel chair); able to make wants/needs known. Does occ. Have paranoid ideations and behavioral issues. Staff are aware of res physical and cognitive limitations, as well as psych issues, and assist res as needed while encouraging participation and indep ....."	F 279		

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F 279	Continued From page 3	F 279		

The care plan dated 5/28/15, indicated: "Potential or actual ADL/ mobility deficit, poor oral hygiene, oral infection r/t res has spacer in L TKA to chronic infection, cognitive impairment, refuses, ... Goal Will propel own wheelchair x 90 days daily" However, the care plan did not address locomotion for resident.

On 7/2/15 at 1:02 p.m., NA-C stated R34 required assist at times from staff especially if not feeling well, otherwise R34 did wheel self in the hallway in most cases.

On 7/2/15 at 1:41 p.m., RN-A stated, "I don't see it in the care plan, but he is someone who is independent with wheel chair propelling and will ask for help if needed. It is not specifically in this care plan."

During an interview on 7/2/15 at 1:45 p.m., RN-C acknowledged not being able to find locomotion in the care plan.

During an interview on 7/2/15 at 2:01 p.m., RN-D explained that the expectation was for locomotion to be addressed in the ADL care plan area.

R81 was admitted to the facility on 6/1/15, and according to progress notes and admission forms dated 6/1/15, no pressure ulcers were noted. However, R81 was assessed as being at risk for the development of pressure ulcers and assessed as requiring repositioning every two hours, but the care plan was not developed to address the frequency of repositioning.

A Braden Risk Assessment Scale form dated 6/1/15, identified a Braden score of 12, which

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F 279	Continued From page 4 indicated R81 was at "High Risk" for development of pressure ulcers. Tissue Tolerance Assessments dated 6/1 and 6/3/15, indicated R81 was bedfast and was to be repositioned every two hours. The Turn and Reposition Program portion of the care plan section titled Skin Integrity Assessment: Prevention and Treatment Care Plan Side 3, dated 6/2/15, was left blank. Further review of the remainder of the care plan also did not address the frequency of repositioning for R81. The care plan policy and procedure was requested on 7/1/15 at 9:30 a.m., however, RN-E explained there was not a care plan policy specific for locomotion. A policy and procedure dated March 2015, read, "Extendicare Health services, Inc. (ENSI) follows RAI philosophy and process on care planning. The comprehensive care plan should be an interdisciplinary communication tool that must have measurable objectives with time frames and describes the services to be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being..... Develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up..... . Also indicated, "The following is a list of EHSIs Plans of Care: ADL/Mobility care Plan. Initiate the appropriate care plan according to the RAI process and as needed with resident change in condition"	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		8/10/15

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F 280	Continued From page 5 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 3 residents (R2) related to pressure ulcers; and for 1 of 3 residents (R51) identified with weight loss. Findings include: A Nutrition Risk Data Collection and Assessment form dated 5/28/15, revealed R51 had a 4.2% weight loss from the prior 30 days. R51's weight decreased from 110.6 pounds to 106 pounds. The assessment indicated R51's ideal body weight was plus or minus 10% from a weight of 115 pounds; and R51 was receiving nutritional supplements. The assessment identified a goal of	F 280	R2 received an air mattress immediately, and care plan was updated accordingly. This was an isolated occurrence. This revision was completed prior to the MDH exit. R 51¿s plan of care was reviewed and updated relating to weight loss by The facilities Dietitian immediately. All residents with identified pressure	

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F 280	Continued From page 6 having R51 consume 75-100% at meals. A registered dietician progress note dated 6/30/15, revealed R51's weight had dropped further to 97 pounds, was 84% of ideal body weight and the nutritional supplement was increased from four ounces, twice a day to six ounces twice a day. The care plan reviewed on 2/27/15, had not been revised to reflect the increase in the amount of the nutritional supplement, or R51's current weight loss. The care plan identified a goal of consuming at least 75% of meals, but was not revised to reflect the goal of 75-100% intake, which had been addressed on the 5/28/15 assessment. The care plan also identified R51's weight was to remain stable plus or minus 3%, however, there was no indication what weight was to be used as a baseline for determining the plus or minus 3%. On 7/2/15, at 8:43 a.m., the director of nurses (DON) identified that R51's weight loss would be discussed with the registered dietician and explained that R51 was receiving supplements even though the weight loss had not been addressed on the care plan. On 7/2/15, at 3:21 p.m., the registered dietician stated the care plan had been revised and the missing items, pertaining to R51's weight loss, had been identified. R2's care plan was not revised to include an air mattress, to minimize the risk of development of a pressure ulcer.	F 280	ulcers were evaluated Their current care plan reflects their intervention needs. (including an air mattress if indicated) by 8/10/15. All resident care plans were reviewed and reflect their current nutritional needs by 8/10/15. All nursing staff received education regarding The residents care plan process emphasizing when revision are needed and completed timely by 8/10/15. DON or designee will audit 5 charts per week through the next quarter. Results of the audits will be reviewed at QAPI.	

