DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: H29U

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	F	acility ID: 00507
MEDICARE/MEDICAID PROVIDER (L1) 245421 2.STATE VENDOR OR MEDICAID NO. (L2) 799342100	NO.	3. NAME AND AL (L3) NEW BRIGH (L4) 805 SIXTH A (L5) NEW BRIGH	HTON CARE AVENUE NOF	CENTER	(L6) 55112	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
6. DATE OF SURVEY 01/27/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDIN	IG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	57 (L18) 57 (L17)	Compliance1. A B. Not in Comp		am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of Ser 7. Medical Dire	vices Limit ector
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 57 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):			
17. SURVEYOR SIGNATURE Chris Campbell, Unit S	upervisor	Date : 0	01/28/2016	(L19)	18. STATE SURVEY AGENCY		Date: 01/28/2016 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Particle. 2. Facility is not Eligible.			MPLIANCE WITH	ł CIVIL		ncial Solvency (HCFA-2572 ol Interest Disclosure Stmt (e :	
OF PARTICIPATION 02/01/1987 (L24)	23. LTC AGREE BEGINNING (L41)	G DATE	4. LTC AGREEN ENDING DA		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	INVOLUN 05-Fail to M	L30) TARY feet Health/Safety feet Agreement
25. LTC EXTENSION DATE: 2 (L27)	A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		04-Other Reason for Withdrawal	OTHER	r Status Change
28. TERMINATION DATE:	29	O. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32 (L32)	2. DETERMINATION 01/20/2016	N OF APPROVAL	DATE (L33)	DETERMINATION APP	ROVAL	
	/			(/	DETERMINATION ALL	110 1/11	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245421

January 28, 2016

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

Dear Mr. Chies:

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

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

Effective January 12, 2016 the above facility is certified for:

57 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

January 28, 2016

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

RE: Project Number S5421026

Dear Mr. Chies:

On December 17, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 3, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 12, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 3, 2015, effective January 12, 2016 and therefore remedies outlined in our letter to you dated December 17, 2015, will not be imposed.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245421 _{Y1}	B. Wing	Y2	1/27/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BRIGHTON CARE CENTER		805 SIXTH AVENUE NORTHWEST		
		NEW BRIGHTON, MN 55112		

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

ITE	M		DATE	ITEM			DATE	ITEM			DATE
Y4	ļ		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0156		Correction	ID Prefix	F0221		Correction	ID Prefix	F0242		Correction
Reg. #	483.10(b)(5) - (10 483.10(b)(1)	0),	Completed	Reg.#	483.13(a)	 Completed	Reg. #	483.15(b)		Completed
LSC			01/12/2016	LSC			01/12/2016	LSC			01/12/2016
ID Prefix	F0244		Correction	ID Prefix	F0272		Correction	ID Prefix	F0280		Correction
Reg.#	483.15(c)(6)		Completed	Reg.#	483.20(b)(1)	Completed	Reg. #	483.20(d)(3), 483.7 (2)	10(k)	Completed
LSC			01/12/2016	LSC			01/12/2016 	LSC			01/12/2016
ID Prefix	F0282		Correction	ID Prefix	F0309		Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)		Completed	Reg.#	483.25		Completed	Reg. #	483.25(c)		Completed
LSC			01/12/2016	LSC			01/12/2016 	LSC			01/12/2016
ID Prefix	F0323		Correction	ID Prefix	F0329		Correction	ID Prefix	F0371		Correction
Reg. #	483.25(h)		Completed	Reg.#	483.25(1)	Completed	Reg. #	483.35(i)		Completed
LSC			01/12/2016	LSC			 01/12/2016 	LSC			01/12/2016
ID Prefix	F0411		Correction	ID Prefix	F0425		Correction	ID Prefix	F0428		Correction
Reg.#	483.55(a)		Completed	Reg.#	483.60(a),(b)	Completed	Reg. #	483.60(c)		Completed
LSC			01/12/2016	LSC			01/12/2016	LSC			01/12/2016
REVIEWE STATE AC		REVIEWS (INITIALS		DATE 01/28/	2016	SIGNATURE OF S	SURVEYOR 13922	l		DATE 01/	27/2016
REVIEWE CMS RO	ED BY	REVIEWE (INITIALS	ED BY	DATE		TITLE				DATE	

POST-CERTIFICATION REVISIT REPORT

DBOV/IDE	R / SUPPLIER / C			ATION NEVION I	CLI OICI	DATE OF REVISIT
IDENTIFIC	CATION NUMBER	A. Building	INOCTION			1/27/2016 v ₂
245421		Y1 B. Wing		1		Y2 1/2//2016 Y3
	FACILITY	OFNITED		STREET ADDRESS, (CITY, STATE, ZIP CODE	
NEW BR	IGHTON CARE	CENTER		NEW BRIGHTON, MN		
program, corrected provision	to show those of and the date so	deficiencies previously repouch corrective action was a	orted on the CMS-25 ccomplished. Each	Medicaid and/or Clinical Labora 567, Statement of Deficiencies a deficiency should be fully ident the CMS-2567 (prefix codes si	and Plan of Correction, thi ified using either the reg	hat have been julation or LSC
ITE		DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix	F0465	Correction				
Reg.#	483.70(h)	Completed				
LSC		12/31/2015				
REVIEWE STATE AG		REVIEWED BY (INITIALS) CC/mm	DATE 01/28/2016	SIGNATURE OF SURVEYOR	922	DATE 01/27/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
12/3/201	JP TO SURVEY C	OMPLETED ON		ANY UNCORRECTED DEFICIENC ED DEFICIENCIES (CMS-2567) S		YES NO
	05075 (00(00)	EE (44/00)	•	D 0.10	EVENT.	

POST-CERTIFICATION REVISIT REPORT

	R / SUPPLIER / CL ATION NUMBER	_IA /	MULTIPLE CONST	TRUCTION MAIN BUILDING 0)1				DATE O	F REVISIT
245421		Y1	B. Wing					Y2	1/12/20	16 _{Y3}
NAME OF						STREET ADDRESS, CIT		E		
NEW BRI	GHTON CARE	CENTER				805 SIXTH AVENUE NOF NEW BRIGHTON, MN 55				
						NEW BRIGHTON, MIN 35	0112			
program, corrected provision	to show those d and the date su	eficiencie ch correc	s previously repo	rted on the CMS-25 ccomplished. Each	567, Staten deficiency	and/or Clinical Laborator ment of Deficiencies and y should be fully identifie 2567 (prefix codes shov	Plan of Correctio d using either the	n, that have l regulation or	LSC	
ITEN	Л		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#	NFPA 101		Completed	Reg.#		Completed	Reg. #			Completed
LSC	K0050		01/09/2016	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
			_							
Reg.#			Completed -	Reg. #		Completed	Reg. #			Completed
LSC				LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #		Completed	Reg.#			Completed
LSC			_	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #		Completed	Reg.#			Completed
LSC			_	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #		Completed	Reg.#			Completed
LSC			_	LSC			LSC			
REVIEWEI		REVIEW (INITIAL		DATE 01/28/2016	SIGNATUR	re of surveyor 12424			DATE 01/12	2/2016
REVIEWEI	D ВҮ	REVIEW (INITIAL		DATE	TITLE				DATE	
FOLLOW L 12/1/2015	OLLOWUP TO SURVEY COMPLETED ON				CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: H29U

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	- TO BE COMPLETED BY TH	IE STAT	E SURVEY AGENCY	Facility ID: 00507						
MEDICARE/MEDICAID PROVIDER NO. (L1) 245421 2.STATE VENDOR OR MEDICAID NO. (L2) 799342100	3. NAME AND ADDRESS OF FACIL (L3) NEW BRIGHTON CARE C (L4) 805 SIXTH AVENUE NORT (L5) NEW BRIGHTON, MN	ENTER	(L6) 55112	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint						
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGO 01 Hospital 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint						
6. DATE OF SURVEY 12/03/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	03 SNF/NF/Distinct 07 X-Ray	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 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	A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC X B. Not in Compliance with Progra Requirements and/or Applied	am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B *	7. Medical Director						
14. LTC CERTIFIED BED BREAKDOWN	l	1	15. FACILITY MEETS							
18 SNF 18/19 SNF 19 SN 57	F ICF IID		1861 (e) (1) or 1861 (j) (1):	(L15)						
(L37) (L38) (L39)	(L42) (L43)									
16. STATE SURVEY AGENCY REMARKS (IF APPLI	6. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):									
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY	APPROVAL Date:						
Kathie Killoran, HFE NEII	01/13/2016	(L19)	Mark Meath	, Enforcement Specialist 01/15/2016 (L20)						
PART II - TO B	E COMPLETED BY HCFA REG	GIONAL	OFFICE OR SINGLE S	TATE AGENCY						
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH C RIGHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)						
22. ORIGINAL DATE 23. LTC AGRI	EMENT 24. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)						
OF PARTICIPATION BEGINNI 02/01/1987	NG DATE ENDING DATE		VOLUNTARY 000 01-Merger, Closure							
(L24) (L41)	(L25)		02-Dissatisfaction W/ Reimburse	** - *** - *******						
A. Suspen	TIVE SANCTIONS ion of Admissions: (L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active						
(L27) B. Rescino	Suspension Date:									
28. TERMINATION DATE:	(L45) 29. INTERMEDIARY/CARRIER NO.		30. REMARKS							
26. TERMINATION DAIL.	03001		JU. KEMAKKS							
(L28)	03001	(L31)								
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL D	DATE								
(L32)		(L33)	DETERMINATION APPI	ROVAL						



Certified Mail # 7015 0640 0003 5695 5293

December 17, 2015

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

RE: Project Number S5421026

Dear Mr. Chies:

On December 3, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 12, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 12, 2016 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 3, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

North Cities Health Care, Inc. dba

New Brighton Care Center

805 6th Ave NW

New Brighton, Minnesota

Michael R. Chies, Administrator: Direct Dial: 651403-5241

Mark Meath, Enforcement Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

SEND TO: mark.meath@state.mn.us

January 21st, 2106

Dear Mr. Meath,

Per our communication via email today, I am sending you via email the properly completed and signed 2567.

I thank you for your email and again apologize for the error. Please contact me with any further questions or concerns and I will immediately respond.

The facility general number is: 651-633-7200, press #2 for the Business Office and ask for Michael Chies.

My direct line is: 651-403-5241

I can also be reach on my cell: 651-260-5190

It is my deepest desire to promptly address any issues or concerns.

Regards

Administrator, New Brighton Care Center

RECEIVED

PRINTED: 12/17/2015 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	(X3) DATE COMF	SURVEY	
		245421	B. WING _	MN Dept of Health Duluth	12/0	3/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		···
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F 000	INITIAL COMMEN	тѕ	F 00	00		
	you allegation of co department's accep	otance. Your signature at the page of the CMS-2567 form will				
F 156 SS=D	revisit of your facilit validate that substa regulations has bee your varification. 483.10(b)(5) - (10),	acceptable POC, an onsite by may be conducted to antial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 18	56		
	and in writing in a launderstands of his regulations governi responsibilities duri facility must also protice (if any) of the §1919(e)(6) of the made prior to or up resident's stay. Re	form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The rovide the resident with the estate developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in				
	entitled to Medicaid of admission to the resident becomes e items and services facility services und which the resident other items and ser and for which the re	form each resident who is I benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing der the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and	1/3/11			

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.

