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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H01U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00507

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245421**

2.STATE VENDOR OR MEDICAID NO.
(L2) **799342100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/01/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 10/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/13/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/04/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 13, 2021

CMS Certification Number (CCN): 245421

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

Dear Administrator:

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 September 2, 2021 the above facility is certified for:

57 Skilled Nursing Facility/Nursing Facility Beds

Nursing Facility I Beds

Nursing Facility II Beds(certified Board and care homes delete this note)

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 13, 2021

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: August 11, 2021

Dear Administrator:

On September 2, 2021, we notified you a remedy was imposed. On October 1, 2021 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 17, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 17, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 2, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 17, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 17, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H01U

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

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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 **08/11/2021** (L34)

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2 AOA 3 Other

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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

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From (a) :
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A. In Compliance With Program Requirements Compliance Based On:
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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
	57			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Magdalene Jares, HFE NE II — 09/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 10/01/2021 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 2, 2021

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: August 11, 2021

Dear Administrator:

On August 11, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 17, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 17, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 17, 2021.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 17, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, New Brighton Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 17, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 11, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals

Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 08/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/9/21, through 8/11/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/9/21 to 8/11/21, a standard recertification survey was conducted at your facility. In addition, complaint investigations were conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5421026C (MN00050653), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5421023C (MN00052427), H5421024C (MN00062024), H5421027C (MN00074751) and H5421028C (MN00067765). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 08/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		9/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 08/11/2021

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

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F 578	Continued From page 2 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident cardiopulmonary resuscitation (CPR) status was accurately reflected throughout the medical record for 1 of 1 resident (R14) who was reviewed for advance health care directives. Findings include: R14's diagnoses included bone infection of the right ankle and foot, diabetes, peripheral vascular disease, muscle weakness, and absence of right foot obtained from the significant change Minimum Data Set (MDS), dated 5/25/21. In addition, the MDS identified R14 had moderately impaired cognition. R14's care plan identified R14's code status as do not resuscitate (DNR) with a date initiated on 8/25/20. R14's physician orders dated 7/2/21, indicated R14 was full code [perform chest compressions]. During an interview on 8/9/21, at 5:20 p.m. R14 stated "I don't want CPR (cardio-pulmonary	F 578	POC F578 Advance Directives in the EHR for R14 immediately reviewed and updated to reflect the hard chart upon notification there was a discrepancy. Audit complete for all residents residing in facility to ensure accuracy of resident wishes and consistency between hard chart and EHR. Education provided to staff member who placed updated POLST in hard chart without ensuring consistency with EHR. Advance directives to be reviewed upon admission and during care conferences to ensure residents wishes remain the same, and that they are consistent with EHR and hard chart. Audits of 5 resident records will be completed weekly for 4 weeks, then monthly until 100% compliance is reached. Any conflicting information identified from audits will be immediately corrected. Audit results to be reviewed by QAPI program members, QAPI may implement continued audits as needed. Director of Health Information will be responsible party.	

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resuscitation), I signed a yellow piece of paper." R14 further stated "I saw what my wife went through, and I don't want to go through that."

During an interview on 8/9/21, at 5:21 p.m. licensed practical nurse (LPN)-A stated "if I was told someone was not responsive, I would go and check the POLST [Provider Orders for Life-Sustaining Treatment] in the hard chart for the code status of that resident."

During an interview on 8/9/21, at 5:22 p.m. registered nurse (RN)-D indicated she would have gone to check the hard chart for the patient's code status which is located on the POLST if a resident was found unresponsive, not breathing and/or without pulse. During interview with RN-D, RN-B/Staff Development both stated the preferred method for nurse's was to go to hard chart to review the POLST because it was the "source of truth."

During an interview on 8/9/21, at 5:25 p.m. heath unit coordinator (HUC) indicated the POLST was found in the front section of the hard chart. The HUC verified the POLST was not in the section where it was supposed to be filed for R14. The HUC then was observed to review the entire hard chart and found a white colored POLST from the back of the chart and placed it in the front of R14's chart. Upon review of the white colored POLST dated 8/24/20, it was revealed it indicated R14 was a DNR.

During an interview on 8/9/21, at 5:39 p.m. RN-E indicated if a resident was unresponsive, she would look in the front of the chart, at the POLST and go by that information.

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F 578	Continued From page 4 Following staff interviews on 8/9/21, at 6:05 p.m. R14's hard chart was reviewed and a yellow colored POLST dated 7/6/21, was added to the hard chart on top of the white colored POLST dated 8/24/20, both indicated R14 as DNR. During an interview on 8/9/21, at 6:09 p.m. director of nursing (DON) verified R14's code status in (Point Click Care) PCC indicated full code and R14's POLST dated 7/6/21, indicated DNR. The DON then stated, "I get why it's conflicting." The DON further indicated whoever did the POLST with R14, should have made it matched in the computer. A Do Not Resuscitate Order policy revised 5/18/21, directed our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a DNR order in effect. The policy further directed that a DNR order must be signed by the resident's attending provider on the physician's order sheet maintained in the resident's medical record.	F 578		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was offered and/or provided for 1 of 3 residents (R40) who was dependent upon staff assistance for activities of daily living (ADLs).	F 677	POC F667 R40 is offered assistance with ADL nail care daily, R40 depends on staff for assistance with ADLs including nail care. Residents who are dependent on staff for	9/14/21