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F 280	Continued From page 7 During interview, on 6/29/15 at 6:10 p.m., RN-A reported R2 had an unstageable ulcer on the right heal. RN-A indicated the ulcer originated at the nursing facility, but did not know the cause. RN-A added that at times, R2 refused to wear padded boot. On 7/1/15 at 7:45 a.m, R2 was transferred from the bed to the wheelchair by nursing assistant (NA)-A and NA-G. Soft "Easy" boots were applied bilaterally to the feet and a regular, not an air mattress was noted on the bed. NA-A identified that R2 had a sore on the right heel and did not like to wear the soft boots. R2's diagnoses included quadriplegia, muscle weakness, chronic pain, diabetes and spinal cord injury. A skin assessment, completed on 5/28/15, indicated the resident had a large blister on right heel. The July 2015 physician orders were reviewed and included: Air mattress (skin prevention) R2's current plan of care indicated R2 required extensive staff assist for bed mobility and transfers, and directed staff to: turn and reposition R2 every 2 hours and as needed, to reposition side to side and to lie down after meals as resident allows. The care plan did not identify any pressure reduction or pressure relief surface. On 7/1/15 at 11:40 a.m., RN-A verified R2 pressure ulcer measured 6.0 x 6.0 on 5/26/15, but was healing. RN-A added they were not aware if R2 had an air mattress on the bed as ordered. RN-A then checked R2's bed at this time and verified a regular mattress and not an air mattress was on the bed. On 7/2/15 at 7:30 a.m., RN-A verified the air mattress was not added to R2's care plan.	F 280		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		8/10/15

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F 282 SS=D	Continued From page 8 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 regarding repositioning for 1 of 3 residents (R78) identified as requiring staff assistance with repositioning, and failed to follow the care plan for 1 of 2 residents (R35) in the sample with an indwelling Foley catheter. Findings include: R78's care plan dated 3/16 and 4/10/15, revealed R78 had a Braden score of 14, indicating a moderate risk for skin breakdown, and directed staff to turn and reposition F78 every two hours. The care plan indicated R78 was non-weight bearing and required a mechanical lift and two staff for transfers. On 6/30/15, at 8:48 a.m., R78 was observed being wheeled back to R78's room from breakfast. R78 was positioned in the wheelchair in front of the television. R78 was continuously observed in the room from 8:48 a.m. until 12:00 p.m. without being repositioned. At 12:00 p.m. R78 was taken from the room to the dining room for lunch, without having been repositioned, for a total of three hours and 12 minutes. On 7/2/15, at 7:19 a.m., R78 was observed sitting	F 282	Employees assigned to provide cares for R 78 on 6/30 and 7/2 was provided education regarding repositioning. Resident R35 did not acquire any adverse effects as a result of the surveyor¿s observation. Our facility uses an anti-back up valve located on the drainage bag to avoid urine flow back into the bladder, in the event the drainage bag was accidently placed above the level of the bladder. Employees assigned to provide care for R 35 received education regarding position and cares with a catheter. All residents with catheters and risk for skin impairments have been reviewed to ensure the plan of care is accurate and up to date by 8/10/15. All direct care staff received education regarding following the residents care plan, emphasizing positioning and the location of the urinary	