Event ID: H29U11

Facility ID: 00507

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		245421	B. WING		12	2/03/2015	
	PROVIDER OR SUPPLIER	ËR		STREET ADDRESS, CITY, STATE, ZIP CO 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 156 SS=D	The facility plan of you allegation of codepartment's accept bottom of the first poe used as verifical. Upon receipt of an revisit of your facilit validate that substate regulations has been your varification. 483.10(b)(5) - (10), RIGHTS, RULES, Some the facility must infinate and in writing in a launderstands of his regulations governing facility must also promotice (if any) of the facility must also promotice (if any) of the facility must also promotice (if any) and prior to or upon to a made prior t	correction (POC) will serve as impliance upon the otance. Your signature at the lage of the CMS-2567 form will ion of compliance. acceptable POC, an onsite y may be conducted to intial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ing resident conduct and ing the stay in the facility. The existence developed under location to the resident with the existence of such information, and it, must be acknowledged in form each resident who is benefits, in writing, at the time	F 15	responses are solely wromaintain certification in Medicare and Medical Aprograms. The written redoes not constitute an aprogram of noncompliance with a requirement nor an agree with any finding. We wis preserve our right to disfindings in their entirety	tten to the assistance esponse admission any " eement sh to pute these at any cion. We equest for	01/12/16	
	resident becomes e items and services facility services und which the resident r other items and ser- and for which the re	nursing facility or, when the ligible for Medicaid of the that are included in nursing er the State plan and for nay not be charged; those vices that the facility offers sident may be charged, and les for those services; and		a es]	12/31/15	
BORATORY	DIRECTOR'S OR RROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE		(X6) DATE	

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01/07/2016

PRINTED: 12/17/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING ___ B WING 245421 12/03/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 12/31/2015 The facility will continue to ensure F 156 Continued From page 1 F 156 that residents are provided proper inform each resident when changes are made to liability and appeal rights notices the items and services specified in paragraphs (5) upon termination of Medicare (i)(A) and (B) of this section. skilled services. The facility must inform each resident before, or A log was developed to track at the time of admission, and periodically during the resident's stay, of services available in the liability notices to ensure the facility and of charges for those services, completion. including any charges for services not covered under Medicare or by the facility's per diem rate. The facility follows the current requirements for issuance of The facility must furnish a written description of legal rights which includes: liability notices. A description of the manner of protecting personal funds, under paragraph (c) of this section; Education with the employee's responsible for issuing denials A description of the requirements and procedures occurred on 12/10 and 12/11/15. for establishing eligibility for Medicaid, including Random audits of the log for the right to request an assessment under section 1924(c) which determines the extent of a couple's completion of liability notices will non-exempt resources at the time of be conducted weekly for 4weeks institutionalization and attributes to the community with results reported to the spouse an equitable share of resources which facility QA committee to cannot be considered available for payment determine ongoing compliance. toward the cost of the institutionalized spouse's DON will be responsible for medical care in his or her process of spending down to Medicaid eligibility levels. ongoing compliance. Date of compliance will be 1/12/16. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy

groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and

advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the

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		245421	B. WING			12/0	3/2015	
	PROVIDER OR SUPPLIER	ER		808	REET ADDRESS, CITY, STATE, ZIP CODE 5 SIXTH AVENUE NORTHWEST EW BRIGHTON, MN 55112			
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F 156	The facility must in name, specialty, ar physician responsion. The facility must prwritten information, applicants for adminformation about he Medicare and Medicare.	mpliance with the advance	F	156				
	by: Based on interview facility failed to pro residents (R46) rew beneficiary appeal Findings include: R46's Admission R R46 was admitted was discharged on R46 was receiving to weakness from On 9/3/15, at approved to the p.m. the health inforstated she was not Liability Notices and single processes of the p.m. the health inforstated she was not Liability Notices and processes of the p.m. the health inforstated she was not Liability Notices and processes of the p.m. the health inforstated she was not Liability Notices and processes of the proces	ecord dated 12/3/15, indicated to the facility on 9/14/15, and 9/24/15. While at the facility, physical therapy services due						

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	PROVIDER OR SUPPLIER	ER		80	REET ADDRESS, CITY, STATE, ZIP CODE 15 SIXTH AVENUE NORTHWEST EW BRIGHTON, MN 55112			
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F 221 SS=D	R46 discharged fro The facility's undate Procedure indicated the resident and/or prior to discontinua 483.13(a) RIGHT T PHYSICAL RESTR The resident has the physical restraints in discipline or conventreat the resident's This REQUIREMED by: Based on interview facility failed to comobtain a physician's self-release alarmed (R65) reviewed for Findings include: R65's 14 day Minin 10/19/15, identified with diagnoses included Alzheimer's. In add admission, no physicognitive impairmed R65's care plan, day prior to admission a risk for falls related impulsiveness. The intervention of a see	m the facility the same day. ed Medicare Policy and do social services would notify the responsible party 48 hours tion of Medicare coverage. TO BE FREE FROM SAINTS The right to be free from any imposed for purposes of nience, and not required to medical symptoms. In the responsible party 48 hours to medical symptoms. The right to be free from any imposed for purposes of nience, and not required to medical symptoms. The right to be free from any imposed for purposes of nience, and not required to medical symptoms. The right to be free from any imposed for purposes of nience, and not required to medical symptoms. The right to be free from any imposed for purposes of nience, and not required to medical symptoms. The right to be free from any imposed for purposes of nience, and not required to medical symptoms.	F 1		Resident R 65 no longer resides a the facility. A facility audit was completed to identify all residents with self-releasing alarm belts. All residents residing in the facility were comprehensively re assessed for the use of the self-release seat belt. Residents are evaluated for physical devices in conjunction with the RAI process. The policy for Physical Devices wareviewed and is current. Education was provided on 12/10 and 12/11/15 for the use of physical devices for staff responsible for evaluating the use of a self-releasing wheelchair belt	S	31/2015	

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NEW BRIC	ROVIDER OR SUPPLIER GHTON CARE CENT	ER TEMENT OF DEFICIENCIES	ID	80	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST IEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION	N	(X5)
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	11/2/15, indicated sper facilities policy. R65's record did not a physician's order alarmed seat belt on the consultant (of failed to include an self-release alarme wheelchair. During interview on the assistant directs she did not remembed alarmed seat belt on the director of nursing interview on the director of nursing in R65's care plan of the director of nursing in R65's care plan of the director of nursing in R65's care plan of the director of nursing in R65's care plan of the director of nursing in R65's care plan of the director of nursing in R65's care plan of the director of nursing in R65's care plan of the director of nursing the did not reself-release alarme wheelchair. The DC to include a physicing self-release alarme wheelchair. The DC to should have been of the director of nursing the plant of the policy of the plant of th	hary progress notes, dated afety belt engaged and fit/use of include an assessment and for the use of a self-release in R65's wheelchair. 12/3/15, at 12:19 p.m., the C)-L verified R65's record assessment for the use of a d seat belt on R65's 12/03/2015, at 12:19 p.m., or of nursing (ADON)-C stated per the use of a self-release in [R65's] wheelchair. 12/03/2015, at 12:19 p.m., and per the use of a self-release in [R65's] wheelchair. 12/03/2015, at 12:19 p.m., and per the use of a deted 10/29/15, and per the use of a desat belt on [R65's] on verified R65's record failed and seat belt on [R65's] on stated she would expect to any when the self-release ad been placed on [R65's] on stated an assessment done at the time the d seat belt had been hould have been monitored for DON stated she did not know a lairmed seat belt was	F2	221	Audits will be completed weekly for 4 weeks on the use of physical devices with results reported to the facility QA committee to determine ongoing compliance. The Director of Nursing will be responsible for ongoing compliance. Date of compliance will be 1/12/16.		

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F 242 SS=D	indicated staff was restraint use, obtain restraint use and of the restraint. 483.15(b) SELF-DE MAKE CHOICES The resident has the schedules, and heather interests, assessinteract with member inside and outside the about aspects of his are significant to the significant to the series. This REQUIREMENT by: Based on observative review, the facility for the series include: R64 requested two preferences assessione. R64's Admission R684's diagnoses indepression, and psecond in the series in the series of the series in the series of the series in the series of the series	r policy Restraints (Physical), to assess resident's need for a informed consent for otain a physician's order for extending to choose activities, alth care consistent with his or issments, and plans of care; ers of the community both the facility; and make choices or her life in the facility that extended to ensure frequency and ferences were honored for 3 of 14, R75) reviewed for showers a week during a sment but was only receiving ecord dated 12/2/15, indicated cluded dementia, anxiety,		2221	Residents R 75, R 64, R 14 were interviewed for bathing preferences and the care plans and care guide were updated. All residents are asked for their bathing preferences minimally upon admission and quarterly. The quarterly care conference form and activity preference evaluation was updated to include any changes in preferences. Education was provided to staff members responsible for completion of the activity preferences evaluation and the IDT. 10% of resident and/or family interviews will be conducted weekly for 4 weeks on meeting resident preferences and the results will be reported to QA committee to determine ongoing compliance. The Director of Nursing will be responsible for		1/2015	
ORM CMS-21	567(02-99) Previous Versions		1	Fac	ongoing compliance. Date of compliance will be 1/12/16. If continua	tion sheet	Page 6 of 53	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245421	B. WING	_		12/0	3/2015
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F 242	Continued From paintact. R64 required one staff with transbathing. On 12/1/15, at 8:38 a shower once a witwice a week. R64 how many times a shower. The Annual Activity preferences dated a shower twice a washower twice a witwice a with the Activities of Darevised on 8/1/15, it assistance of one sher lower body. R6 hands and upper bit to complete what significated R64's based on Wednesday and assistant (NA) care indicated R64's based on 12/2/15, at 1:33 sheet directed R64 Wednesday. NA-B weekend and R64 only on Wednesda her bath today (Wednesda). A verified the	Inge 6 If the extensive assistance of ferring, personal hygiene and a.m. R64 stated she received eek but would like a shower stated she had not been asked week she would like a bath or Evaluation for resident 4/14/15, indicated R64 wanted eek. In Evaluation for resident 4/14/15, indicated R64 wanted eek. In Evaluation for resident 4/14/15, indicated R64 wanted eek. In Evaluation for resident 4/14/15, indicated R64 wanted eek. In Evaluation for resident 4/14/15, indicated R64 wanted eek. In Evaluation for resident 4/14/15, indicated R64 needed the staff for a weekly bath to wash 4 was able to wash her face, ody after set up and staff washe was unable to finish. In Evaluation for resident 4/14/15, indicated R64 in edded the staff for a weekly bath to wash her face, ody after set up and staff washe was unable to finish. In Evaluation for resident 4/14/15, indicated R64 in edded the staff for a weekly bath to wash her face, ody after set up and staff washe was unable to finish. In Evaluation for resident 4/14/15, indicated R64 in edded the staff for a weekly bath to wash her face, ody after set up and staff washe was unable to finish. In Evaluation for resident 4/14/15, indicated R64 in edded the staff for a weekly bath to wash her face, ody after set up and staff washe was unable to finish. In Evaluation for resident 4/14/15, indicated R64 in edded the staff for a weekly bath to wash her face, ody after set up and staff washe was unable to finish. In Evaluation for resident 4/14/15, indicated R64 in edded the staff for a weekly bath to wash her face, ody after set up and staff washe washe a staff for a weekly bath to wash her face, ody after set up and staff washe washe a staff for a weekly bath to wash her face, ody after set up and staff washe washe a staff for a weekly bath to wash her face, ody after set up and staff washe washe washe a staff for a weekly bath to wash her face, ody after set up and staff washe washe washe washe a staff for a weekly bath to wash her face, ody after set up and staff w	F2	242	DEFICIENCY)		5
	for resident prefere	ences was done 4/14/15. AS-A ment indicated R64 wanted a					

PRINTED: 12/17/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING_ B. WING 12/03/2015 245421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 242 F 242 Continued From page 7 On 12/2/15, at 2:35 p.m. licensed practical nurse (LPN)-C checked the Brain Board sheet and verified the sheet directed R64 was to receive a bath on Wednesday and Saturday. The LPN stated her family member was in R64's bed prior and received a bath on Wednesdays and Saturdays. The LPN stated the sheet may not have been changed. The LPN stated she worked every other weekend and R64 only received a bath on Wednesday. The LPN had never seen R64 get a bath on Saturday. A policy was requested and not received. R14 would like the option to take a bath, but did not know if one was available at the facility. R14's 2/24/15 care plan indicated R14 wished to remain in long term care through a planned knee replacement surgery, then return to the facility for rehabilitation. The care plan continued to identify

sponge bath.

R14 had limited physical mobility related to diagnoses of osteoarthritis, weakness and pain.

R14's quarterly Minimum Data Set, dated 9/1/15, indicated R14 was cognitively intact, but required extensive assistant with bed mobility, transfers, dressing and toileting. The MDS further indicated R14 required limited assistance with personal hygiene, and one person to physically assist with bathing, but R14 can do part of the activity.

R14's admission activity evaluation dated 3/5/15, indicated it was somewhat important for R14 to choose between a tub bath, shower, bed bath or

In an interview on 11/30/15, at 6:48 p.m., R14 stated she took a shower, but would like to take a

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not ask about this preference after admission.

In an interview on 12/3/15, at 3:22 p.m., the Assistant Director of Nursing (ADON) stated she "believes" bath or shower choices are reviewed in

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F 242	resident care confet the Activities Super would have more a have further inform. In an interview on 1 Registered Nurse (Supervisor (AS) is residents the frequencestions. The AS the Health Unit Codassistants have the group sheets. RN-E baths or a shower is basis, but if a residuaccommodate the In an interview on Practical Nurse (LF many care confere asked a resident's LPN-A could not reabout the choice of conferences. LPN-shower choices are R14's group sheet of one staff under to sheet did not state for R14 or any other R75's significant chindicated R75 had impairments. The Nextensive assistance to bather R75's care plan daneeded an assist of the R75's	rences. The ADON felt that visor and MDS Coordinator nswers, as the ADON did not ation on this topic. 2/3/15, at 3:27 p.m., RN)-B stated that the Activities responsible for asking ency and type of bath/shower would give the information to ordinators and the nursing information available on their a stated the choice between a saked only on an annual ent asked for one they could request. 12/3/15, at 3:33 p.m., Licensed PN)-A stated she attended nces. LPN-A stated the facility choice at admission, but member asking specifically bath versus shower at care A stated resident bath or elisted on the group sheet. dated 12/2/15, identified assist bath information. The group preference of shower or bath ar resident on the group sheet. The program of the group sheet of the group sheet of the group sheet. The group sheet of the group sheet of the group sheet of the group sheet. The group sheet of the gr	F 2	242			