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F 677	Continued From page 5 Findings include: R40's quarterly Minimum Data Set (MDS) assessment dated 7/13/21, included diagnoses of wedge compression fracture of first lumbar vertebra, generalized muscle weakness, difficulty in walking, encephalopathy and low back pain. In addition, the MDS indicated R40 did not reject cares and required extensive assistance of one staff with personal hygiene which included shaving and dressing. R40's ADL Care Area Assessment (CAA) dated 1/18/21, indicated staff was to provide extensive assist of one to complete hygiene tasks. The cognitive loss/dementia CAA dated 1/18/21, indicated R40 had severely impaired cognition for daily decision-making and family was involved with care. R40's care plan dated 7/12/21, indicated resident had a ADL self care performance deficit related to pain secondary to lumbar fracture, weakness and deconditioning. The care plan directed staff to provide assistance of one staff with bathing, dressing and personal hygiene. During interview on 8/9/21, at 12:30 p.m. family member (FM)-A stated R40 used to be very meticulous about his looks when he was able to care for himself which included grooming. On 8/10/21, at 7:57 a.m. R40 was observed lying in bed, and had long thin gray facial hair that was scruffy, uneven and had grown in sporadically. In addition, R40's hands were observed uncovered and the fingernails were approximately a quarter (1/2) inch long with brown matter under them.	F 677	ADLs have the potential to be affected if those ADLs are not offered. Education on ADLs, specifically nail care initiated to nursing staff, if a resident refuses the care, this must be documented. Audits of 5 residents dependent on staff for ADLs will be completed weekly for 4 weeks, then monthly until 100% compliance on offering/providing nail care is reached. Director of Nursing will be responsible party.	

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F 677	Continued From page 6 -At 8:00 a.m. nursing assistant (NA)-C went to R40's room and asked R40 if she could open the blinds and R40 declined. At 8:01 a.m. as NA-C came out of the room into the hallway, licensed practical nurse (LPN)-B stated she had also been to R40's room offered R40 to get out of bed and R40 had declined. NA-C then stated to LPN-B R40 preferred to stay in bed mostly. -At 8:02 a.m. the administrator was observed going into R40's room, approached R40 and asked if she could open the blinds and R40 declined. -At 8:21 a.m. LPN-B was observed going into R40's room, left the door wide open and brought medications and nutritional supplement. LPN-B administered the medications handed R40 the nutritional supplement carton however never offered to trim the fingernails or to clean them. -At 8:46 a.m. NA-C went into R40's room and offered resident cereal for breakfast however R40 declined. -At 10:39 a.m. both NA-A and NA-C were observed going into R40's room. NA-C then asked NA-A to assist R40 with washing up and morning cares, then NA-C left the room. -At 10:44 a.m. NA-A was observed standing at R40's bedside assisting R40 with shaving then set the electric razor to the side. -At 10:47 a.m. to 11:00 a.m. during continuous observations, NA-A was observed getting wash towels wet in the bathroom after she applied a pair of gloves. NA-A then approached R40 and was observed wiping the face, chest and armpits then pat dried them. At 10:52 a.m. NA-A provided pericare to R40. During the continuous observations on 8/10/21, at 7:56 a.m. to 11:08 a.m. although multiple staff including NA-A who provided cares, NA-C, LPN-B	F 677		

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and the administrator were observed to approach and assist R40 who was lying in bed, no staff offered to trim and clean the fingernails.

On 8/11/21, at 8:47 a.m. R40 was observed lying in bed and the fingernails were observed to be still long with brown matter under them. During the observation NA-B was observed standing over R40 and adjusted the pillow on the head. The fingernails were uncovered and NA-B never offered to trim or clean the fingernails.

On 8/11/21, at 9:41 a.m. to 9:55 a.m. NA-B was observed assisting R40 with morning cares which included personal hygiene and changed the incontinent pad. After NA-A lowered the head of bed she proceeded to wipe R40's face, chest, and armpits after she physical assisted R40 to remove the gown. R40's fingernails were visibly long and had brown matter underneath them as NA-B physically assisted R40 to put on a clean gown before proceeding. NA-B offered R40 oral care, combed the hair and then covered R40 up but never offered nail care or to wash R40's fingernails. NA-B then gathered all the garbage and linen in clear plastic bags and as she left the room, she cleansed her hands with hand sanitizer at the door.

During a follow up interview on 8/11/21, at 8:31 a.m. FM-A stated R40 liked to have his nails trimmed and staff was supposed to assist him with that.

During interview on 8/11/21, at 9:58 a.m. NA-B stated "we do nails on shower days once weekly, he uses his hands to eat and that is why the food is in his fingernails." NA-B stated although R40 did not like his fingernails trimmed he would still

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F 677	Continued From page 8 allow staff to clean them when he was approached. NA-B verified the fingernails were long and had brown matter under them. NA-B also acknowledged she had not done hand hygiene between the glove changes during the care observation and that she was supposed to do it. On 8/11/21, at 10:04 a.m. registered nurse (RN)-A observed R40's fingernails and stated "they need to be trimmed and washed underneath for sure. When people shower they are to be trimmed because they are wet and I do them when doing the skin check but I don't know what other nurses do." During review of R40's Weekly Shower Skin Checks forms dated 7/31/21 and 8/9/21, it was revealed the nurses had documented R40's skin had no concerns however, there was no documentation on nail care being offered or refused. During interview on 8/11/21, at 10:18 a.m. the director of nursing (DON) stated staff should be offering nail care to residents on shower days when nails were long and if the resident(s) requested to have them trimmed. The DON further stated he had clipped R40's fingernails about a month ago.	F 677		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		9/14/21