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F 282	Continued From page 9 in a wheelchair outside of R78's room. At 8:47 a.m., R78 was wheeled from the hallway to the dining room for breakfast, and remained there until 9:17 a.m. when wheeled back to R78's room. There was no repositioning observed during this time period. R78 remained in the room without being repositioned, and at 9:38 a.m., a member of the activity department took R78 from the room to an activity in the front lounge. At 9:40 a.m., nursing assistant (NA)-F was interviewed regarding the type of assistance provided to R78 from when R78 had gotten up until this time. NA-F stated that during that time frame, NA-F had only taken R78 to the dining room for breakfast. Once in the dining room NA-F stated R78 was left in the dining room and NA-F stated there were other people on his list that needed to be taken care of. R78 remained in the front lounge until the end of the activity at 11:00 a.m. and the activity director returned R78 to R78's room. At 11:19 a.m., registered nurse (RN)-A was informed R78 had not been repositioned since 7:19 a.m., a total of four hours. RN-A replied that she would make sure that R78 was assisted into bed. At 11:20 a.m., during interview, R78 stated, "I'm hurting." When asked where the pain was located, R78 indicated the buttocks and between the legs. At 11:22 a.m., in the presence of RN-A, R78 again stated the buttocks hurt and between the legs hurt. RN-A informed R78 a nursing assistant would lay R78 down. R78 was laid down at this time and the skin on R78's buttocks was observed to be red, but blanchable and there were no further complaints of discomfort when RN-A checked R78's skin.	F 282	drainage bag by 8/10/15. DON or designee will audit 3 staff members per week, regarding observations of following a residents care plan. Results of the audits will be reviewed at QAPI.	

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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 282	Continued From page 10 A review of R35's care plan dated 6/17/15, revealed R35 had an indwelling suprapubic catheter because of a neurological condition and a neurogenic bladder. The care plan directed staff to provide daily catheter care which included keeping the catheter and drainage bag below the level of the bladder. During observation of a transfer on 7/1/15, at 10:45 a.m. the care plan was not followed. On 7/1/15, at 10:45 a.m. R35 was transferred via a Hoyer lift and two staff from the bed to the wheelchair. The urinary drainage bag was not kept lower than the bladder, as during the transfer the urinary drainage bag was placed on one of the loops of the Hoyer seat, which was above R35's bladder and at head level. The urinary drainage bag remained in the position above the bladder during the entire transfer and was not placed in a position below the bladder, until such time as R35 was settled into the wheelchair. Medium colored clear urine was noted in the catheter tubing and drainage bag at the time of the transfer. On 7/2/15, at 1:59 p.m., the director of nurses (DON) was interviewed regarding proper positioning of a urinary drainage bag during a transfer. The DON stated the urinary drainage bag should not go on a resident's lap and the DON stated that either someone could hold the urinary drainage bag or place it on the lift. The DON had no comment when told R35's urinary drainage bag had been placed above the resident's bladder during an observed transfer. Also at this time the DON, in the presence of the surveyor checked the catheter drainage bag and noted an anti-backup valve was located on the drainage bag.	F 282		

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F 282	Continued From page 11 On 7/2/15, a request for the facility's policy and procedure on indwelling catheter was requested. On this date the facility provided an undated procedure titled Procedure 21-6 Providing Catheter Care. This procedure did not address placement of the urinary drainage bag below the bladder.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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, record review and document review, the facility failed to ensure 2 of 3 residents (R2, 78) identified as having pressure ulcers or a history of pressure ulcers; and 1 of 1 residents (R81) identified as being at risk for pressure ulcer development, were provided the necessary care and services to heal and/or minimize pressure ulcer development. Findings include: During stage one interviews, on 6/29/15 at 6:10 p.m., RN-A reported R2 had a unstageable ulcer on the right heal. RN-A indicated the ulcer	F 314	R2¿s care plan was revised and an air mattress was added. R78¿s Care plan was reviewed and revised to indicates R78 is repositioned every two hours to aide the prevention of pressure ulcers. Resident R81¿s care plan reflects R81¿s is repositioned every Two hours to aide with the prevention of pressure ulcers. The revisions were completed prior to the MDH exit. All resident care plans received a review	8/10/15

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F 314	Continued From page 12 originated at the nursing facility, but did not know the cause. RN-A added that at times, R2 would refuse to wear padded boots. On 7/1/15 at 7:45 a.m., R2 was transferred from the bed to the wheelchair by nursing assistant (NA)-A and NA-G. Soft "Easy" boots were applied bilaterally to the feet. A regular mattress was noted on the bed. NA-A indicated R2 had a sore on the right heel and did not like to wear the soft boots. R2's diagnoses included quadriplegia, muscle weakness, chronic pain, diabetes and spinal cord injury. R2's quarterly Minimum Data Set (MDS) dated 4/10/15, indicated R2 was cognitively intact, and required extensive assistance of two staff for bed mobility and transfers. The quarterly MDS also indentified R2's skin was intact, but R2 was at risk for pressure ulcer development. A skin assessment completed 5/28/15, indicated R2 had developed a large blister on right heel. The July 2015 physician orders were reviewed and included: Air mattress (skin prevention) R2's current plan of care directed staff R2 required extensive staff assist for bed mobility and transfers and to be turned and repositioned every 2 hours and as needed, to reposition side to side and to lie down after meals as resident allows. The care plan did not identify any pressure reduction or pressure relief surface. On 7/1/15 at 11:40 a.m., RN-A stated R2's right heel pressure ulcer measured 6.0 x 6.0 on 5/26/15, but was healing. RN-A added the resident wore foot boots, but would refuse them at times. RN-A also stated they were not aware if R2 had an air mattress on the bed as ordered, but when checked at this time RN-A verified the bed did not have an air mattress. On 6/30/15, at 8:48 a.m., R78 was observed	F 314	regarding their positioning needs in relation to pressures ulcers by 8/10/15. Direct care nursing staff received education regarding: following the residents care plan, with emphasis regarding prevention of pressure sore and the importance of repositioning by 8/10/15. DON or designee will audit 3 nursing staff/medical records per week to ensure the residents receive appropriate interventions to prevent pressure sore to through the next quarter. Results of the audits will be reviewed at QAPI.	