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F 242	cues to have reside upper body as able directed staff to finito complete. The East Wing aid 12/2/15, indicated F Wednesdays. When interviewed a stated she got a she would really like to On 12/2/15, at 7:39 getting R75 prepare When interviewed I one shower a week that R75 had never shower a week but be reported to the residents for the frefurther stated that residents for the frefurther stated that requency of baths placed it on the aid When interviewed activity supervisor (resident's bathing fadmission and ann residents can requence a week and enough for them. A frequency is not brefrequency is	ent wash face, hands and The care care plan further sh what the resident is unable assignment sheet dated R75's bath day was on 12/1/15, at 10:35 a.m. R75 ower one time a week, but have two showers per week. a.m. NA-B was observed ed to go take her shower. NA-B stated that R75 received con Wednesdays. NA-B stated requested more than one if a resident did, then it would	F2	242			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		SURVEY PLETED
		245421	B. WING	1122		12/	03/2015
	PROVIDER OR SUPPLIER			80	REET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	how many times a vishower and let nurs the documentation provide evidence the how often she wand 483.15(c)(6) LISTE GRIEVANCE/RECO When a resident or must listen to the vigrievances and recand families conceroperational decision life in the facility. This REQUIREMENT by: Based on interview facility failed to resogrievances in regar and maintenance do to the facility by the Findings include: Review of the Resident condicated a nursing getting ready for beconcerns for two reading to the facility of the concerns for two reading details and the following setting ready for beconcerns for two reading details and the facility of the concerns for two reading details and the following setting ready for beconcerns for two reading details and the facility of the concerns for two reading details and the facility of the concerns for two reading details and the facility of the	she recorded on the MDS week the resident wanted to sing know. Due to a change in process, AS-A could not lat R75 had ever been asked led to shower. N/ACT ON GROUP DMMENDATION family group exists, the facility lews and act upon the commendations of residents ming proposed policy and les affecting resident care and NT is not met as evidenced of and document review, the love resident council ds to nursing, dietary, laundry lepartment concerns reported of resident council. dent Council meeting minutes		242	It is the policy of New Brighton Care Center to follow up on all grievances and concerns. A resident council meeting was held on 12/4/15. A new tracking form was created to track concerns brought up at resident council along with a new format for resident council to include follow of concerns brough up at the last resident council for review. The grievance policy was reviewed and is current. Education was provided to the Activity Director on the new forms and tracking of concerns. Audits will be completed for 3 months on follow up of resident council concerns documentation the results of the audits will be reported QA committee to determine ongoing compliance. The Administrator will be responsible for ongoing compliance will be 1/12/16.	t	1/2015

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245421	B. WING	_		12/0	3/2015
	PROVIDER OR SUPPLIER	ER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLÉTION DATE
F 244	change, maintenan resident bed squea needed to be clean included a resident 8/5/15 - resident coindicated nursing caides and going to were tough meat, to complaints and lau pants. 9/2/15 - resident coidentified nursing caides do not know concerns raised recomplaints, laundry shirts, and maintenair. 10/7/15 - resident coindicated nursing conglaints, laundry shift aide, diecomplaints, laundry laundry and maintenair. 11/4/15 - resident coidentified nursing complaints, laundry laundry and maintenat/temperature.	ige 12 ce concerns were one iked and outdoor areas ed up, and activities concerns request for more music. Suncil meeting minutes oncerns included not enough bed too early, dietary concerns on much fish, vegetable indry concerns were missing oncerns including rude pool how to do their job, dietary lated to multiple resident food y concern related to shrinking fance concerns related to dry concerns related to a rough tary had multiple food y concerns because of missing enance concerns for	F	244			
	include documenta	ating tables. cil meeting minutes failed to ation of follow up for the 1 from 6/3/15 through 11/14/15.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , ,	TIPLE CONSTRUCTION			E SURVEY PLETED
		245421	B. WING			12/0	03/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP C 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112	OODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 244	documented the coaddressed by the diservice. However, to documentation of haddressed and reservice. On 12/2/15, at 1:36 (AS)-A and the facithe resident councithrough 11/4/15 fail of follow up regardiby residents during. On 12/3/15, at 8:45 given a copy to each the resident concerfrom 6/3/15 through not received any doback from the department one date on 12/3/15, at 8:59 (DON) provided do regarding follow up handling and quick DON confirmed ship had not documented 12/3/15, when she surveyor. On 12/3/15, at 10:4 system was to forw each department were follow up to her. As previous months cosome might take loger the surveyor and the surveyor of th	rising department had neerns with night staff were irector of nursing and social here had been no ow the concern had been polved. In p.m., the activities supervisor lity consultant (C)-L verified I meeting minutes from 6/3/15 ed to include documentation ng the grievances expressed the resident council meetings. In a.m., AS-A stated she had the department separately for this expressed every month in 11/4/15. AS-A stated she had becomented follow up reports artments, except the nursing	F 2	2.4.4			

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(X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	COMPLETED	
		245421	B. WING		12/0	3/2015
	PROVIDER OR SUPPLIER	ER	8	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272 SS=D	concerns was addr satisfaction, but the documented. On 12/3/15, at 12:3 social worker (SW) received no grievar SW-A stated she hand he was not aw grievances were do The undated facility indicated resident obe documented an supervisors for follous 483.20(b)(1) COMI ASSESSMENTS The facility must consider a comprehensive, reproducible assess functional capacity A facility must make assessment of a reresident assessment of a reresident assessment of a reresident faction and contined contined contined continence; wision; Mood and behavior Psychosocial well-Physical functioning Continence;	essed as well as resident information was not a sinformation was not as power information was not as power information was not as power information, and spoken to the administrator are of any grievance file as ealt with as they came up. Y Resident Council Bylaws concerns and suggestions shall deforwarded to department ow through. PREHENSIVE Induct initially and periodically accurate, standardized is sment of each resident's each resident's needs, using the ent instrument (RAI) specified assessment must include at the demographic information; It is patterns;	F 244	R33 no longer resides at the facility. An oral assessment was completed on residents R17 and F16. The MDS assessments were corrected to include R17 and R16 dental status. A new oral evaluation and policy was developed to include residents' oral status being evaluated upon admission and according to the RAI process. Education for the clinical staff responsible for completion of the MDS and oral evaluation was completed on 12/10 and 12/11/15.	5	1/2015

(X2) MULTIPLE CONSTRUCTION

Facility ID: 00507

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A BUILDING		COMPLETED				
		245421	B. WING	_		12/	03/2015
	PROVIDER OR SUPPLIER	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOBLICIENCY)	BE	(X5) COMPLETION DATE
F 272	Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional assessareas triggered by the Data Set (MDS); are	and procedures; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	F2	272	Audits will be completed weekly for 4 weeks on the completion of the oral evaluation and coding of the MDS with results reported to the facility QA committee to determine ongoing compliance. The Director of Nursing will be responsible for ongoing compliance. Date of compliance will be 1/12/16.		
	by: Based on observation review the facility for control of the facility fa	num Data Set (MDS) dated ed no oral concerns were ual MDS failed to identify R16					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MIII	TIPLI	(X3) DATE SURVEY			
	OF DEFICIENCIES OF CORRECTION	,			COMPLETED		
		245421	B. WING			12/03/2015	
	PROVIDER OR SUPPLIER	ER		80	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	teeth. ADON-C sta	ige 16 verified R16 had no lower ted R16 had her last tooth ession done for lower dentures	Fí	272			
	R16 had two lower cracked and right k notes dated 8/10/1 identified R16 had	te initiated 1/13/15, identified teeth with the left lower tooth ower tooth intact. R16's dental 5, 9/10/15 and 11/13/15, extractions of teeth and on pression for dentures.					
	director of nursing identified R16 had	n 12/3/15, at 1:01 p.m., the (DON) verified R16's care plan missing and cracked teeth. R16's annual MDS was not					
	concerns were pre	dated 1/6/15, identified no oral sent. R17's annual MDS failed missing and broken teeth.					
	have some missing	01 p.m., R17 was observed to g teeth and R17 stated she had declined to show teeth.					
	had missing teeth	02 a.m., ADON-C verified R17 on the top and bottom gum eeth on the bottom.					
	cares, full upper ar	ited, 4/23/15, identified oral nd lower dentures and assist of and soak overnight.					
	registered nurse (Fidentified R17 had	n 12/02/15, at 2:05 p.m., RN)-B verified R17's care plan full upper and lower dentures. 's annual MDS failed to include broken teeth.					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245421	B. WING			12/0	03/2015
	PROVIDER OR SUPPLIER	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPO DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 17	F 2	272			
	of nursing verified Fidentify R17 had mi	12/3/15, at 1:08 p.m., director R17's annual MDS failed to ssing and broken teeth and expect the MDS to be filled out					
	requested, but not R33's 10/21/15 adm (MDS) indicated sh cognition. The MDS extensive assist wit R33's MDS identified	nission Minimum Data Set e had severely limited indicated R33 required th personal hygiene. Review of ed no issues with oral/dental the MDS included: obvious or					
	revealed R33's teet outside of the teeth	11/30/15, at 6:28 p.m., th to be dark in color on the , and the inside, as if decayed. sing and some teeth appeared rn down.					
	Practical Nurse (LF assessments upon determination of breexperiencing pain,	2/2/15, at 8:40 a.m., Licensed PN)-A stated she did dental admission to include oken teeth, if a resident was if a resident had dentures, ving issues and if the resident ferral.					
	registered nurse (R assessments were and nursing - which admission work. R nurse (LPN)-A will of	2/2/15, at 1:20 p.m., :N)-B stated dental done by the dietary manager never nurse is completing the N-B stated licensed practical often assist with MDS data ing term care side of the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245421	B. WING	_		12/	03/2015
	PROVIDER OR SUPPLIER	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
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F 272		ge 18 t comprehensive evaluations, and dental was completed	F 2	272			
	upon admission, an RN-B stated she did examinations, but g the admitting floor n she had information on the bottom and c RN-B did not reply to	nual and significant changes. If not do the dental athered this information from turse or LPN-A. RN-B stated that R33 had her own teeth couple of her own teeth on top when directly asked if the an accurate assessment of	× •		_		
	on 12/2/15, at 2:08 assessment note with R33 had her own teher own teeth on to denture. The note a dental referral. A co	and observation with LPN-A p.m., the 10/14/15 admission as reviewed which indicated eth on the bottom, a couple of p and an upper partial lso indicated to provide a py of this assessment and of was requested but not acility.			*		Ð
	plan indicated assis which included brus before bed. The ca exams per facility por R33's medical recor	ties of Daily Living (ADL) care t of 1 staff for oral cares, hing teeth in the morning and re plan also indicated dental rotocol. R33's care plan and d were absent of information the condition of R33's teeth.				1.0/2	1/2015
F 280 SS=D	483.20(d)(3), 483.10 PARTICIPATE PLAI The resident has the incompetent or othe incapacitated under	O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged rwise found to be the laws of the State, to ng care and treatment or	F 2	280	R 29 was comprehensively reassessed on 12/3/15 for falls and physical devices and care plan was updated.		1/2015
11					×		

PRINTED: 12/17/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 12/03/2015 B. WING 245421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 F 280 Continued From page 19 All residents care plans are A comprehensive care plan must be developed updated with changes and within 7 days after the completion of the reviewed following the RAI comprehensive assessment; prepared by an process. interdisciplinary team, that includes the attending physician, a registered nurse with responsibility The policy for care plans and for the resident, and other appropriate staff in disciplines as determined by the resident's needs, physical devices was reviewed and and, to the extent practicable, the participation of is current. the resident, the resident's family or the resident's legal representative; and periodically reviewed Education for the staff responsible and revised by a team of qualified persons after for the revision of a care plan each assessment. were educated on 12/10 and 12/11/15 to include the care plan policy and revision. This REQUIREMENT is not met as evidenced Audits will be completed weekly Based on observation, interview and document for 4 weeks on following the care review the facility failed to revise the care plan to

Findings include:

R29's care plan revised on 10/29/15, identified a high risk for falls related to dementia, incontinence's, poor safety awareness, and inability to use call light for assistance. Interventions included anticipate and meet the resident's needs, contact guard assistance of one to ambulate with walker when resident becomes restless, ensure the resident is wearing appropriate footwear when transferring, ambulating or mobilizing in wheelchair, follow facility fall protocol, update physician as needed, physical therapy to evaluate and treat as ordered or as needed, needs activities that minimize

include interventions implemented related to falls

for 1 of 3 residents (R29) reviewed for accidents.

Audits will be completed weekly for 4 weeks on following the care plan and include the accuracy of the nursing assistant assignment sheets and the results reported to the facility QA committee to determine ongoing compliance. The Director of Nursing will be responsible for ongoing compliance will be 1/12/16.