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 10 (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform appropriate hand hygiene and glove use for 4 of 5 residents (R40, R38, R150, R23) observed during cares and insulin administration. In addition facility failed to sanitize shared resident equipment after use by residents before returning equipment to storage for 1 of 2 residents (R42). Findings include: R40's quarterly Minimum Data Set (MDS) assessment dated 7/13/21, included diagnoses of wedge compression fracture of first lumbar vertebra, generalized muscle weakness, difficulty in walking, encephalopathy and low back pain.	F 880	DPOC Submitted to SH. POC F880 All residents in the facility have the potential to be affected. Immediate electronic staff education was assigned post survey to all staff members regarding appropriate hand hygiene. The policies and procedures regarding infection control to include hand hygiene, peri-care, cleaning lifts and glove usage were reviewed and remain appropriate. Nursing staff were re-educated on policies and procedures regarding infection control relating to proper hand hygiene including glove usage, lift cleaning expectations and proper donning and doffing of PPE. Nursing staff will prove competence by	

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F 880	Continued From page 11 On 8/10/21, at 10:39 a.m. both NA-A and NA-C were observed to go into R40's room. NA-C then asked NA-A to assist R40 to wash up and morning cares then NA-C left the room. -At 10:44 a.m. NA-A was observed to shave R40. -At 10:47 a.m. to 11:00 a.m. during continuous observations, NA-A was observed to wet wash towels in the bathroom after she applied a pair of gloves. NA-A then approached R40 and was observed to wipe the face, chest and armpits then pat dried them. NA-A changed R40's gown then removed the pair of gloves and reached into the closet across from R40's bed and obtained a clean pad. NA-A then came back to R40's bedside then applied another pair of gloves, did not wash her hands and cued R40 she would do pericare and change the soiled incontinent pad. -At 10:52 a.m. NA-A then was observed to provide R40 pericare and used one of the wet wipes which were observed to have brown smears of bowel movement. NA-A then tossed the soiled pad and wipes in the garbage, then with the same gloves, applied the clean pad under R40 and cued R40 to turn side to side as she adjusted and fastened it. NA-A, still with the same gloves used to provide pericare, used the bed remote, handled clean linen to cover R40, adjusted the pillow on R40's head and placed the call light next to R40. At this time surveyor intervened and asked NA-A to remove the gloves and wash her hands before proceeding. NA-A after washing her hands and applying another pair of gloves, was observed cleaning a red liquid spill on the floor under the heat register using wipes. After completing that, NA-A with the same gloves rolled the soiled linen in her hand, was then observed exiting R40's room after she opened the door with the same gloves used to clean the spill and with soiled linen not contained.	F 880	assessment until proven re-competent. Audits of hand hygiene and proper glove usage (including when completing peri-care) will be completed on all shifts for one week, then daily for 2 weeks until 100% compliance has been reached. Audit results to be reviewed by QAPI program members, QAPI may implement continued audits as needed. Infection Preventionist will be responsible party.	

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NA-A then went across the hallway removed the right glove, opened the door to the soiled utility room and tossed the linen in a container then removed the left glove. NA-A then immediately came out of the soiled utility room without washing her hands or using hand sanitizer by the door. NA-A then went into the clean linen closet and got a towel and went back into R40's room.

On 8/11/21, at 9:41 a.m. to 9:55 a.m. NA-B was observed assisting R40 with morning cares which included personal hygiene and changed the incontinent pad. After NA-A lowered the head of bed she proceeded to wipe R40's face, chest, and armpits after she physical assisted R40 to remove the gown. NA-B then removed the gloves and re-applied another pair and cued R40 she was going to provide pericare. NA-B unfastened the soiled incontinent pad R40 had on and then was observed providing pericare. NA-B then removed the soiled pad from underneath R40 tossed it in the garbage, removed gloves and re-applied another pair without washing hands or using hand sanitizer. NA-B then reached for the clean pad, tucked it under R40's bottom and then cued resident to turn side to side as she adjusted and fastened the clean pad. NA-B then removed the gloves, re-applied another pair and then was observed applying lotion to R40's face. NA-B never washed her hands after she changed her gloves. NA-B then gathered all the garbage and linen in clear plastic bags and as she left the room, she cleansed her hands with hand sanitizer at the door.

During interview on 8/11/21, at 9:58 a.m. NA-B acknowledged she had not done hand hygiene through the cares observations in between glove changes and that she was supposed to do it.