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F 314	Continued From page 13	F 314		

being brought back to the room from the dining room by a staff member. R78 was continuously observed to remain in the room without repositioning until 12:00 p.m., when taken, by another staff member, to the dining room for lunch. This was a total of three hours and 12 minutes, without being repositioned.

On 7/2/15, at 7:19 a.m., R78 was observed sitting in a wheelchair outside of R78's room. At 8:47 a.m., R78 was wheeled from the hallway to the dining room for breakfast, and remained there until 9:17 a.m., when wheeled back to R78's room. There was no repositioning observed during this time period. R78 remained in the room without being repositioned, and at 9:38 a.m., a member of the activity department took R78 from the room to an activity in the front lounge.
At 9:40 a.m., nursing assistant (NA)-F was interviewed regarding the type of assistance provided to R78 from when R78 had gotten up until this time. NA-F stated that during that time frame, NA-F had only taken R78 to the dining room for breakfast. Once in the dining room NA-F stated R78 was left in the dining room and NA-F stated there were other people on his list that needed to be taken care of and NA-F had not repositioned R78. R78 remained in the front lounge until the end of the activity at 11:00 a.m., when the activity director returned R78 to R78's room. At 11:19 a.m., registered nurse (RN)-A was informed R78 had not been repositioned since 7:19 a.m., a total of four hours. RN-A replied that she would make sure that R78 was assisted into bed.

At 11:20 a.m., during interview, R78 stated, "I'm hurting." When asked where the pain was located, R78 indicated the buttocks and between

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the legs. At 11:22 a.m., in the presence of RN-A, R78 again stated the buttocks hurt and between the legs hurt. RN-A informed R78 a nursing assistant would lay R78 down.

R78 was laid down at this time and the skin on R78's buttocks was observed to be red, but blanchable and there were no further complaints of discomfort when RN-A checked R78's skin.

A review of Wound data collection sheets revealed R78 had developed a Stage I pressure ulcer above the coccyx on 3/3/15, which had healed by 3/25/15.

A Braden Risk Assessment Scale form completed on 4/10/15, revealed a score of 14, indicating R78 was at moderate risk for skin breakdown. The Resident Lifting Transferring and Repositioning Data Collection form dated 4/10/15, revealed the 4/15 documentation was a quarterly review and there were no changes in the plan of care. The quarterly reviews since the original assessment dated 8/7/14, revealed the resident was extensive to total assistance with the use of a Hoyer lift, as well as extensive assist of 1-2 for repositioning, but there was no indication of the frequency of the repositioning on this form.

A Tissue Tolerance Assessment dated 4/4/15, indicated R78's skin was red after 2.5 hours of lying and sitting. The plan was to have the resident turned and repositioned every two hours. The care plan revised 3/16/15, instructed staff to reposition R78 every two hours.

R81 on 6/30/15, at 8:45 a.m., was observed seated in a Broda chair in their room. At 10:56

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a.m. R81 received medications and began coughing. At 11:07 a.m. R81 was still coughing and without repositioning, licensed practical nurse (LPN)-B moved R81 from the room to the medication cart, where LPN-B was passing medications. At 11:26 a.m. R81 was taken to the toilet and repositioned. A total of two hours and 41 minutes had elapsed without R81 being repositioned. At 11:48 a.m. R81 was transferred from the toilet, back to the Broda chair and taken to the dining room for lunch. R81's skin was observed to be intact and not red.