OLIVIE	O TOTT MEDIONITE	St Title - To Title				WOLDATE	CHOVEN
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION		SURVEY PLETED
		245421	B. WING			12/0	03/2015
	PROVIDER OR SUPPLIER	ER		80	REET ADDRESS, CITY, STATE, ZIP CODE IS SIXTH AVENUE NORTHWEST EW BRIGHTON, MN 55112		
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F 280	distraction, needs a free of clutter/spills working and reached two as ordered, had items within reach. During observation was observed to had Licensed practical alarm was implementater a fall. The use R29's care plan. During observation was lying in bed and to be on R29's bed On 12/1/15, at 3:08 working when R29	nile providing diversion and safe environment with floors, adequate glare free light, a able call light, grab bars times ndrails on walls, and personal on 12/1/15, at 1:44, p.m., R29 ave an alarm on R29's recliner. nurse (LPN)-A stated the ented for safety on 11/29/15, e of an alarm failed to be on on 12/2/15 at 7:10 a.m., R29 and no grab bars were observed	F2	280			
	stated the care pla changes when inte	o p.m., the director of nursing n should be updated with rventions are discontinued and he nursing assistant care be updated.			W s		
F 282 SS=D	dated 8/10, indicate changed and upda the resident. It was 483.20(k)(3)(ii) SE PERSONS/PER C	lan Policy And Procedure, ed the care plan was to be ted as the care changed for s to be current at all times. RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in	F	282	R 29 was comprehensively re assessed on 12/3/15 for falls and physical devices and care plan was updated.		31/2015

PRINTED: 12/17/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B. WING 12/03/2015 245421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER** NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 All residents care plans are F 282 | Continued From page 21 updated with changes and accordance with each resident's written plan of reviewed following the RAI care. process. This REQUIREMENT is not met as evidenced The policy for care plans and physical devices was reviewed and Based on observation, interview and document review, the facility failed to ensure the care plan is current. was followed for 1of 3 residents (R29) reviewed for accidents. Education for the staff responsible for the care of the residents was Findings include: done on 12/10 and 12/11/15 to R29's care plan revised on 10/29/15, indicated include following the care plan. high risk for falls related to diagnoses of right side hemiparesis (weakness), dementia, Audits will be completed weekly incontinences, poor safety awareness, inability to for 4 weeks on following the care use call light for assistance. Interventions plan results reported to the facility included anticipate and meet the resident's needs, encourage to participate in activities, OA committee to determine contact guard assistance of one to ambulate with ongoing compliance. The Director walker when resident becomes restless, ensure of Nursing will be responsible for the resident is wearing appropriate footwear when ongoing compliance. Date of transferring, ambulating or mobilizing in compliance will be 1/12/16. wheelchair, follow facility fall protocol, physical therapy to evaluate and treat as ordered or as needed, needs activities that minimize potential for falls while providing diversion and distraction, needs safe environment with floors free clutter/spills, adequate glare free light, a working and reachable call light, the bed in low position at night, grab bars times two as ordered, handrails

at all times.

on walls, personal items within reach. Revision of the care plan on 12/1/15, included staff to leave light on in bathroom so resident is able to see when transferring and bed alarm and chair alarm

During observation on 12/1/15, at 1:44, p.m., the

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F 282	call light was on ou sitting on the edge walked over to the recliner. No alarm is R29 stood up. The R29's recliner was nurse (LPN)-A walk the call light and re box. While reattach LPN-A stated R29 use of alarms. LPN had a fall and the afor safety on 11/29/toilet herself, was in changing the incon R29 was inconsisted. During observation was lying in bed wi and all lights were no grab bars were At 7:38 a.m., LPN-assisted R29 to stathe edge of the bed sat in the recliner. I during the transferred R2 no lights were on in o grab bars on R2 the room and R29 socks on both feet. An incident note id found on the floor i when getting up. Tidentified as footwer.	tside of R29's room. R29 was of the bed, stood up and recliner, sitting down in the sounded on R29's bed when cord to the alarm box for detached. Licensed practical ked into R29's room to answer attached the cord to the alarming the cord to be continent and had a hard time tinent product. LPN-A stated ent with the use of the call light. On 12/2/15 at 7:10 a.m., R29 th regular socks on both feet off in R29's room. In addition, observed to be on R29's bed. Centered R29's room, and and transfer from sitting on d, walking a few steps and R29 R29 had regular socks on feet. LPN-C verified at the time she 9 with regular socks on feet, a R29's room and there were 29's bed. LPN-C walked out of continued to have only regular entified on 10/29/15, R29 was n her room, having slipped the "root cause" of the fall was	F2	282			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		E CONSTRUCTION		E SURVEY IPLETED
		245421	B, WING			12/	03/2015
	PROVIDER OR SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	to the light being of On 12/1/15, at 3:23 what fall intervention nursing assistant (Nas she was new. On 12/1/15, at 3:24 what fall intervention stated staff check on R29 the call light, "It keep walker within have alarms in place. On 12/1/15, at 3:27 what fall intervention NA-J stated she had chair. R29 did not lich check on R29 and I on 12/1/15, at 3:08 (LPN)-C stated she an alarm on R29's LPN-C verified the failed to include R2 on 12/3/15, at 2:05	p.m., when queried regarding ns were in place for R29, NA)-K stated she didn't know, p.m., when queried regarding ns were in place for R29, NA-I she R29 every 30 minutes, give but she forgets to use it" and reach. NA-I stated R29 did not be. p.m., when queried regarding ns were in place for R29, did not be. p.m., when queried regarding ns were in place for R29, d an alarm on the bed and ke to use the call light. Staff keep the walker in reach. p.m., licensed practical nurse had implemented the use of bed and chair on 11/29/15. nursing assistant care sheets	F2	282			
F 309 SS=D	be followed.	CARE/SERVICES FOR	F:	309	Resident R 49 no longer resides in	12/3	31/2015
mil .	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, associal well-being, in a comprehensive assessment			the facility.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION		E SURVEY IPLETED
		245421	B. WING	_		12/	03/2015
	PROVIDER OR SUPPLIER	ER		8	STREET ADDRESS, CITY, STATE, ZIP CODE B05 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	and plan of care. This REQUIREMENT by: Based on observation review the facility fadialysis center in a laboratory results a for 1 of 1 residents services. Findings include: R49's admission mind 11/16/15, identified diabetes, dialysis, a identified R49 was delivered a breat 120 cc (cubic cention of hot water for tea, oatmeal, blueberry scrambled eggs. On 12/2/15, at 1:39 a diabetic diet but we required for dialysis much she drank. R49's care plan, da required dialysis relikidney disease stag dialysis three times report to physician at the service of th	ion, interview and document alled to communicate with the timely manner regarding and a physician's order for diet (R49) reviewed with dialysis inimum data set (MDS) dated diagnoses of renal disease, and therapeutic diet. The MDS cognitively intact in a cognitively intact on 12/2/15, at 8:24 a.m., R49 eakfast tray, which contained meters) of apple juice, 240 cc 240 cc of milk, yogurt, bake, two bacon strips and p.m., R49 stated she was on as unsure about the diet are R49 stated she watched how ted 11/25/15, indicated R49 ated to diagnosis of chronic ge four. Interventions included a week, monitor labs and as needed, explain and	F3	309	It is the policy of New Brighton Care Center to communicate with the dialysis center attended by it residents. The policy and procedure for diet orders was reviewed and is current. A new form was developed to assure all diet orders are obtained or clarified upon admission. A preprinted dialysis flow sheet was implemented to include requesting information from the dialysis center. Education was provided to staff responsible for obtaining dialysis communication and diet orders o 12/10 and 12/11/15 to include dialysis communication and diet orders. Audits will be completed weekly for 4 weeks on obtaining diet orders and communication with dialysis unit and will reported to the facility QA committee to determine ongoing compliance. The Director of Nursing will be responsible for ongoing compliance. Date of compliance	S	
		ice of maintaining diet as ered dietician) to evaluate and			will be 1/12/16.		[. }

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		PLETED
		245421	B, WING	-		12/0	03/2015
	PROVIDER OR SUPPLIER	ER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	make diet change of monitoring as order R49's medication a dated 11/15, indicated 12/15, identificated 12/16, iden	dministration record (MAR) ted a regular diet and the MAR ied a renal diet. cord on 12/2/15, identified a ated 11/11/15, for dialysis draw complete blood count) and send results to NBCC (New ter). cord failed to include a address the diet to be defailed to include the lab dered blood draw on 11/11/15. In p.m., registered nurse (RN)-B and failed to include lab results so order dated 11/11/15. She as no communication from the R49's status on dialysis days addition, RN-B verified R49's ude a physician's order for the	F	309			

(X1) PROVIDER/SUPPLIER/CLIA

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(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V -/		ONSTRUCTION		PLETED
		245421	B. WING			12/	03/2015
	PROVIDER OR SUPPLIER			805	EET ADDRESS, CITY, STATE, ZIP CODE SIXTH AVENUE NORTHWEST V BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	was adequate. RD fluid restriction at to not aware R49 had and she would expect to address what did On 12/3/15, at 1:1 (DON) stated laborate next day and to The DON verified documentation of dialysis center for dialysis treatment. expect the dialysis documentation to dialysis treatments.	p-K stated R49 did not require a hat time. RD-K stated she was done physician's order for a diet beet an order from the physician let was to be provided. O p.m., the director of nursing results should be followed up the physician should be notified. R49's record failed to include communication from the the days R49 had received. The DON stated she would be center to provide the facility regarding R49's so The DON verified R49's clude a physician's order for the	F3	09			
F 314 SS=D	lab results and co center were reque 483.25(c) TREATI PREVENT/HEAL Based on the com	PRESSURE SORES prehensive assessment of a	F	314	R 33 no longer resides at the	12	2/31/2015
	who enters the factors and develop individual's clinical they were unavoice pressure sores reservices to promote the control of the control o	ty must ensure that a resident cility without pressure sores pressure sores unless the all condition demonstrates that dable; and a resident having aceives necessary treatment and the healing, prevent infection and s from developing.	i		All residents with wounds that currently reside in the facility had been comprehensively re assess and care plans revised as needed.	sed	
	This REQUIREM	ENT is not met as evidenced			A new ulcer checklist was initiated.		

(X2) MULTIPLE CONSTRUCTION

by:

PRINTED: 12/17/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A BUILDING_ B. WING 12/03/2015 245421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER** NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE **PRFFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 27 Based on observation, interview and document All residents are comprehensively review, the facility failed to prevent the assessed for skin risk in development of pressure ulcers for 1 of 1 conjunction with the RAI process residents (R33). and with new onset of wounds. Findings include: The care plan policy, pressure R33 was admitted without pressure ulcers, but ulcer policy and skin risk policy developed pressure ulcers on both heels. In was reviewed and is current. addition, observations on 12/2/15 revealed reddened areas on R33's coccyx and the top of Education for staff responsible for her right foot. updating the care plan and policy R33's 10/14/15, admission record identified for pressure ulcers and evaluation diagnoses that included Alzheimer's disease, of skin risk were educated on hypertension, edema, and muscle weakness. 12/10 and 12/11/15 to include the R33's 10/21/15 admission Minimum Data Set new checklist, pressure ulcer (MDS) indicated she had severely limited policy and care plan policy. cognition, a reduction in interest for activities and a poor appetite. The MDS indicated R33 required Audits will be completed weekly extensive assist of bed mobility, transfers, dressing, toileting and personal hygiene. The for 4 weeks on pressure ulcers and MDS indicated R33 was not at risk of pressure following the care plan and ulcers and did not have any pressure ulcers at reported to the facility QA that time. committee to determine ongoing compliance. The Director of A 10/16/15 Skin Risk Evaluation recommended to Nursing will be responsible for reposition R33 every 3 hours and as needed. An

accompanying 10/16/15 Braden identified low

staff are to provide perineal care after incontinence and apply barrier creams as

risk. The Skin Risk Evaluation stated R33 was at

risk for pressure ulcers. Recommendations were to use a pressure reduction mattress on bed and cushion in wheelchair. The Evaluation stated R33 was occasionally incontinent of bladder and

needed. R33's heels were also to be elevated off the bed with proper fitting footwear that provided

ongoing compliance. Date of

compliance will be 1/12/16.

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST	3/2015
805 SIXTH AVENUE NORTHWEST	
NEW BRIGHTON CARE CENTER NEW BRIGHTON, MN 55112	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
An 11/19/15 Skin Risk Evaluation indicated R33 was at high risk of pressure ulcers. The 11/19/15 Skin Risk Evaluation stated R33 was noted on 11/19/15 to have pressure ulcers on both heels. According to the summary, the a wound on the left heel measured 4 centimeters (cm) by 3 cm and was a dark fluid filled blister and the right heel had a 2 cm by 3 cm brown area, that was flat and dry. The narrative stated both areas were cleansed, skin prep applied and dry foam dressings applied. Bi-lateral heel lift boots were placed to relieve pressure to R33's heels. The new recommendation stated to turn and reposition R33 every 2 hours and as needed. Staff was directed to provide perineal care after incontinence. The narrative concluded "resident has had a decline and family is planning to sign up on hospice." R33's oral intake was noted to be poor; staff was directed to anticipate R33's needs and provide total care. An accompanying 11/19/15 progress note directed bilateral heel lift boots be worn at all times to relieve pressure. Review of R33's Weekly Wound documentation progress sheet indicated R33's had bilateral heel wounds that were pressure acquired and first noted on 11/13/15. The right heel wound was identified as a deep tissue injury and the left heel wound was described as a Stage II pressure ulcer. R33's right heel was noted to have no change on 11/23/15, but to have improved when assessed on 11/30/15. R33's left heel was noted to not have changed on 11/23/15, and was identified as "Stable" on 11/30/15. An 11/23/15 progress note described the right heel as a 4x3 cm fluid filled blister, dark purple and mushy. The note described the left heel as a	