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F 880	Continued From page 13 During interview on 8/11/21, at 10:20 a.m. the director of nursing stated staff was supposed to do hand hygiene before and after cares; before applying another pair of clean gloves and when staff took dirty soiled gloves off they were to use soap and water to clean their hands. During interview on 8/11/21, at 11:08 a.m. with the DON and the infection control nurse RN-B, the DON stated for soiled linen the staff was supposed to put it in a plastic bag, tie the bag before transporting it to the utility room and when leaving a resident room they were to use hand sanitizer at the door. The facility Handwashing/Hand Hygiene policy revised August 2019 directed the staff to use an alcohol based hand rub containing at least 62% alcohol or alternatively soap and water for the following situations: "b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene..." The facility Laundry and Bedding, Soiled policy revised October 2018 directed staff the following for handling soiled linen: "b. Laundry that is contaminated with blood or body substances is placed in leak-proof bags or containers. c. Contaminated laundry is placed in a bag or container at the location where it is used and not sorted or rinsed at the location of use..."	F 880		

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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
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R38's Face Sheet dated 7/9/21, indicated R38's diagnoses included acute kidney failure (when the kidney suddenly loses its filtering ability), retention of urine, and chronic kidney disease (gradual loss of kidney function).

R38's admission Minimum Data Set dated 7/15/21, indicated R38 had moderate cognitive impairment, required extensive assist of one to two staff for personal hygiene, transfers and toileting. R38 was frequently incontinent of bladder.

R38's care plan dated 7/9/21, indicated R38 was occasionally incontinent of bladder related to urge incontinence (the sudden need to urinate) with interventions that included staff were to provide peri cares after each incontinent episode and were to change incontinent product.

R38's Orders Summary Report dated 7/9/21, to 8/31/21, indicated a physician order on 8/7/21, for Ciprofloxacin hydrochloride (HCL- medication used to treat bacterial infection) tablet, give 250 milligrams (mg) by mouth two times a day for urinary tract infection (UTI) for seven days.

During continuous observation on 8/10/21, at 7:06 a.m. to 7:24 a.m. nursing assistant (NA)-B took a standup lift into R38's room. R38 was sitting at the edge of her bed. NA-B began to attach R38 to the standup lift when RN-A entered to room and wanted to inspect R38 buttock dressing to ensure was intact. NA-B attached the sling to R38's upper body and then secured the bottom attachment to secure legs. NA-B then used the remote after fully attaching R38 to the standup lift and with the remote control, lifted R38 to a standing position. RN-A inspected R38's

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buttock area and left room. NA-B then transported R38 from the bedroom to the bathroom with use of the standup lift. NA-B situated R38 onto the toilet to a sitting position and left the bathroom. NA-B then went into R38's bedroom and made the bed. While making the bed, a pillowcase with two ice packs fell into the trash can near R38's bed. NA-B picked up the pillowcase from the trash can, opened it and took out the two ice packs and placed and placed them back into the pillowcase, and place the pillowcase on top of the nightstand next to R38's bed. NA-B then touched dirty cups, and utensils on R38's tray table next to lower end of the bed and touched other items to straighten up tray table. NA-B then took the dirty pillowcase which had fallen into the trash from the nightstand and placed onto the tray table. R38 then indicated she was done. NA-B then left room and went into the bathroom and took wipes and cleaned R38's peri anal area without changing gloves. NA-B then changed gloves after cleaning R38's peri anal area, pulled up depends and transferred R38 into wheelchair.

During interview on 8/10/21, at 10:10 a.m. NA-B stated she was unaware that R38 had a UTI as she did not receive report from the nurse, RN-A about R38's UTI but she should have changed her gloves after touching multiple dirty items in R38's room including a pillowcase which had fallen into the trash and was removed by NA-B from the trash can, before providing peri care to R38.

During interview on 8/10/21, at 1:47 p.m. director of nursing (DON) stated it was the expectation that gloves were changed after dirty surfaces or items were touched before providing peri care to

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a resident.

During interview on 8/11/21, at 12:41 p.m. infection preventionist (RN)-B stated although NA-B stated she had not been informed by the nurse through report that R38 had a UTI, infection control processes should be the same with all residents using universal precautions and gloves should have been changed after touching dirty items before providing peri anal care to R38.

The facility's Personal Protective Equipment-Gloves Policy dated 7/2009, indicated the use of disposable gloves was indicated and included when handling soiled linen or items that may be contaminated.
During observation on 8/9/21 at 5:20 p.m. RN-C was observed administering insulin without donning gloves. RN-C wiped R150's abdomen with an alcohol wipe, injected the insulin and wiped the area with an alcohol wipe. RN-C washed her hands after administration.
-At 5:27 p.m. RN-C was observed administering insulin without gloves. RN-C wiped R23's arm with an alcohol wipe, injected the insulin and wiped the area with a alcohol wipe after. RN-C then washed her hands after.

During interview on 8/9/21 at 5:30 p.m., RN-C indicated she will wear gloves when checking a blood sugar but did not wear gloves when administering insulin, as there is not a risk of contamination.

On 8/11/21 at 1:03 p.m., Infection control nurse, RN-B indicated the facility policy directs nurses to wear gloves when administering insulin, but the CDC (Center for Disease Control) does not require it.

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Review of the facility policy titled Subcutaneous Injection dated 2001 and revised March 2011, indicated the following:
Steps in the Procedure
1. Perform hand antisepsis.
2. Put on gloves.
6. Clean the site with an alcohol swab using a circular motion from the proposed site of injection outward.
12. Slowly inject medication
13. Withdraw needle quickly while placing alcohol swab above or over site.
14. Massage site lightly
17. Remove gloves and discard in designated container. Perform hand antisepsis.