On 7/1/15, R81 was observed receiving morning cares from a hospice aide at 8:24 a.m. At 8:34 a.m. R81 was transferred from the toilet into a Broda chair and at 8:37 a.m. was taken to the dining room for breakfast by the hospice aide, who stated they were done for the day at the facility. R81 remained in the dining room and was fed by staff from 8:50 a.m. to 9:19 a.m. when R81 was taken back to their room and placed in the hallway outside the room. R81 was observed to remain in the hallway outside their room from 9:19 a.m. to 10:50 a.m. when R81 was invited to and then taken to an activity in the east lounge at 10:52 a.m. At 10:53 a.m. R81 was repositioned in the Broda chair, which was two hours and 19 minutes without being repositioned.

On 7/1/15, at 11:35 a.m. nursing assistant (NA)-A verified R81 had not been repositioned every two hours on 6/30/15, but had been repositioned on 7/1/15, when taken to the activity. NA-A stated that if R81 was asleep in the chair NA-A would let R81 sleep and "yesterday" R81 had been sleeping a lot.

On 7/1/15, at 2:19 p.m. NA-A stated the yellow

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F 314	Continued From page 16 dot on the nameplate outside of the resident's room meant the residents in the room were to be repositioned every 2-2½ hours. A Braden Risk Assessment Scale form dated 6/1/15, identified a Braden score of 12, which indicated R81 was at "High Risk" for development of pressure ulcers. Tissue Tolerance Assessments dated 6/1 and 6/3/15, indicated R81 was bedfast and was to be repositioned every two hours. The admission Minimum Data Set dated 6/8/15, identified R81 as being at risk for pressure ulcer development, and as having no history of past or current pressure ulcers.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate indwelling Foley catheter care to 1 of 2 residents (R35) in the sample with indwelling Foley catheters. Findings include:	F 315	Resident R35 did not acquire any adverse effects as a result of the surveyor¿s observation. Our facility uses an anti-back up valve located on the drainage bag to avoid urine flow back into the bladder, in the event the drainage bag was accidently	8/10/15

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F 315	Continued From page 17 On 7/1/15, at 10:45 a.m. R35 was transferred via a Hoyer lift and two staff from the bed to the wheelchair. The urinary drainage bag was not kept lower than the bladder, as during the transfer the urinary drainage bag was placed on one of the loops of the Hoyer seat, which were above R35's bladder and at head level. The urinary drainage bag remained in the position above the bladder during the entire transfer and was not placed in a position below the bladder, until such time as R35 was settled into the wheelchair. Medium colored clear urine was noted in the catheter tubing and drainage bag at the time of the transfer. A review of R35's care plan revised on 6/17/15, revealed R35 had Cauda Equina syndrome (the syndrome could cause bladder elimination problems and prevention of urinary tract infections was essential in treating the disease), with a neurogenic bladder. The care plan also indicated the catheter and drainage bag were to be placed below the level of the bladder. On 7/2/15, at 1:59 p.m., the director of nurses (DON) was interviewed regarding proper positioning of a urinary drainage bag during a transfer. The DON stated the urinary drainage bag should not go on a resident's lap and the DON stated they would either have someone hold the urinary drainage bag or place it on the lift. The DON had no comment when told R35's urinary drainage bag had been placed above the resident's bladder during an observed transfer. Also at this time the DON, in the presence of the surveyor checked the catheter drainage bag and noted an anti-backup valve was located on the drainage bag.	F 315	placed above the level of the bladder. Employees assigned to provide resident care on 7/1 was provided education accordingly. Direct care nursing staff received education regarding: Following the residents care plan, with emphasis regarding the placement of the urinary catheter bag by 8/10/15. DON or designee will audit 4 residents per week that have a urinary drainage bag to assure compliance regarding the placement of the urinary collection bags by 8/10/15.	

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F 315	Continued From page 18 On 7/2/15, a request for the facility's policy and procedure on indwelling catheter was requested. On this date the facility provided an undated procedure titled Procedure 21-6 Providing Catheter Care. This procedure did not address placement of the urinary drainage bag below the bladder.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure hand splints were consistently applied at night, to provide comfort and to prevent/minimize contractures from increasing, for 1 of 1 resident (R76), who had a nursing order to apply hand splints at night. Findings include: During an interview on 7/1/15 at 7:45 a.m., R76 explained having contracted fingers and needed to wear bilateral hand splints at night. R76 raised up hands and showed the surveyor his hands with fingers spread. The fingertips on both hands were bent over. R76 stated, "staff are to put hand splints on every night but they don't do it" and added "I can't remember to do it." R76 explained that the hand splints made his hands feel better and R76 did not want the fingers to become more	F 318	R76¿s care plan was reviewed and updated to include the use of hand Splints at night. R76¿s treatment record was revised to include a signature indicating R76¿s hand splints are placed during the night shift. All residents care plans with splints were reviewed and changes made if appropriate by 8/10/15. Direct care nursing staff received education regarding: following the residents care plan, with emphasis	8/10/15