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	PROVIDER OR SUPPLIER	ER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	An 11/28/15 progre was a 2 x 2 cm dry heel was described eschar. In an interview on 1 said R33 had bliste Practical Nurse (LF currently dry, dark, the touch. During an observat LPN-C and Trained entered R33's room the heels. LPN-C re Medical boots. Undon socks and the tomark which correla strap. LPN-C descheel as necrotic (dedrainage and spondid not need to be described the right and not as spongy observation, both we dark brown to purp prep and a dry dresalso added kerlex a further redness to the stated she put the latest they would not rub LPN-C checked to properly, and TMA-knees to ensure the bed.	ge 29 wn, thin eschar area. ss note indicated the right heel area with eschar. The left as 2 x 3 cm with thick dry 2/1/15, at 9:47 a.m., LPN-A rs on her heels. Licensed PN)-A stated they were healing Stage II ulcers, hard to ion on 12/2/15, at 9:44 a.m., Medical Assistant (TMA)-A reproved the Restorative for the boots, R33 did not have been of her right foot had a red ted to the edge of the boot's ribed the wound on R33's left read tissue), dry, with no gy. LPN-C stated the wounds measured today. LPN-C heel wound as dry, necrotic, as the left. During the wounds were observed to be le in color. LPN-C applied skin ssings to both heels. LPN-C around the feet to prevent the top of the feet. LPN-C plue boots on more loosely so on the top of R33's feet. ensure the boots were on A put a pillow under R33's enheels were floated off the	F	314			

CENTE	3 FOR MEDICANE	T WILDIGAID GERVIGES	()(0) 14111	TIDLE C	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		PLETED
		245421	B. WING	_		12/	03/2015
	PROVIDER OR SUPPLIER	ER		805	EET ADDRESS, CITY, STATE, ZIP CODE SIXTH AVENUE NORTHWEST W BRIGHTON, MN 55112		
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F 314	a.m. until 10:20 a.m bed on her back ar 7:30 a.m. (per inter Staff was in and out time, including the In an interview on assistant (NA)-E st dressed R33 at 6:3 her at 7:30 a.m. N repositioned R33 wbut did not observed On 12/2/15, at 10:1 not reposition R33' breakfast. NA-D sunder her head, but During an observationed R33. but had a small am NA-D. Observationarge reddened are Review of the nurs not provide any guichange R33. It also the use of the blue R33's 11/3/15 pres R33 had the poten development. The intact, free of rednermand and the poten development. The intact, free of rednermand and the poten development. The intact, free of rednermand and the poten development. The intact, free of rednermand and the poten development. The intact, free of rednermand and the poten development. The intact, free of rednermand and the poten development. The intact, free of rednermand and the poten development.	n., revealed R33 was lying in and was not repositioned from view below) until 10:20 a.m. at of R33's room during this dressing changes. 12/2/15, at 10:09 a.m., nursing rated she and a colleague to a.m., and NA-E repositioned A-E stated she assumed NA-D when passing breakfast trays, at this. 14 a.m., NA D stated she did is body when offering tated she readjusted the pillow at did not readjust her body. 15 tion on 12/2/15, at 10:20 a.m., necked, changed, and R33's incontinent brief was dry nount of stool, according to a around the coccyx. 16 sing assistant group sheet did idance on when to check and o did not provide information on a boots. 18 sure ulcer care plan indicated tial for pressure ulcer goal was to keep R33's skin ess, blisters or discoloration.		314	DETICIENTY		
	R33's 11/3/15 pres R33 had the poten development. The intact, free of redn- Interventions inclu- nursing assistants body skin check of read to turn/reposi	ssure ulcer care plan indicated tial for pressure ulcer goal was to keep R33's skin					

PRINTED: 12/17/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 12/03/2015 245421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER** NEW BRIGHTON, MN 55112 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 31 existing ulcers or the use of bilateral boots to protect the heels. R33's care plan printed on 12/2/15, did not include interventions for the bilateral heel wounds. Review of the nursing assistant group sheet dated 12/2/15 revealed no direction to staff about the use of the blue boots or repositioning 12/31/2015 schedule. R 29 was comprehensively re F 323 483.25(h) FREE OF ACCIDENT F 323 assessed on 12/3/15 for falls and HAZARDS/SUPERVISION/DEVICES SS=D physical devices and care plan and group sheet was updated. The facility must ensure that the resident The IDT reviews the falls for root environment remains as free of accident hazards as is possible; and each resident receives cause analysis. adequate supervision and assistance devices to All residents are comprehensively prevent accidents. assessed for falls in conjunction with the RAI process and care plans are updated with changes and reviewed following the RAI This REQUIREMENT is not met as evidenced process. by: Based on observation, interview and document The policy for care plans and review the facility failed to comprehensively physical devices was reviewed and assess the root cause of falls, implement is current. appropriate interventions and evaluate effectiveness of interventions for 1 of 3 residents Audits will be completed weekly (R29) reviewed for accidents. for 4 weeks on following the care Findings include: plan and fall risk the results

walker for mobility.

R29's annual minimum data set (MDS) dated

fall no injury, two falls with injury, unsteady

10/13/15, identified diagnoses of dementia, one

balance during transitions and walking, limited assist of one for transfers and ambulation and

reported to the facility QA

compliance. The Director of

Nursing will be responsible for

ongoing compliance. Date of

compliance will be 1/16/15

committee to determine ongoing

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245421	B. WING)	12	/03/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE
F 323	During observation call light was on ou sitting on the edge walked over to the recliner. No alarms R29 stood up. The R29's recliner was nurse (LPN)-A wall the call light and rebox. While reattack LPN-A stated R29 use of alarms. LPN the alarms in the gher choice if she distated "I don't." LP had a fall and the afor safety on 11/29 toilet herself, was inchanging the incorrection R29 was inconsisted. During observation alarm on R29's recwas not sitting in the continued to sound recliner at 3:22 p. In the alarm sounding walk from the end station toward R29 was softly sounding difficult to hear due televisions on, visi and staff talking by During observation R29's recliner, on practical nurse (LF)	on 12/1/15, at 1:44, p.m., the tside of R29's room. R29 was of the bed, stood up and recliner, sitting down in the sounded on R29's bed when cord to the alarm box for detached. Licensed practical red into R29's room to answer attached the cord to the alarm hing the cord to the alarm, was non-compliant with the I-A stated R29 was throwing arbage. LPN-A told R29 it was d not want the alarm. R29 N-A stated R29 just recently alarm was put back into place (15. LPN-A stated R29 tried to incontinent and had a hard time of the timent product. LPN-A stated ent with the use of the call light. In on 12/1/15, at 3:18 p.m., the cliner was sounding and R29 he recliner. The alarm of until R29 sat back down in the in. During the four minutes of g, no staff was observed to of the hallway by the nurse's et of the hallway, and was et to other noise such as tors talking with other residents of the nurse's station. In of the alarm sounding from 12/1/15, at 3:36 p.m., licensed the nurse's station.		323		

PRINTED: 12/17/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 12/03/2015 245421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 33 F 323 the end of the hall before the nurse station. During observation on 12/2/15 at 7:10 a.m., R29 was lying in bed with regular socks on both feet and all lights were off in R29's room. In addition, no grab bars were observed to be on R29's bed. At 7:38 a.m., LPN-C entered R29's room, assisted R29 to stand and transfer from sitting on the edge of the bed, walking a few steps and R29 sat in the recliner. R29 had regular socks on feet during the transfer. LPN-C verified at the time she had transferred R29 with regular socks on feet, no lights were on in R29's room and there were no grab bars on R29's bed. LPN-C stated we can put gripper socks on R29, but R29 can remove the gripper socks too. LPN-C walked out of the room and R29 continued to have only regular socks on both feet. R29's care plan dated as revised on 10/29/15, indicated high risk for falls related to right side hemiparesis, history of cerebral vascular accident (CVA), dementia, incontinence, and poor safety awareness. Interventions included contact quard assistance of one to ambulate with walker when resident becomes restless, ensure the resident is wearing appropriate footwear when transferring, ambulating or mobilizing in wheelchair, follow facility fall protocol, physical therapy to evaluate

and treat as ordered or as needed, adequate glare free light, a working and reachable call light,

R29's Fall Scene Investigation/Incident Reports and progress notes indicated the following:

On 6/25/15, R29 was found on the floor in room at 3:30 p.m. and at 6:00 p.m., was reaching for item and slipped. No injury. The form indicated

grab bars times two as ordered.

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY
		245421	B. WING			12/0	3/2015
	PROVIDER OR SUPPLIER	ER		80	REET ADDRESS, CITY, STATE, ZIP CODE 5 SIXTH AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	the "root cause of the within reach." Initial falls included items remind to use call I notes identified a binformation was do meeting regarding 2:05 p.m., director was no follow up to the with the "root cause" of lighting, standing use and bare feet. Initial future falls included chair alarm, and key meeting notes identifications, anticipate reall times, call light.	the fall" to be "item was not a interventions to prevent future is placed within reach and ight. In addition, progress and alarm was placed. No ocumented from the fall team this incident. On 12/3/15, at of nursing (DON) verified there are meeting documentation.	F	323			
	room, with an abra head on the wall. I identified as "slipp prevent future falls or non-skid socks, No information wa team meeting rega 12/3/15, at 2:05 p. no follow up fall te no new intervention. On 9/3/15, R29 was turned quickly and There was bruising	vas found on the floor in her asion to her back and hit her The "root cause" of the fall was ed." Initial interventions to included needs to wear shoes use walker, and call for assist s documented from the fall arding this incident. On m., the DON verified there was am meeting documentation and ons had been implemented. as carrying a tray in the hallway, I fell. The fall was witnessed. I g and a cut by the right eye, Ilder, bruise to her right arm,				ě	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245421	B. WING	_		12/0	3/2015
	PROVIDER OR SUPPLIER	ER		80	TREET ADDRESS, CITY, STATE, ZIP CODE D5 SIXTH AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	cause", no initial interverse and follow up team On 9/16/15, R29 w. She fell attempting She received multip. The "root cause" of inappropriate foot versech. Initial interverse included re-educate therapy evaluate an initiated, and frequeteam meeting ident remind resident to however these interimplemented and the addressed. On 12/2 verified no new interimplemented. R29's quarterly car 10/29/15, indicated when a bed alarm or creating more issued it off. On 10/29/15, R29 or room, having slipped complained of a sofall was identified a included keep show	and. There was no "root terventions and no fall meeting On 12/3/15, at 2:05 p.m., the was no documentation se, interventions implemented		323			
	team meeting identified make sur footwear on at all ti	re resident has appropriate imes.					

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CLIVILLI	13 FOR MEDICANE	& WEDICAID SERVICES			Wes 5.7	COURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245421	B. WING			03/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COD 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	room. She had a be tear right arm, and An alarm was being but the sound was hear the alarm. The determined to be v. The initial intervent included checking encouraged to use lights on in the root identified staff was with transferring so alarms in place, re. Although these interinitiated, there was efficacy and ongoin On 12/1/15, at 3:23 what fall intervention nursing assistant (as she was new. On 12/1/15, at 3:24 what fall intervention stated staff check R29 the call light, '	was found on the floor in her ruise above her right eye, skin she reported she hit her head g used at the time of the fall, too low and staff was unable to e "root cause" of the fall was ision due to the light being off. ions to prevent future falls the alarm, resident call light, and staff to leave the m. The fall team meeting to leave on the light to assist o resident can see, make sure sident will try to disarm alarms. Erventions had been previously to evidence of review for		23		
	what fall intervention NA-J stated she had chair. R29 did not check on R29 and	ce. 7 p.m., when queried regarding ons were in place for R29, ad an alarm on the bed and like to use the call light. Staff keep the walker in reach. 8 p.m., licensed practical nurse e was working when R29 fell or		y: *		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245421	B. WING			12/0	03/2015
	PROVIDER OR SUPPLIER	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	11/29/15, and had is alarm on R29's been turns off the alarms non-compliant. Starcall light, but she do pressure pad alarm LPN-C verified the failed to include R2 nursing assistants are port the alarms w. LPN-A stated we us update staff on chat the report sheet frowas no documenta of alarms was imple On 12/1/15, at 3:30 alarms were stopped put back into place the alarms were cawere more of a haz was bending over to On 12/3/15, at 2:05 nursing (ADON)-C discussed and the beneficial to have the verified the team had discussion. On 12/3/15, at 2:05 (DON) stated she with the alarm was re-impreviously identified stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all stopped after the dalarms were to be in the stated she did not all	mplemented the use of an and chair. LPN-C stated R29 is, monkeys with them and is ff encourage R29 to use the pesn't. The alarms are as for the bed and chair. In the alarms are shown that care sheets 9's alarms. LPN-C stated the would have known through were put into place for R29. Is a daily shift to shift report to a daily shift to shift report to a daily shift to shift report to a daily shift and verified there tion R29 had a fall and the use	F	323			