During observation on 8/10/21 at 9:55 a.m. NA-D and NA-E were observed transfer R42 with an EZ Stand lift (lift that the assists the resident to transfers by lifting under the resident's arms, and the resident has to be able to bear weight). After transfer was complete, NA-D pushed the lift into the hallway and walked down the hall. At 10:02 a.m. NA-E came out of the room and walked to the dirty utility room. At 10:30 a.m. NA-D was observed to remove a Hoyer lift from another resident's room, and wipe the lift with disinfectant wipes.
-At 10:40 a.m. NA-D was interviewed about cleaning lift and she indicated all lifts were to be cleaned after each use. When questioned about the EZ Stand that was used on R42, NA-D indicated she forgot to clean it.
-At 10:45 a.m. NA-E indicated the lifts are to be wiped down after every use and she did not realize that the EZ Stand was not cleaned.

During interview with RN-B on 8/12/21 at 1:10

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F 880	Continued From page 18 p.m., she indicated the expectation was to wipe down lifts with wipes from the purple container, especially where the resident holds on and where the staff touch. Review of the facility's lifting machine policy dated 2001 and revised July 2017, directed: Lift Care: 1. Disinfect lift surface.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/11/2021. At the time of this survey, New Brighton Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2021

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of construction, the building was surveyed as 1 building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm	K 000		

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K 000	Continued From page 2 system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 57 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.1 through 14.4.5.3.7. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 8/11/2021, between 8:00 AM to 1.00 PM, it was revealed that the facility did not have a current sensitivity test being completed within the	K 345	Sensitivity testing was completed as required by vendor. The facility failed to store the documentation on site. Documentation of completed required sensitivities testing received, stored on site and provided to State Fire Marshall from facility vendor. Facility will ensure sensitives testing will be printed after each testing, and stored in a binder in the facility. Maintenance director will be responsible party.	9/14/21

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K 345	Continued From page 3 last two years. This deficient condition was verified by the Facility Administrator.	K 345		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 8/11/2021, between 8:00 AM to 1:00 PM, it was revealed that the facility did not have a current out of service policy for the fire alarm system. This deficient condition was verified by the Facility Administrator.	K 346	Facility had a policy in place, but the policy had not been updated with the current SFM's contact information. The facility policy and procedure has been properly updated and distributed, sent to State Fire Marshall for review. If the facility is notified that the SFM has changed, or a revision to the policy is needed, the facility will update the policy and redistribute. Policy will be reviewed during emergency preparedness planning and review. Administrator to be responsible party for ensuring policy is accurate.	9/14/21
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101	K 354		9/1/21

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K 354	Continued From page 4 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an automatic fire sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.7.6 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 15.1.1 through 15.7. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/11/2021, between 9:00 AM to 1:00 PM, it was revealed that the facility did not have a current out of service policy for the fire sprinkler system. This deficient condition was verified by the Facility Administrator.	K 354	Facility had a policy in place, but the policy had not been updated with the current SFM's contact information. The facility policy and procedure has been properly updated and distributed, sent to State Fire Marshall for review. If the facility is notified that the SFM has changed, or a revision to the policy is needed, the facility will update the policy and redistribute. Policy will be reviewed during emergency preparedness planning and review	
K 521 SS=F	HVAC	K 521		9/17/21

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K 521	Continued From page 5 CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect smoke and fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2, NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.7.1, and NFPA 80 (2010 edition, Standard for Fire Doors and Other Opening Protectives, section 19.4.1.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/11/2021, between 9:00 AM to 1:00 PM, it was revealed that the facility had not completed its smoke and fire damper testing within the last four years. This deficient condition was verified by the Facility Administrator.	K 521	Regular scheduled inspection, testing and maintenance were disrupted d/t COVID. Maintenance director and Administrator coordinated with vendor for an inspection and testing. Vendor came out on 9/16 to inspect and test dampeners. Facility is working with vendor for required repairs. The vendor restarted a PM program as of 9/16 to ensure adequate inspections and testing. Maintenance director to be responsible party.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		9/17/21

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K 914	Continued From page 6 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical outlets in resident bed locations per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.4 through 6.3.4.2.1.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/11/2021, between 9:00 AM to 1:00 PM, it was revealed that the facility had not conducted the annual electrical outlet testing in all resident sleeping rooms.	K 914	Facility completed facility-wide outlet audit to ensure no faulty outlets. Facility created a schedule to test outlets per NFPA standards, and will follow through with the scheduled audits. The NHA will review the audits on a reoccurring basis to ensure completion and accuracy of outlet audits. Maintenance Director to be responsible party.	

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K 914	Continued From page 7 This deficient condition was verified by the Facility Administrator.	K 914		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 2, 2021

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: H01U11

Dear Administrator:

The above facility was surveyed on August 9, 2021 through August 11, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 08/11/2021

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/9/21, through 8/11/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5421026C (MN00050653), however NO licensing orders were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5421023C (MN00052427), H5421024C (MN00062024), H5421027C (MN00074751) and H5421028C (MN00067765).	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.	2 860		9/14/21