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F 318	Continued From page 19 contracted. R76 stated that the splints just got thrown on the floor in the closet by staff. At this time, the hand splints/grips were noted on the floor of R76's closet. R76's diagnoses included diabetes, osteoarthritis, peripheral vascular disease, bone and cartilage disorder. A quarterly Minimum Data Set, dated 4/10/14, identified a moderate cognition and that physical assist of one staff was required for activities of daily living. A review of the July, 2015, physician orders indicated R76 had an ongoing nursing order to wear hand splints bilaterally at night. The nursing assistant assignment sheet directed staff to apply the hand splints at night to decrease contracture's and the nursing order was written and signed off on the June and July, 2015 monthly treatment administration record (TAR). A review of the June, 2015 TAR indicated the hand grips/splints were applied to R76's bilateral hands on 11 of 30 nights and the May, 2015 TAR indicated 6 nights were missed. On 7/2/15 at 1:00 p.m., registered nurse (RN)-A verified the nursing order and the information placed on the nursing assistant work sheet. RN-A acknowledged the hand splints were not being applied consistently every night.	F 318	regarding range of motion and any devices needed to prevent decline by 8/10/15. DON or designee will audit 3 records per week to ensure the residents receive interventions identified on the care plans related to splints. Results of the audits will be reviewed at QAPI.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		8/10/15

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F 431	Continued From page 20 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were disposed of in a timely manner after opening for 3 of 4 medication carts that affected 5 residents (R33, R19, R64, R93, R50) in the sample. Findings include: During the medication storage tour with licensed practical nurse (LPN)-C on 7/3/15, at approximately 11:05 a.m. the following concerns	F 431	R 33, R19, R64, R93, and R50 medications were reviewed by the consulting pharmacist on 7/2/15. The review included checking for outdated and open medication to indicate a date. All of these medication were destroyed and/ or replaced with new medications when indicated.	

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F 431	Continued From page 21 were identified with the north unit medication cart 1: R33's Nitrostat 0.4 mg bottle was dispensed 7/23/13, and not dated when opened, Lantus insulin dispensed 5/10/15 and expired 6/10/15 remained in the medication cart available to the resident and Novolog opened 5/15/15 and expired 6/15/15 remained in the cart available to the resident. The Novolog vial lacked an identifying label for R33, however was stored in a round plastic container labeled with R33's name. R19's Timolol maleate 0.5% solution eye drops, dispensed 4/16/15, were not dated when opened. R's 19's latanoprost 0.005% eye drops dispensed 6/13/15, were not dated when opened. R64's latanoprost 0.005% sol eye drops were not dated when opened. LPN-C verified these findings and indicated the medications were not dated when opened. LPN-C verified the Novolog vial lacked an identification label for R33. North cart 2 was reviewed and the following concerns were noted: R93's Nitrostat 0.4 mg bottle dispensed 11/21/14, was not dated when opened. LPN-B verified this finding on 7/3/15 at approximately 11:20 a.m. Central cart 2 was reviewed and the following concerns were noted: R50's Nitrostat 0.4 bottle dispensed 6/10/14, was opened and not dated when opened. LPN-A confirmed this finding on 7/3/15 at 11:30 a.m. On 7/3/15, at approximately 2:00 p.m. registered nurse manager (RN)-A verified medications should be dated when opened and removed when expired. A policy that identified dating medications when opened, removing expired medications or the need for accurate labels on medications was requested, but not provided.	F 431	All residents medications were audited to ensure medications were labelled, dated, with current expiration dates on 7/2/15. All licensed nurses and TMA¿s received education regarding: 1) Dating a new medication when the medication is opened. 2) The proper administration of all medications. 3) Timely disposal of expired medications by 8/10/15. DON or designee will audit two medication carts and 1 medication room for compliance 1 time week, Results of the audits will be reviewed at QAPI.	