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CENTER	S FUR MEDICARE	& MEDICAID SERVICES					E 01101/EV
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245421	B. WING			12/	03/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5 SIXTH AVENUE NORTHWEST		
NEW BRI	GHTON CARE CENT	ER		NE	W BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	alarms on 11/29/15 of the alarm was not expect staff to replay was loud enough to she would expect to the DON stated the assess the resident vitals/neuro's if need notify the physician the fall incident reporting or injury of unknown per facility protocol and supervisor whe implement an interwhat to do the DON reviews for follow to the undated facility Report, correspond 483.25(I) DRUG RUNNECESSARY DEACH resident's drunnecessary drugs drug when used in duplicate therapy); without adequate reindications for its undated adverse conseques should be reduced combinations of the Based on a compresident, the facility who have not used.	she had implemented the . The DON stated if the sound of loud enough she would ace the alarm with one that to be heard. The DON stated he care plan to be followed. The facility system for falls was to for injury, and take edd. If there was an injury, and provide first aid. Fill out ort of head trauma or no injury or origin. Continue to monitor. Notify the family, physician, and fall occurs. Immediately vention and if questions about is to be called. The team up during the daily meeting. The policy Resident Incident ded with the DON's description. EGIMEN IS FREE FROM DRUGS The gregimen must be free from and the presence of the p	F 3	23	R 10 and R 29 medication sheet was updated to include monitoring of Bp and/or BP and The care plan for R29 was updat to include risk of anticoagulation therapy. The consultant pharmacist completed and audit of all curre residents to assure monitoring was in place. An audit was completed on all residents on anticoagulation therapy to assure	P. ed	2/31/2015
	given these drugs	unless antipsychotic drug					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	COMPLETED	
		245421	B. WING			12	/03/2015
	PROVIDER OR SUPPLIER	ER		80	REET ADDRESS, CITY, STATE, ZIP CODE 5 SIXTH AVENUE NORTHWEST EW BRIGHTON, MN 55112	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	therapy is necessar as diagnosed and or record; and resident drugs receive gradus behavioral intervent contraindicated, in a drugs. This REQUIREMENT by: Based on observative review, the facility for pressures and/or puredication administ (R10, R29) and failst that included monitoranti-coagulant med residents (R29) revided medications. Findings include: R10's quarterly Min 9/15/15, indicated Find MDS included the contract of the staff to administ antihypertensive (to medications: - Atenolol 50 milligrafor hypertension. In	by to treat a specific condition locumented in the clinical ts who use antipsychotic and dose reductions, and tions, unless clinically an effort to discontinue these with the clinical to monitor blood alses as ordered prior to the tration for 2 of 5 residents and to develop a plan of care oring for side effects of an ication (Coumadin) for 1 of 5 iewed for unnecessary in the clinication (Marchael and the clinication of the clin	F3	329	the risk factors had been care planned. All care plans are reviewed in conjunction with the RAI process Medication sheets are reviewed monthly to assure proper monitoring is present. The policy and procedure for carplans has been reviewed and updated. A procedure was developed to assure medication sheet checks are reviewed for accuracy. Education was provided to staff responsible for updating the carplans and checking the medicati sheets for accuracy on 2/10 and 12/11/15. Audits will be completed on medication sheets weekly to assure proper monitoring is present and audits with all new orders for anticoagulation thera to assure potential risk factors a care planned the results reported to the facility QA committee to determine ongoing compliance. The Director of Nursing will be responsible for ongoing compliance. Date of compliance.	e on py re	
-	Atenolol for a systo 100.	lic blood pressure of less than			will be 1/12/16.		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		PLETED
		245421	B. WING	_		12/	03/2015
	PROVIDER OR SUPPLIER	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 105 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 40	F3	329			
	hypertension. Instru	1 capsule orally daily for uctions provided to hold the olic blood pressure of less	14				
	(LPN)- C was obse morning medication take R10's blood page	a.m. licensed practical nurse rved administering R10 her ns. LPN-C was not observed to ressure prior to the tenolol and Diltiazem.					
	was reviewed for 1 MAR lacked docum	dministration Record (MAR) 0/15, 11/15, and 12/15. The nentation of blood pressures dministration of Atenolol and					
	LPN-C stated she of pressure's prior to and Diltiazem, but	on 12/3/15, at 10:59 a.m. checked R10's blood administering R10's Atenolol had not been documenting the there was not a place to the MAR.					
	director of nursing the nurses to obtain pressures as order R29's annual MDS diagnoses of deme	on 12/3/15, at 3:37 p.m. the (DON) stated she expected in, document and monitor blood red by the physician. dated 10/13/15, included entia, atrial fibrillation, and received anticoagulation					
	order for Metoprolomg (milligrams) take times daily, hold fo	ders dated 11/15, identified an ol (for high blood pressure) 25 to three tablets (75 mg) two r SBP (systolic blood pressure) r HR (heart rate) < 60 and					

Facility ID: 00507

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		COMPLETED	
		245421	B. WING		12/0	03/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	Review of R29's Maidentified the medical administered. Howe MAR's lacked doculand pulses taken pulses taken pulses taken pulses risk fact potential for excess the use of Coumad During interview on registered nurse (Rorders for metoprol for 11/15, lacked dopressure and pulse In addition, RN-B vaccoumadin medication and R29's care plan and interventions for DON stated she explood pressure and administration of the physician. In additional care plan failed to interventions for the would expect R29's information. The facility policy for the facility policy for the dated 1/15, indicated to the medical care plan failed to interventions.	AR dated 11/15 and 12/15, sations were being ever, the 11/15 and 12/15 mentation of blood pressures rior to the administration of the are plan dated 12/1/15, failed ors and interventions for the sive bleeding associated with in. 12/2/15, at 3:08 p.m., the process of the blood everified R29's physician of medication and R29's MAR occumentation of the blood everified R29 was receiving ion, had a history of bruising in failed to include risk factors for the use of Coumadin.	F 3:	29		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
		245421	B. WING			12/	03/2015
	PROVIDER OR SUPPLIER	ER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 371 F 371 SS=F	The facility must - (1) Procure food froconsidered satisfact authorities; and (2) Store, prepare, under sanitary conditions. This REQUIREMENT by: Based on observative, the facility f	ROCURE, //SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food ditions NT is not met as evidenced sion, interview and document ailed to ensure food was methods: sausages were in the cooler, bread was during rotation task, and foods d in the basement freezer. If the potential to affect all 47 in the facility. Our with the facility Dietary 11/30/15, at 2:29 p.m., link	F3			en ors d ords	/31/2015
	in plastic bags, dire before putting them DS confirmed the b the floor during the	ctly on the floor of the kitchen back in the cupboard. The read was not to be placed on			×		

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM.	12/17/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245421	B WING		12/0	03/2015
NAME OF F	PROVIDER OR SUPPLIER	+		STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	IGHTON CARE CENT	ER		805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	not dated. DS state opened and the cor in order to fit into th space. DS stated hast Friday, but con- labeled and dated. 483.55(a) ROUTIN	yed in bags, but the bags were ed the original boxes were ntents put into several freezers e facility's limited freezer he knew the food had arrived firmed the bags were not	F 371			
SS=D	SERVICES IN SNF The facility must as routine and 24-hour A facility must proving resource, in accord part, routine and enteresident aroutine and emergenecessary, assist that appointments; and to and from the derivation of the derivative of the facility of the services for 1 of 3 of dental services. Findings include: R33's 10/14/15, additional aroutine and emergenecessary, assist that appointments; and to and from the derivation of the service of the facility of the services for 1 of 3 of dental services. Findings include:	sist residents in obtaining remergency dental care. de or obtain from an outside ance with §483.75(h) of this nergency dental services to each resident; may charge a an additional amount for ency dental services; must if ne resident in making by arranging for transportation dist's office; and promptly referor damaged dentures to a NT is not met as evidenced alled to provide routine dental residents (R33) reviewed for emission record identified		R 33 no longer resides at the facility. All residents are offered dental services upon admission and it is reviewed at minimally quarterly. The facility has contracted service with dental services. A new oral evaluation and policy was developed. Education for the staff responsible for completion of the MDS, oral evaluation and offering of dental services was completed on 12/10 and 12/11/15 to include new oral evaluation, updated care conference form and offering dental services upon admission.	2	
	diagnoses that inclu	uded Alzheimer's disease. mission Minimum Data Set				

Facility ID: 00507

(MDS) indicated she had severely limited

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		1PLETED
		245421	B. WING			12/	03/2015
NEW BR	PROVIDER OR SUPPLIER		10	8	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 411	cognition, and a pool indicated R33 requimobility, transfers, opersonal hygiene. Review of R33's 10/related to oral needs are present." Choice obvious or likely case. An observation on 1 revealed R33's teethoutside of the teeth, decayed. R33 had appeared to be broken an interview on 12 Practical Nurse (LPI assessments upon a determination of brokening or swallowin needed a dental referencing pain, it chewing or swallowin needed a dental referencing pain, it chewing or swallowin needed a dental referencing pain, it chewing or swallowin needed a dental referencing pain, it chewing or swallowin needed a dental referencing pain, it chewing or swallowin needed a dental referencing for the long facility. RN-B continued that which included oral admission, annual a stated she does not but gathers this information.	or appetite. The MDS red extensive assist of bed dressing, toileting and dressing and some teeth. The dressing and some teeth dressing and dressing to include dressing is a resident had dentures, and is the resident dressing issues and if the resident dressing issues and if the resident dressing is at 1:20 p.m.,	F	411	Audits will be completed weekly for 4 weeks on the completion of the oral evaluation and coding of the MDS with results reported to the facility QA committee to determine ongoing compliance. The Director of Nursing will be responsible for ongoing compliance. Date of compliance will be 1/12/16.		

PRINTED: 12/17/2015 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245421 B. WING 12/03/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER** NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 411 F 411 Continued From page 45 information that R33 had her own teeth on the bottom and couple of her own teeth on top. She did not reply when asked if the 10/21/15 MDS was accurate. During an interview and observation with LPN-A on 12/2/15, at 2:08 p.m., a 10/14/15 admission assessment note was reviewed which indicated R33 had her own teeth on the bottom, a couple of her own teeth on top and an upper partial denture. The note also indicated to provide a dental referral. A copy of this assessment and of referral information was requested but not received from the facility. R33's 11/3/15 Activities of Daily Living (ADL) care plan indicated assist of 1 staff for oral cares, which included brushing teeth in the morning and before bed. The care plan also indicated dental exams per facility protocol. R33's care plan and R33's medical record were absent of information on dental exams or the condition of R33's teeth. F 425 F 425 483.60(a),(b) PHARMACEUTICAL SVC -ACCURATE PROCEDURES, RPH SS=D Medication omission was 12/31/2015 completed and the MD contacted The facility must provide routine and emergency

drugs and biologicals to its residents, or obtain

§483.75(h) of this part. The facility may permit

A facility must provide pharmaceutical services (including procedures that assure the accurate

unlicensed personnel to administer drugs if State

them under an agreement described in

law permits, but only under the general

acquiring, receiving, dispensing, and

supervision of a licensed nurse.

for R10.

The policy and procedure for

and medication errors was

reviewed and is current.

transcription of medication orders

PRINTED: 12/17/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING_ 245421 B. WING 12/03/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER** NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 425 Continued From page 46 F 425 administering of all drugs and biologicals) to meet the needs of each resident. Education was completed for staff responsible to transcribing The facility must employ or obtain the services of medications on 12/10 and a licensed pharmacist who provides consultation 12/11/15 to include the process to on all aspects of the provision of pharmacy assure accuracy. services in the facility.

This REQUIREMENT is not met as evidenced by:

Based on interview and document review the facility failed to administer Tylenol as ordered for 1 of 5 residents (R10) reviewed for unnecessary medications.

Findings include:

R10's quarterly Minimum Data Set (MDS) dated 9/15/15, indicated R10 was cognitively intact. The MDS indicated R10 was on a scheduled pain medication regimen. R10's Admission Record included the diagnosis of osteoarthritis of the knee.

R10's care plan dated 7/2/15, indicated R10 had chronic pain related to diabetic neuropathy, osteoarthritis of the left shoulder and both knees. The care plan directed staff to administer pain medications per orders.

R10's physician orders dated 10/7/15, directed the facility to discontinue the current extra strength Tylenol order and resume the previous Tylenol order of 650 milligrams (mg) three times daily (TID) by mouth (po) for pain.

Audits will be completed weekly for 4 weeks on the accuracy of transcription of orders with results reported to the facility QA committee to determine ongoing compliance. The Director of Nursing will be responsible for