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2 860	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was offered and/or provided for 1 of 3 residents (R40) who was dependent upon staff assistance for activities of daily living (ADLs). Findings include: R40's quarterly Minimum Data Set (MDS) assessment dated 7/13/21, included diagnoses of wedge compression fracture of first lumbar vertebra, generalized muscle weakness, difficulty in walking, encephalopathy and low back pain. In addition, the MDS indicated R40 did not reject cares and required extensive assistance of one staff with personal hygiene which included shaving and dressing. R40's ADL Care Area Assessment (CAA) dated 1/18/21, indicated staff was to provide extensive assist of one to complete hygiene tasks. The cognitive loss/dementia CAA dated 1/18/21, indicated R40 had severely impaired cognition for daily decision-making and family was involved with care. R40's care plan dated 7/12/21, indicated resident had a ADL self care performance deficit related to pain secondary to lumbar fracture, weakness and deconditioning. The care plan directed staff to provide assistance of one staff with bathing, dressing and personal hygiene. During interview on 8/9/21, at 12:30 p.m. family member (FM)-A stated R40 used to be very meticulous about his looks when he was able to care for himself which included grooming.	2 860	corrected	

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2 860	Continued From page 3 On 8/10/21, at 7:57 a.m. R40 was observed lying in bed, and had long thin gray facial hair that was scruffy, uneven and had grown in sporadically. In addition, R40's hands were observed uncovered and the fingernails were approximately a quarter (1/2) inch long with brown matter under them. -At 8:00 a.m. nursing assistant (NA)-C went to R40's room and asked R40 if she could open the blinds and R40 declined. At 8:01 a.m. as NA-C came out of the room into the hallway, licensed practical nurse (LPN)-B stated she had also been to R40's room offered R40 to get out of bed and R40 had declined. NA-C then stated to LPN-B R40 preferred to stay in bed mostly. -At 8:02 a.m. the administrator was observed going into R40's room, approached R40 and asked if she could open the blinds and R40 declined. -At 8:21 a.m. LPN-B was observed going into R40's room, left the door wide open and brought medications and nutritional supplement. LPN-B administered the medications handed R40 the nutritional supplement carton however never offered to trim the fingernails or to clean them. -At 8:46 a.m. NA-C went into R40's room and offered resident cereal for breakfast however R40 declined. -At 10:39 a.m. both NA-A and NA-C were observed going into R40's room. NA-C then asked NA-A to assist R40 with washing up and morning cares, then NA-C left the room. -At 10:44 a.m. NA-A was observed standing at R40's bedside assisting R40 with shaving then set the electric razor to the side. -At 10:47 a.m. to 11:00 a.m. during continuous observations, NA-A was observed getting wash towels wet in the bathroom after she applied a pair of gloves. NA-A then approached R40 and was observed wiping the face, chest and armpits then pat dried them. At 10:52 a.m. NA-A	2 860		

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2 860	Continued From page 4 provided pericare to R40. During the continuous observations on 8/10/21, at 7:56 a.m. to 11:08 a.m. although multiple staff including NA-A who provided cares, NA-C, LPN-B and the administrator were observed to approach and assist R40 who was lying in bed, no staff offered to trim and clean the fingernails. On 8/11/21, at 8:47 a.m. R40 was observed lying in bed and the fingernails were observed to be still long with brown matter under them. During the observation NA-B was observed standing over R40 and adjusted the pillow on the head. The fingernails were uncovered and NA-B never offered to trim or clean the fingernails. On 8/11/21, at 9:41 a.m. to 9:55 a.m. NA-B was observed assisting R40 with morning cares which included personal hygiene and changed the incontinent pad. After NA-A lowered the head of bed she proceeded to wipe R40's face, chest, and armpits after she physical assisted R40 to remove the gown. R40's fingernails were visibly long and had brown matter underneath them as NA-B physically assisted R40 to put on a clean gown before proceeding. NA-B offered R40 oral care, combed the hair and then covered R40 up but never offered nail care or to wash R40's fingernails. NA-B then gathered all the garbage and linen in clear plastic bags and as she left the room, she cleansed her hands with hand sanitizer at the door. During a follow up interview on 8/11/21, at 8:31 a.m. FM-A stated R40 liked to have his nails trimmed and staff was supposed to assist him with that. During interview on 8/11/21, at 9:58 a.m. NA-B	2 860		

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2 860	Continued From page 5 stated "we do nails on shower days once weekly, he uses his hands to eat and that is why the food is in his fingernails." NA-B stated although R40 did not like his fingernails trimmed he would still allow staff to clean them when he was approached. NA-B verified the fingernails were long and had brown matter under them. NA-B also acknowledged she had not done hand hygiene between the glove changes during the care observation and that she was supposed to do it. On 8/11/21, at 10:04 a.m. registered nurse (RN)-A observed R40's fingernails and stated "they need to be trimmed and washed underneath for sure. When people shower they are to be trimmed because they are wet and I do them when doing the skin check but I don't know what other nurses do." During review of R40's Weekly Shower Skin Checks forms dated 7/31/21 and 8/9/21, it was revealed the nurses had documented R40's skin had no concerns however, there was no documentation on nail care being offered or refused. During interview on 8/11/21, at 10:18 a.m. the director of nursing (DON) stated staff should be offering nail care to residents on shower days when nails were long and if the resident(s) requested to have them trimmed. The DON further stated he had clipped R40's fingernails about a month ago. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff on performing activities of daily living including finger nail care for residents. The director of nursing or designee could schedule	2 860		