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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

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F 431	Continued From page 22 Based on observation and interview the facility failed to ensure medications were disposed of in a timely manner (opened but undated Tubersol with 1/2 vial used in the South medication room. Finding include: On 7/2/15, at 10:35 a.m. a tour of Transitional Care Unit (TCU), South medication room was conducted with registered nurse (RN)-G, stored in the medication refrigerator was an opened but undated vial of Tubersol, from which half of the doses had been used. RN-G, stated that the Tubersol was given to residents within 72 hours of admission and then repeated 7 days after that. RN-G, was not able to say how long the vial had been opened, and did not know that Tubersol was only good for 30 days once opened. At 1:50 p.m. RN-F, was asked to review the medication storage room, the open Tubersol (medicine bottle) holder had a sent from the pharmacy date of 3/2015, which was more than 90 days from 7/2/15. RN--F, verified the Tubersol should have been dated when the vial was opened. The Tubersol was discarded because it was unable to be determined when it had expired.	F 431		
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.	F 441		8/10/15

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F 441	Continued From page 23 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 1 of 3 residents (R35) during the provision of bowel incontinence care; and for 1 of 6 residents (R93) during	F 441	Employee assigned to provide care for R 35 received education. Employee assigned to provide care for R93 received education.	

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F 441	Continued From page 24 observation of medication administration. Findings include: On 7/01/15, at 10:16 a.m., nursing assistant (NA)-B was observed wearing gloves during provision of morning cares to R35. During the observation R35 was noted to be incontinent of stool and, while wearing gloves, NA-B was observed to provide the appropriate incontinent care. However, after cleansing R35, NA-B failed to remove the soiled gloves prior to placing a new, clean bed pad and clean incontinent product beneath R35. Without removing the soiled gloves NA-B covered R35 with a sheet and placed all soiled linens and incontinent items into plastic bags. NA-B then removed the gloves and without washing their hands, took the bags to the soiled utility room. NA-B left the soiled utility room, without washing hands, returned to R35's room, without washing hands and donned new gloves. NA-B proceeded to dress R35, touching R35's clothing, pillow and glasses. The facility's policy and procedure titled Hand Hygiene-Plain Soap and Water Handwash, revised 11/11, directed staff to use soap and water handwash or alcohol hand rub during resident care if moving from a contaminated body site to a clean body site and after removing gloves. On 6/29/15 at 5:36 p.m., registered nurse (RN)-B gave medications to R93. A white pill had fallen onto the resident's shirt and RN-B was observed to pick up the white pill, placed it on R93's tongue and provided water. RN-B picked up and disposed of the used medication cups and	F 441	All staff received re- education regarding: 1)Hand washing during a medication administration. 2)Hand washing and proper protocol for perineal cares. 3)Handling of soiled linens and incontinent products by 8/10/15. DON or designee will audit 3 nursing assistants per week to assure the compliance. Results of the audits will be reviewed at QAPI.	

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F 441	Continued From page 25 returned to the medication cart. At 5:46 p.m., another resident asked for pain pills and RN-B obtained the medications from the medication card, returned it to the drawer, signed out the medication in a book and dispensed the medication to R55. RN-B did not wash hands in-between the two residents who received medications. On 6/29/15 at 5:40 p.m., RN-B acknowledged the findings. Interview with RN-A, at 7:30 p.m., RN-A agreed the nurse should not have dispensed the medication that had fallen and stated that hands are to be washed in-between patient care.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that essential equipment; fourteen pots/pans and the walk in freezer were in good repair. Finding include: On 06/29/15, at 12:05 p.m., the initial kitchen tour was conducted with the dietary manager (DM) and registered dietitian (RD). During the tour, 7 of 12 stainless steel rectangular pans, stored on the dry pan storage rack, were noted to be heavily dented and pitted at the corners. Although no dried food was visibly noted in the dented areas,	F 456	The facility strives to ensure all essential equipment is in safe operating condition. Fourteen pots/pans from the kitchen will be replaced by 8/10/15. Facility walk in freezer will be restored to safe operating Condition, or if unable to be restored facility will order a replacement freezer to be installed by 10/15/15. All staff have been educated regarding identifying any equipment in poor repair	8/10/15