ongoing compliance. Date of compliance will be 1/12/16

F 425 F 425 Continued From page 47 R10's Medication Administration Record (MAR) for 10/15, indicated the Tylenol 1000 mg po TID was discontinued (dc'd) on 10/6/15. The new order Tylenol 650 mg po TID started and documented d/dc'd. R10 did not receive the scheduled Tylenol for the entire month of 11/15. R10's MAR for 11/15, had a line drawn through the Tylenol 650 mg po TID order and documented d/dc'd. R10 did not receive the scheduled Tylenol for 12/11/5, 12/2/15 or the a.m. dose scheduled for 12/3/15. When interviewed on 12/3/15, at 11:20 a.m. licensed practical nurse (LPN)-A verified R10 had not received the scheduled Tylenol 650 mg po TID in November and so far this month in December. LPN-A stated that the nurses are to check the MAR's before putting them in the book at the beginning of every month. LPN-A further stated that the new MAR's are compared to the previous months MAR and orders are d/c'd accordingly. LPN-A stated that the nurse checking the MAR from 10/15, to 11/15, must not have seen the hand written order on the 10/15,		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		COMPLETED		
Sos SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112			245421	B. WING		12	/03/2015		
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG FAUS Medication Administration Record (MAR) for 10/15, indicated the Tylenol 1000 mg po TID was discontinued (dc'd) on 10/6/15. The new order Tylenol 650 mg po TID started and documented on 10/7/15, through 10/31/15. R10's MAR for 11/15, had a line drawn through the Tylenol 650 mg po TID order and documented d/dc'd. R10 did not receive the scheduled Tylenol for the entire month of 11/15. R10's MAR for 12/15, had a line drawn through the Tylenol 650 mg po TID order and documented d/c'd. R10 did not receive the scheduled Tylenol for 12/11/15, 12/2/15 or the a.m. dose scheduled for 12/3/15. When interviewed on 12/3/15, at 11:20 a.m. licensed practical nurse (LPN)-A verified R10 had not received the scheduled Tylenol 650 mg po TID in November and so far this month in December. LPN-A stated that the nurses are to check the MAR's before putting them in the book at the beginning of every month. LPN-A further stated that the new MAR's are compared to the previous months MAR and orders are d/c'd accordingly. LPN-A stated that the nurse checking the MAR from 10/15, to 11/15, must not have seen the hand written order on the 10/15,			ER		805 SIXTH AVENUE NORTHWEST				
R10's Medication Administration Record (MAR) for 10/15, indicated the Tylenol 1000 mg po TID was discontinued (dc'd) on 10/6/15. The new order Tylenol 650 mg po TID started and documented on 10/7/15, through 10/31/15. R10's MAR for 11/15, had a line drawn through the Tylenol 650 mg po TID order and documented d/dc'd. R10 did not receive the scheduled Tylenol for the entire month of 11/15. R10's MAR for 12/15, had a line drawn through the Tylenol 650 mg po TID order and documented d/c'd. R10 did not receive the scheduled Tylenol for 12/11/15, 12/2/15 or the a.m. dose scheduled fylenol for 12/11/15, 12/2/15 or the a.m. dose scheduled for 12/3/15. When interviewed on 12/3/15, at 11:20 a.m. licensed practical nurse (LPN)-A verified R10 had not received the scheduled Tylenol 650 mg po TID in November and so far this month in December. LPN-A stated that the nurses are to check the MAR's before putting them in the book at the beginning of every month. LPN-A further stated that the new MAR's are compared to the previous months MAR and orders are d/c'd accordingly. LPN-A stated that the nurse checking the MAR from 10/15, to 11/15, must not have seen the hand written order on the 10/15,	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
MAR for Tylenol 650 mg po TID which started 10/7/15. LPN-A stated the process continued on through the 12/15, MAR. LPN-A filled out a medication error report at the time the error was reported and telephoned R10's physician. When interviewed on 12/3/15, at 9:45 a.m. the assistant director of nursing (ADON) stated that the health unit coordinator processes incoming	F 425	R10's Medication A for 10/15, indicated was discontinued (order Tylenol 650 r documented on 10 R10's MAR for 11/1 the Tylenol 650 mg d/dc'd. R10 did not for the entire month R10's MAR for 12/1 the Tylenol 650 mg d/c'd. R10 did not for 12/1/15, 12/2/15 for 12/3/15. When interviewed licensed practical r not received the so TID in November a December. LPN-A check the MAR's bat the beginning of stated that the new previous months Maccordingly. LPN-A checking the MAR have seen the han MAR for Tylenol 65 10/7/15. LPN-A stathrough the 12/15, medication error rereported and telept. When interviewed assistant director of the state of the stat	administration Record (MAR) I the Tylenol 1000 mg po TID dc'd) on 10/6/15. The new mg po TID started and (7/15, through 10/31/15. 15, had a line drawn through po TID order and documented receive the scheduled Tylenol nof 11/15. 15, had a line drawn through po TID order and documented receive the scheduled Tylenol or the a.m. dose scheduled or the a.m. dose scheduled or the a.m. dose scheduled on 12/3/15, at 11:20 a.m. nurse (LPN)-A verified R10 had sheduled Tylenol 650 mg po and so far this month in stated that the nurses are to refore putting them in the book every month. LPN-A further MAR's are compared to the MAR and orders are d/c'd a stated that the nurse from 10/15, to 11/15, must not d written order on the 10/15, 50 mg po TID which started at the process continued on MAR. LPN-A filled out a port at the time the error was shoned R10's physician.		125	78			

PRINTED: 12/17/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A BUILDING B. WING 12/03/2015 245421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 805 SIXTH AVENUE NORTHWEST **NEW BRIGHTON CARE CENTER** NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 425 F 425 Continued From page 48 accuracy. The ADON further stated nurses were to check the MAR's every month for accuracy. When interviewed on 12/3/15, at 3:37 p.m. the director of nursing (DON) stated the nurses were expected to check new MAR's every month for correct orders. A policy on medication reconciliation was requested and not provided by the facility. 483.60(c) DRUG REGIMEN REVIEW, REPORT F 428 F 428 IRREGULAR, ACT ON The consulting pharmacist was SS=D made aware. The drug regimen of each resident must be reviewed at least once a month by a licensed The consulting pharmacist pharmacist. completed an audit on all resident MARs to assure proper monitoring The pharmacist must report any irregularities to the attending physician, and the director of is included. nursing, and these reports must be acted upon. The consulting pharmacist will complete a comprehensive monthly chart review. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consultant pharmacist failed to identify the facility was not monitoring blood pressures and/or pulses as ordered prior to medication administration for 2 of 5 residents (R10, R29) reviewed for

Findings include:

unnecessary medications.

R10's quarterly Minimum Data Set (MDS) dated 9/15/15, indicated R10 was cognitively intact. The

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION		E SURVEY IPLETED
		245421	B. WING	_		12/	03/2015
	(EACH DEFICIENCY	ER TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	8 1 1	STREET ADDRESS, CITY, STATE, ZIP CODE B05 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	MDS included the decision of the staff to administ antihypertensive (formedications: - Atenolol 50 milligrafor hypertension. Instance Atenolol for a systol 100. An original ord - Diltiazem 240 mg hypertension. Instru Diltiazem for a systot than 90. An original listed. The consultant phar reviews for R10 wer 7/21/15, 8/29/15. 9/11/16/15. On 12/2/15, at 7:08 (LPN)- C was obser morning medications take R10's blood preadministration of Atenomalist R10's Medication Ack was reviewed for 10 MAR lacked docume taken prior to the ad Diltiazem. When interviewed on LPN-C stated she of pressure's prior to a	liagnosis of hypertension. lers dated 10/30/15, directed er the following r decreasing blood pressure) ams (mg) 1 tablet orally daily structions provided to hold the ic blood pressure of less than er date of 6/12/15 was listed. 1 capsule orally daily for ctions provided to hold the blic blood pressure of less I order date of 6/12/15 was I macist monthly medication re conducted on 6/18/15, 16/15, 10/22/15, and a.m. licensed practical nurse wed administering R10 her s. LPN-C was not observed to essure prior to the enolol and Diltiazem. Idministration Record (MAR) /15, 11/15, and 12/15. The entation of blood pressures ministration of Atenolol and m. 12/3/15, at 10:59 a.m.	F	128	Audits will be completed weekly to assure proper monitoring is present on the MARS and the consulting pharmacist will complete a monthly audit to assure proper monitoring is present. The audits will be reported to the facility QA committee to determine ongoing compliance. The Director of Nursing and consulting pharmacis will be responsible for ongoing compliance. Date of compliance will be 1/12/16.	it .	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		SURVEY PLETED
		245421	B. WING			12/0	03/2015
	PROVIDER OR SUPPLIER	ER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		19
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	document them on When interviewed of 3:28 p.m. the constrailed to identify the blood pressures for prior to the adminis. When interviewed of director of nursing of the nurses to obtain blood pressures as R29's annual MDS diagnoses of hyper. R29's physician or corder for Metoprolopressure) 25 mg (n (75 mg) two times of blood pressure) < (rate) < 60. An original listed. Review of R29's Maidentified the medical However, the 11/15 documentation of backen prior to the action of the administration of the administration of During interview or registered nurse (R	there is not a place to the MAR. Via telephone on 12/3/15, at ultant pharmacist stated she facility was not documenting the Atenolol and Diltiazem tration of the medications. On 12/3/15, at 3:37 p.m. the (DON) stated she expected and document and monitor ordered by the physician. dated 10/13/15, included tension. Hers dated 11/15, identified an I (used to treat high blood hilligrams) take three tablets daily, hold for SBP (systolic less than) 100 or HR (heart hall order date of 7/6/15 was AR's dated 11/15 and 12/15, eation was being administered. In an I (2/15) MAR lacked lood pressures and pulses dministration of the Metoprolol. Tracist monthly medication been conducted on 11/16/15, of failed to address the lack of d pulses being completed for	F	428			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(" /		E CONSTRUCTION		iPLETED
		245421	B, WING			12/	03/2015
NAME OF I	ER		80	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH AVENUE NORTHWEST IEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 428	for 11/15, lacked do pressure and pulse During interview on consultant pharmacidentify the facility varies and pulse the administration of During interview on DON stated she explood pressure and administration of the physician. The facility policy Market and pulse the administration of the physician.	ocumentation of the blood being monitored as ordered. 12/3/2015, at 3:31 p.m., the bist (CP)-G stated she failed to was not documenting blood is for the Metoprolol prior to of the medication. 12/03/2015, at 2:23 p.m., the pected the staff to check the	F 42	28			
F 465 SS=F	physician. The facility policy C undated, indicated agreed to review phadministration recodocumentation of mocumentation of mocumentation of material agreed to review phadministration recodocumentation of mocumentation of material agreementation of material agree	onsultant Pharmacist Duties, the consultant pharmacist nysician orders and medication rds to ensure proper hedication orders and hedications to patients. AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for the public. AT is not met as evidenced tion, interview and document	F 46	35	It is the goal of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The concerns of the ice machine were immediate addressed. A professional refrigeration company was brought in the day after the survey to completely clean and sanitize the ice machine		/31/2015

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		245421	B, WING				12/03/2015	
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER				8	STREET ADDRESS, CITY, STATE, ZIP CODE 105 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 PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		(X5) COMPLETION DATE	
F 465	review, the facility facondition of the ice potential to affect al facility. Findings include: On 11/30/15, at 4:5 observation, the facobserved to have confront of the machine addition, the tray has nozzles for the ice abuild-up. On 12/1/15, at 8:49 Maintenance (M)-A H-A stated that hou front of the ice mach housekeeping does components. In an interview on 1 stated he uses lime components monthic couple of months". M-A stated, "It looks In an interview on 1 stated he contacted had ordered new parand treated with rus In an interview on 1 confirmed that hous the ice machine in the before they leave the with a disinfectant. Policies and proced	ailed to maintain the sanitary machine. This had the I 47 residents residing in the I 51 p.m., during a dining illity ice machine was rusted lime build up on the e and under the grill tray. In I 52 did lime and rust on it and the I 52 and the water had dark a.m., Housekeeper (H)-A and observed the lime and rust sekeepers wipe down the nine daily. H-A stated not clean the nozzles or I 52 and cleaned the filter "every Observing the ice machine, is pretty rough." I 52 and I 52 and I 54 p.m., M-A a refrigeration company and arts, will have the grill sanded	F 4	465	Additional training was provided to the Maintenance person by the refrigeration professional. In addition, the policies and procedures were modified and include the manufactures recommended cleaning and sanitizing procedures and time frames between sanitizing. Policies and procedures were reviewed, the monthly preventative Maintenance checklist have been modified to ensure proper documentation of the cleaning and sanitizing of the ice machine. The Maintenance Person will maintain responsibility for continued compliance with the requirement. This concern has been corrected as of Dec 21st, 2015.	ty		

PRINTED: 12/17/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PHOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245421	B, WING			12	01/2015	
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER				8	STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112	1 12/	01/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	JLD BE COMPLÉTIO		
K 000	INITIAL COMMENT	-S	ΚC	000	,			
	FIRE SAFETY							
	ALLEGATION OF CODEPARTMENT'S AND SIGNATURE AT THE PAGE OF THE CMSUSED AS VERIFICATION ON SITE REVISIT CONDUCTED TO NOURS TANTIAL COMPARTMENT OF THE PAGE OF THE PA	MPLIANCE WITH THE						
120	REGULATIONS HA ACCORDANCE WI	S BEEN ATTAINED IN TH YOUR VERIFICATION.				0.		
	Minnesota Departmetime of this survey, I was found not in subrequirements for part Medicare/Medicaid 483.70(a), Life Safer edition of National F	at 42 CFR, Subpart ty from Fire, and the 2000 ire Protection Association 11, Life Safety Code (LSC),						
	PLEASE RETURN 1 CORRECTION FOR DEFICIENCIES (K-1	R THE FIRE SAFETY			21			
	HEALTHCARE FIRE STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510	HAL DIVISION TREET, SUITE 145						
	Or by email to:				17			
AROBATORY	DIRECTORIS OR PROVIDE	BISLIPPLIER REPRESENTATIVE'S SIGN	ATLIDE	_	TITLE			