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2 860	Continued From page 6 audits to monitor for compliance. The DON or designee could bring results of audits to the quality assurance committee for further follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform appropriate hand hygiene and glove use for 4 of 5 residents (R40, R38, R150, R23) observed during cares and insulin administration. In addition facility failed to sanitize shared resident equipment after use by residents before returning equipment to storage for 1 of 2 residents (R42). Findings include: R40's quarterly Minimum Data Set (MDS) assessment dated 7/13/21, included diagnoses of wedge compression fracture of first lumbar vertebra, generalized muscle weakness, difficulty in walking, encephalopathy and low back pain. On 8/10/21, at 10:39 a.m. both NA-A and NA-C were observed to go into R40's room. NA-C then	21375	corrected	9/14/21

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21375	Continued From page 7	21375		

asked NA-A to assist R40 to wash up and morning cares then NA-C left the room.
-At 10:44 a.m. NA-A was observed to shave R40.
-At 10:47 a.m. to 11:00 a.m. during continuous observations, NA-A was observed to wet wash towels in the bathroom after she applied a pair of gloves. NA-A then approached R40 and was observed to wipe the face, chest and armpits then pat dried them. NA-A changed R40's gown then removed the pair of gloves and reached into the closet across from R40's bed and obtained a clean pad. NA-A then came back to R40's bedside then applied another pair of gloves, did not wash her hands and cued R40 she would do pericare and change the soiled incontinent pad.
-At 10:52 a.m. NA-A then was observed to provide R40 pericare and used one of the wet wipes which were observed to have brown smears of bowel movement. NA-A then tossed the soiled pad and wipes in the garbage, then with the same gloves, applied the clean pad under R40 and cued R40 to turn side to side as she adjusted and fastened it. NA-A, still with the same gloves used to provide pericare, used the bed remote, handled clean linen to cover R40, adjusted the pillow on R40's head and placed the call light next to R40. At this time surveyor intervened and asked NA-A to remove the gloves and wash her hands before proceeding. NA-A after washing her hands and applying another pair of gloves, was observed cleaning a red liquid spill on the floor under the heat register using wipes. After completing that, NA-A with the same gloves rolled the soiled linen in her hand, was then observed exiting R40's room after she opened the door with the same gloves used to clean the spill and with soiled linen not contained. NA-A then went across the hallway removed the right glove, opened the door to the soiled utility room and tossed the linen in a container then

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21375	Continued From page 8	21375		

removed the left glove. NA-A then immediately came out of the soiled utility room without washing her hands or using hand sanitizer by the door. NA-A then went into the clean linen closet and got a towel and went back into R40's room.

On 8/11/21, at 9:41 a.m. to 9:55 a.m. NA-B was observed assisting R40 with morning cares which included personal hygiene and changed the incontinent pad. After NA-A lowered the head of bed she proceeded to wipe R40's face, chest, and armpits after she physical assisted R40 to remove the gown. NA-B then removed the gloves and re-applied another pair and cued R40 she was going to provide pericare. NA-B unfastened the soiled incontinent pad R40 had on and then was observed providing pericare. NA-B then removed the soiled pad from underneath R40 tossed it in the garbage, removed gloves and re-applied another pair without washing hands or using hand sanitizer. NA-B then reached for the clean pad, tucked it under R40's bottom and then cued resident to turn side to side as she adjusted and fastened the clean pad. NA-B then removed the gloves, re-applied another pair and then was observed applying lotion to R40's face. NA-B never washed her hands after she changed her gloves. NA-B then gathered all the garbage and linen in clear plastic bags and as she left the room, she cleansed her hands with hand sanitizer at the door.

During interview on 8/11/21, at 9:58 a.m. NA-B acknowledged she had not done hand hygiene through the cares observations in between glove changes and that she was supposed to do it.

During interview on 8/11/21, at 10:20 a.m. the director of nursing stated staff was supposed to do hand hygiene before and after cares; before

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21375	Continued From page 9 applying another pair of clean gloves and when staff took dirty soiled gloves off they were to use soap and water to clean their hands. During interview on 8/11/21, at 11:08 a.m. with the DON and the infection control nurse RN-B, the DON stated for soiled linen the staff was supposed to put it in a plastic bag, tie the bag before transporting it to the utility room and when leaving a resident room they were to use hand sanitizer at the door. The facility Handwashing/Hand Hygiene policy revised August 2019 directed the staff to use an alcohol based hand rub containing at least 62% alcohol or alternatively soap and water for the following situations: "b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene..." The facility Laundry and Bedding, Soiled policy revised October 2018 directed staff the following for handling soiled linen: "b. Laundry that is contaminated with blood or body substances is placed in leak-proof bags or containers. c. Contaminated laundry is placed in a bag or container at the location where it is used and not sorted or rinsed at the location of use..." R38's Face Sheet dated 7/9/21, indicated R38's diagnoses included acute kidney failure (when the kidney suddenly loses its filtering ability), retention of urine, and chronic kidney disease (gradual loss	21375		