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F 456	Continued From page 26 the dented and pitted areas presented potential for an uncleanable surface. The walk-in freezer, next to the dry storage area, had ice buildup on the floor and also on the inside of a cardboard box which stored individual ice-cream containers. Condensation/moisture was observed around the outside of the walk-in freezer door frame and the paint on the door frame had bubbled, where moisture and condensation was noted, which posed potential for an uncleanable surface. During the second tour of the kitchen on 07/02/15, at 12:40 p.m., with the DM, fourteen stainless steel rectangular pans were stored on the dry storage rack that were heavily dented and pitted at the corners. The walk in freezer had several tennis ball size round frozen ice formations on the floor. Heavy condensation/moisture was observed around the outside of the walk-in freezer door frame. The door frame paint remained bubbled, as noted on the first tour of the kitchen. During interview on 07/02/15, at 12:50 p.m., the DM acknowledged the dented/pitted stainless steel pans and attributed the dents to getting banged-up during cooking and transporting food items in the steam table to the dining rooms. DM explained that the walk-in freezer was old and had been checked by the freezer repair company. DM explained that the repair company agreed the freezer was old and that during the 24 hour cycle the condenser dripped water, causing ice to form on the freezer floor. The DM reported the condensation outside the walk-in freezer door frame was also due to the freezer being old.	F 456	and completing a work order slip by 8/10/15. Administrator or designee will complete audit on safety of equipment weekly X4 weeks, and review with monthly QAPI.	

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F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure walls, floors, windows had cleanable surfaces and that a public restroom in the basement was free of odors. This had the potential to affect residents in the rooms identified and residents who used the public restroom near the physical therapy department, of the 75 residents who resided in the facility. Findings include: On 7/2/15, at 2:00 p.m. a tour of the facility was conducted with the administrator, the maintenance director (DM), the maintenance supervisor (MS) and the administrative intern. The following concerns were identified: Room 101-2: The window sill wood was warped and lacked stain. Room 104: Approximately 2 feet of wall paint was peeling off the bottom of the wall, near the bathroom door. Room 107: Paint was peeling off the bottom of the wall, approximately 1.5 feet long. Room 111: There was a crack in the tile floor from the window towards the door, approximately ¾ the width of the room. Room 117: The floor tile was cracked and separated approximately 1/8 inch; the crack ran from bed to window and was in the middle of the	F 465	The facility strives to ensure a safe, functional, sanitary, and comfortable environment for all resident, staff and guests. The concerns identified in rooms: 101, 104, 107, 111, 117, and 124 will be corrected by 8/10/15. The bathroom fan in the public restroom near the therapy gym has been repaired on 7/3/15. All facility staff have received re-education on the facility preventative maintenance and work order policy by 8/10/15. Administrator or designee to complete weekly audits x 4 weeks, with results to be reviewed at QAPI.	8/10/15

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F 465	Continued From page 28 room. Room 124-1: There was a large hole in the wall, to the right of the doorway. The MS stated a trapeze had "been removed not that long ago". MS stated the facility had a work order system, however, staff had not notified him about the hole in the wall, and today was the first time he had seen it. The public restroom in the basement, near the physical therapy (PT) room, had an odor of staleness and dirty garbage. An uncovered plunger was stored next to the toilet. MS held a paper towel up to the vent/fan system which showed poor air out-take. The PT therapists stated the patients used the restroom when needed during therapy. The administrator, DM and MS were not aware that patients were using this restroom. Review of an undated Preventive Maintenance Procedure indicated: There are six basic steps to an effective preventive maintenance program: 1. Identification 2. Cleaning 3. Inspection 4. Lubrication 5. Adjustment 6. Documentation ....Another important tool in properly maintaining the center is the Building Services Work Order Request....enables communication between departments for the planning and scheduling of necessary work. At 2:30 p.m., the administrator stated the facility ownership had changed and the policies were still currently from the prior owner.	F 465		

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	245164	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/30/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Health & Rehabilitation of New Brighton was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/24/2015

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 1 story building, built in 1963, was determined to be of Type II(222) construction. It has a partial basement, and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. that is monitored for automatic fire department notification. Also all resident rooms have single station smoke detectors. The facility has a capacity of 100 beds and had a census of 75 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOTMETas evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029		8/10/15

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K 029	Continued From page 2 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 09:00 AM and 01:00 PM on 06/30/2015, it was observed that the door from the lower level oxygen storage room to an adjacent storage room did not properly close into the frame and positive latch. This deficiency was verified by the facility Administrator (CH) at the time of discovery.	K 029	Facility oxygen storage room door will been repaired to properly close by 8/10/15. Administrator or designess to audit x 4 weeks for proper door latching throughout building and review at facility QAPI.	
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		8/10/15

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K 050	Continued From page 3 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 01:00 PM on 06/30/2015, based on review of available documentation it was reveled that the facility had no documentation for fire drills conducted during the 3rd and 4th quarters of 2014. This deficiency was verified by the facility Administrator (CH) at the time of discovery.	K 050	Facility has new Maintenance Director and since his employment in 02/15 fire drills have been conducted properly. To ensure this continues monthly fire drills will be documented in facility preventative maintenance system (TELS) and turned into Administrator for verification of completion.	