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21375	Continued From page 10 of kidney function). R38's admission Minimum Data Set dated 7/15/21, indicated R38 had moderate cognitive impairment, required extensive assist of one to two staff for personal hygiene, transfers and toileting. R38 was frequently incontinent of bladder. R38's care plan dated 7/9/21, indicated R38 was occasionally incontinent of bladder related to urge incontinence (the sudden need to urinate) with interventions that included staff were to provide peri cares after each incontinent episode and were to change incontinent product. R38's Orders Summary Report dated 7/9/21, to 8/31/21, indicated a physician order on 8/7/21, for Ciprofloxacin hydrochloride (HCL- medication used to treat bacterial infection) tablet, give 250 milligrams (mg) by mouth two times a day for urinary tract infection (UTI) for seven days. During continuous observation on 8/10/21, at 7:06 a.m. to 7:24 a.m. nursing assistant (NA)-B took a standup lift into R38's room. R38 was sitting at the edge of her bed. NA-B began to attach R38 to the standup lift when RN-A entered to room and wanted to inspect R38 buttock dressing to ensure was intact. NA-B attached the sling to R38's upper body and then secured the bottom attachment to secure legs. NA-B then used the remote after fully attaching R38 to the standup lift and with the remote control, lifted R38 to a standing position. RN-A inspected R38's buttock area and left room. NA-B then transported R38 from the bedroom to the bathroom with use of the standup lift. NA-B situated R38 onto the toilet to a sitting position and left the bathroom. NA-B then went into R38's	21375		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 11	21375		

bedroom and made the bed. While making the bed, a pillowcase with two ice packs fell into the trash can near R38's bed. NA-B picked up the pillowcase from the trash can, opened it and took out the two ice packs and placed and placed them back into the pillowcase, and place the pillowcase on top of the nightstand next to R38's bed. NA-B then touched dirty cups, and utensils on R38's tray table next to lower end of the bed and touched other items to straighten up tray table. NA-B then took the dirty pillowcase which had fallen into the trash from the nightstand and placed onto the tray table. R38 then indicated she was done. NA-B then left room and went into the bathroom and took wipes and cleaned R38's peri anal area without changing gloves. NA-B then changed gloves after cleaning R38's peri anal area, pulled up depends and transferred R38 into wheelchair.

During interview on 8/10/21, at 10:10 a.m. NA-B stated she was unaware that R38 had a UTI as she did not receive report from the nurse, RN-A about R38's UTI but she should have changed her gloves after touching multiple dirty items in R38's room including a pillowcase which had fallen into the trash and was removed by NA-B from the trash can, before providing peri care to R38.

During interview on 8/10/21, at 1:47 p.m. director of nursing (DON) stated it was the expectation that gloves were changed after dirty surfaces or items were touched before providing peri care to a resident.

During interview on 8/11/21, at 12:41 p.m. infection preventionist (RN)-B stated although NA-B stated she had not been informed by the nurse through report that R38 had a UTI, infection

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21375	Continued From page 12 control processes should be the same with all residents using universal precautions and gloves should have been changed after touching dirty items before providing peri anal care to R38. The facility's Personal Protective Equipment-Gloves Policy dated 7/2009, indicated the use of disposable gloves was indicated and included when handling soiled linen or items that may be contaminated. During observation on 8/9/21 at 5:20 p.m. RN-C was observed administering insulin without donning gloves. RN-C wiped R150's abdomen with an alcohol wipe, injected the insulin and wiped the area with an alcohol wipe. RN-C washed her hands after administration. -At 5:27 p.m. RN-C was observed administering insulin without gloves. RN-C wiped R23's arm with an alcohol wipe, injected the insulin and wiped the area with a alcohol wipe after. RN-C then washed her hands after. During interview on 8/9/21 at 5:30 p.m., RN-C indicated she will wear gloves when checking a blood sugar but did not wear gloves when administering insulin, as there is not a risk of contamination. On 8/11/21 at 1:03 p.m., Infection control nurse, RN-B indicated the facility policy directs nurses to wear gloves when administering insulin, but the CDC (Center for Disease Control) does not require it. Review of the facility policy titled Subcutaneous Injection dated 2001 and revised March 2011, indicated the following: Steps in the Procedure 1. Perform hand antisepsis.	21375		

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21375	Continued From page 13 2. Put on gloves. 6. Clean the site with an alcohol swab using a circular motion from the proposed site of injection outward. 12. Slowly inject medication 13. Withdraw needle quickly while placing alcohol swab above or over site. 14. Massage site lightly 17. Remove gloves and discard in designated container. Perform hand antisepsis. During observation on 8/10/21 at 9:55 a.m. NA-D and NA-E were observed transfer R42 with an EZ Stand lift (lift that the assists the resident to transfers by lifting under the resident's arms, and the resident has to be able to bear weight). After transfer was complete, NA-D pushed the lift into the hallway and walked down the hall. At 10:02 a.m. NA-E came out of the room and walked to the dirty utility room. At 10:30 a.m. NA-D was observed to remove a Hoyer lift from another resident's room, and wipe the lift with disinfectant wipes. -At 10:40 a.m. NA-D was interviewed about cleaning lift and she indicated all lifts were to be cleaned after each use. When questioned about the EZ Stand that was used on R42, NA-D indicated she forgot to clean it. -At 10:45 a.m. NA-E indicated the lifts are to be wiped down after every use and she did not realize that the EZ Stand was not cleaned. During interview with RN-B on 8/12/21 at 1:10 p.m., she indicated the expectation was to wipe down lifts with wipes from the purple container, especially where the resident holds on and where the staff touch. Review of the facility's lifting machine policy dated 2001 and revised July 2017, directed:	21375		

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21375	Continued From page 14 Lift Care: 1. Disinfect lift surface. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could monitor to assure proper PPE is worn to prevent the potential spread of infections. The DON or designee could monitor to ensure staff was using gloves properly and hand hygiene was performed during care appropriately. The DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		