12/31/15

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
	245421			_		12/01/2015		
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER				8	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE		
K 000	DEFICIENCY MUST FOLLOWING INFO 1. A description of wato correct the deficiency. 2. The actual, or processor of the actual of t	cate.mn.us and @state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE RMATION: That has been, or will be, done ency. Proposed, completion date. Ititle of the person ection and monitoring to nce of the deficiency. Center is a 2-story building The building at 2 different building was constructed in mined to be of Type II (111) That and addition was constructed to determined to be of Type II the cause the original building the same type of liding was surveyed as 1 the phase a complete automatic to the corridors that is the partment notification in the topen to the corridors that is the partment notification. The property of the same type of the s	K	000				
K 050 SS=C		OT MET as evidenced by: FPA 101 LIFE SAFETY CODE STANDARD		50	It is the goal of the facility to		2/31/2015	
	Fire drills are held at unexpected times under				maintain compliance with all	l n		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245421	B, WING	_		12/	01/2015
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE
	The staff is familiar that drills are part of Responsibility for plassigned only to conqualified to exercise conducted between announcement may alarms. 19.7.1.2 This STANDARD is Based on review of interview,, it was deto conduct fire drills LSC (00) Section 19 could affect how staff indings include: On facility tour between 012/01/2015, based on the conducted between This deficient practice.	at least quarterly on each shift. with procedures and is aware of established routine. It is anning and conducting drills is is impetent persons who are eleadership. Where drills are 9 PM and 6 AM a coded of be used instead of audible in accordance with NFPA 101 0.7.1.2. This deficient practice of freact in the event of a fire. The een 01:00 PM and 04:00 PM are on review of available is revelled that fire drills were at the shift during the evening evening shift for 2015 were 3:30 PM and 5:00 PM. The ees was confirmed by the Director (BC) at the time of	Ko	50	requirements. Fire Drill policies have been reviewed with the Maintenance Person. All drills or all shifts are to be staggered to provide for better training of facility staff for emergencies. Staggering drills allows for better training as situations may change during the course of the shift. The Administrator has reviewed the policies with the Maintenance Person and re-trained to ensure that all fire drills on each shift are staggered at different times for each quarterly shift drill. The Administrator will maintain responsibility for the routine compliance with this requirement. This concern will be corrected by January 9th, 2016.	е	

F3421025

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

PROVIDER IDENTIFICATION NUMBER: 245421

Date Survey Completed: 12/03/2015
PLAN OF CORRECTION FOR MDH SURVEY

K 000

INITIAL COMMENTS

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, New Brighton Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standardto 1, Itis SafetyCode (LSO), Chapter 19 Existig Heath Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 65101-5146

Or by email to:

lk 000 AP PROVED The I By Tom Linhoff at 10:46 am, Jan 2, 2016 1 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION

see page 3 for signature and date

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

PROVIDER IDENTIFICATION NUMBER: 245421

Date Survey Completed: 12/03/2015
PLAN OF CORRECTION FOR MDH SURVEY

	Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us			
K 000 end	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:			
	A description of what has been, or will be, done to correct the deficiency.		-	
	2. The actual, or proposed, completion date.			
	The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.			
	New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of construction, the building was surveyed as 1 building. The building has a complete automatio fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification, the facility has a capacity of 67 and had a census of			
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under		it.	
	Miles and Addition of the Control of			
K 050 SS=C	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050	It is the goal of the facility to maintain compliance with all requirements. Fire Drill policies have been reviewed with the Maintenance Person. All drills on	12/31/2015
			all shifts are to be staggered to provide for better training of facility staff for emergencies. Staggering drills allows for better training as situations may change	

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

PROVIDER IDENTIFICATION NUMBER: 245421

Date Survey Completed: 12/03/2015
PLAN OF CORRECTION FOR MDH SURVEY

varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on review of reports, records and
interview,, it was determined that the facility failed
to conduct fire drills in accordance with NFPA 101
LSC (00) Section 19.7.1.2. This deficient practice
could affect how staff react in the event of a fire.

Findings include:

On facility tour between 01:00 PM and 04:00 PM on 012/01/2015, based on review of available documentation it was reveled that fire drills were not varied throughout the shift during the evening shift. All drills on the evening shift for 2015 were conducted between 3:30 PM and 5:00 PM. This deficient practices was confirmed by the facility Maintenance Director (BC) at the time of discovery.

during the course of the shift. The Administrator has reviewed the policies with the Maintenance Person and re-trained to ensure that all fire drills on each shift are staggered at different times for each quarterly shift drill. The Administrator will maintain responsibility for the routine compliance with this requirement. This concern will be corrected by January 9th, 2016.

Administrator Signature

131 12016

Date



Certified Mail # 7015 0640 0003 5695 5293

December 17, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5421026

Dear Mr. Chies:

The above facility was surveyed on November 30, 2015 through December 3, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 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.

New Brighton Care Center December 17, 2015 Page 2

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.

When all orders are corrected, the order form should be signed and returned to this office at:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us

Eman: chris.campben@state.mn.us

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

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 Chris Campbell at the phone number or email listed above.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

New Brighton Care Center & Senior Suites of New Brighton

805 6th Ave NW

New Brighton, Minnesota, 55112

651-633-7200

Writers direct line: 651-403-5241

January 11th, 2016

Minnesota Department of Health

Duluth Technology Building

11 East Superior Street, Suite #290

Duluth, Minnesota 55802

Atten: Chris Campbell, Unit Supervisor,

Re: Plan of Correction for Project Number: \$5421026

Dear Chris Campbell,

Enclosed is the signed State Order Form for the most recent Survey that was done at the New Brighton Care Center. If you have any questions about our Plan of Correction, please contact me. It has always been my goal and intentions for the last 42 years to remain in compliance with the rules and regulations.

Best Regards

Michael R. Chies,

New Brighton Care Center &

Senior Suites of New Brighton

RECEIVED

PRINTED: 12/17/2015 FORM APPROVED

	ota Departiment of He			IAN 1 2 2016		
AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G: MN Dept of Health	(X3) DATE COMP	SURVEY LETED
:		,		Duinth		
		00507	B. WING		12/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE		
NEW BR	IGHTON CARE CENT	L:1		NORTHWEST		
<u></u>		NEW BRI	GHTON, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****		•		
	NH LICENSING	CORRECTION ORDER			:	
	144A.10, this correct pursuant to a survey found that the deficit herein are not corrected shall be with a schedule of fit the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of the lack of compliance. The result in the assessment of the number and the result in the assessment of the number and the result in the assessment of the number and the result in the assessment of the number and the nu	ether a violation has been				
	that may result from orders provided that the Department with	pearing on any assessments non-compliance with these a written request is made to in 15 days of receipt of a t for non-compliance.				
	2015, surveyors of the above provider a orders are issued. V completed, please sithese orders and reti	S: 015, through December 3, nis Department's staff, visited nd the following correction When corrections are gn and date, make a copy of urn the original to the ent of Health, Division of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned to Minnesota state statutes/rules for N Homes.	0	į

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

H29U11

Administrator

(X6) DATE

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7445 1 2744 0	N CONNECTION	BENTI TO THOU NO BENT	A. BUILDING: _		COMIT LETED
		00507	B. WING		12/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
NEW BRIG	HTON CARE CENTER		AVENUE NOR HTON, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule When a rule contains	ther a violation has been mpliance with all ule provided at the tag number indicated below. several items, failure to			
	lack of compliance. L re-inspection with any result in the assessment	e items will be considered ack of compliance upon them of multi-part rule will ent of a fine even if the item and the initial inspection was			
	that may result from norders provided that a	earing on any assessments con-compliance with these written request is made to 15 days of receipt of a for non-compliance.			
	2015, surveyors of thi the above provider an orders are issued. W completed, please sig these orders and retu	15, through December 3, s Department's staff, visited d the following correction hen corrections are in and date, make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			/		
		00507	B. WING		12/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
NEW BRIG	HTON CARE CENTER		AVENUE NOR HTON, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Compliance Monitorin	ng, Licensing and ; 11 East Superior Street,	2 000	The assigned tag number appears in far left column entitled "ID Prefix Tag. The state statute/rule number and the corresponding text of the state statute 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 whare in violation of the state statute after statement, "This Rule is not met as evidenced by." Following the surveyofindings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR SUB	" /rule iich er the ors G OF
2 535	MN Rule 4658.0300 S Restraints	Subp. 5 A-D Use of	2 535		
	resident placed in a p home must also: A. develop a syst restrained resident is specified in the writte B. assist the resident	etraints. At a minimum, for a hysical restraint, a nursing tem to ensure that the monitored at the interval order from the physician; dent as often as necessary ty, comfort, exercise, and			

Minnesota Department of Health

STATE FORM 6899 H29U11 If continuation sheet 2 of 52

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
		00507	B WING		40/0	
		00507	D. WING		12/0	3/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
NEW BRIG	GHTON CARE CENTER		H AVENUE NOR' GHTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE) BE	(X5) COMPLETE DATE
2 535	exercise, and eliminal minutes during each the restraint is employed; D. release the restraint is employed; D. release the restraint is employed; D. release the restraint is employed. This MN Requirement by: Based on interview and facility failed to comprostain a physician's of self-release alarmed is (R65) reviewed for accomplete and the self-release alarmed is (R65) reviewed for accomplete and the self-release included Alzheimer's. In additional admission, no physical cognitive impairment. R65's care plan, date prior to admission and risk for falls related to impulsiveness. The call intervention of a self-release and the self-release alarmed is sel	cortunity for motion, tion for not less than ten wo-hour period in which a and ident from the restraint as It is not met as evidenced and document review the rehensively assess and order for the use of a seat belt for 1 of 3 residents cidents. In Data Set (MDS) dated 65 was admitted on 10/5/15, ing hip fracture and on, R65 had one fall since all restraints and severe Ind 10/29/15, indicated a fall of at facility, remained a high Alzheimer's, and are plan identified the release alarmed seat belt in aff of self- transfer attempts. The progress notes, dated eaty belt engaged and fit/use include an assessment and	2 535			
		r the use of a self-release				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			551251110.		
		00507	B. WING		12/03/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
NEW BRIG	HTON CARE CENTER		H AVENUE NOR		
			GHTON, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 535	Continued From page	e 3	2 535		
	facility consultant (C)- failed to include an as self-release alarmed wheelchair.	2/3/15, at 12:19 p.m., the -L verified R65's record ssessment for the use of a seat belt on R65's 2/03/2015, at 12:19 p.m.,			
	the assistant director	of nursing (ADON)-C stated r the use of a self-release			
	the director of nursing in R65's care plan dar multi-disciplinary notes stated she did not remself-release alarmed wheelchair. The DON to include a physician self-release alarmed wheelchair. The DON be notified right away alarmed seat belt had wheelchair. The DON should have been do self-release alarmed simplemented and shoeffectiveness. The DO why the self-release a placed on [R65's] who	es, dated 11/2/15. The DON member the use of a seat belt on [R65's] I verified R65's record failed it's order for the use of a seat belt on [R65's] I stated she would expect to when the self-release I been placed on [R65's] I stated an assessment me at the time the seat belt had been build have been monitored for DN stated she did not know alarmed seat belt was eelchair.			
	indicated staff was to restraint use, obtain in restraint use and obtain the restraint. SUGGESTED METH	assess resident's need for nformed consent for ain a physician's order for OD OF CORRECTION:			
	The Director of Nursin develop, review, and/	-			

Minnesota Department of Health

STATE FORM H29U11 If continuation sheet 4 of 52

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00507	B. WING		12/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
NEW BRIC	SHTON CARE CENTER		I AVENUE NOR		
			GHTON, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 535	Continued From page	e 4	2 535		
	procedures. The Director of Nursir	ysical restraints. ng or designee could te staff on the policies and			
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty-one			
2 540	MN Rule 4658.0400 S Resident Assessment	Subp. 1 & 2 Comprehensive t	2 540		
	conduct a comprehent resident's needs, which capability to perform a significant impairment nursing assessment of Minnesota Statutes, so 15, may be used as president assessment. Comprehensive reside used to develop, reviet comprehensive plant of 4658.0405. Subp. 2. Informatic comprehensive reside include at least the formatic states.	ent assessment must be ew, and revise the resident's of care as defined in part on gathered. The ent assessment must			
	B. medical status C. physical and n D. sensory and p E. nutritional stat F. special treatme	measurement; nental functional status; hysical impairments; us and requirements; ents or procedures; sychosocial status;			

Minnesota Department of Health

STATE FORM H29U11 If continuation sheet 5 of 52

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		, ,	E SURVEY PLETED
		00507	B. WING		1:	2/03/2015
NAME OF P	ROVIDER OR SUPPLIER			ZIP CODE	, 12	2/03/2013
NAME OF T	NOVIDEN ON OUT FEEL		TH AVENUE NORTH			
NEW BRI	GHTON CARE CENTER		RIGHTON, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 540	Continued From page	e 5	2 540			
	H. discharge pote I. dental condition J. activities poter K. rehabilitation p L. cognitive statu M. drug therapy; N. resident prefe This MN Requirement by: Based on observation review the facility faile	ential; n; ntial; cotential; ss; and rences. It is not met as evidenced n, interview and document ed to comprehensively 3 of 3 residents (R16, R17,				
	4/7/15, had identified	m Data Set (MDS) dated no oral concerns were Il MDS failed to identify R16 sen teeth.				
	surveyor viewed R16 full upper dentures ar gum line. R16 stated and an impression was On 12/2/15, at 10:02 nursing (ADON)-C veteeth. ADON-C stated	n 11/30/15, at 5:20 p.m., 's teeth and noted R16 had nd no teeth on the bottom she had the last tooth pulled as done for lower dentures. a.m., assistant director of erified R16 had no lower d R16 had her last tooth				
	on 11/13/15. R16's care plan date R16 had two lower te cracked and right low notes dated 8/10/15,	initiated 1/13/15, identified eth with the left lower tooth err tooth intact. R16's dental 9/10/15 and 11/13/15, tractions of teeth and on ession for dentures.				

Minnesota Department of Health

STATE FORM 6899 H29U11 If continuation sheet 6 of 52

Minnesota Department of Health

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S	
	00507	B. WING		12/0	3/2015
ROVIDER OR SUPPLIER					
SHTON CARE CENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETE DATE
Continued From page	6	2 540			
director of nursing (Didentified R16 had mix The DON verified R16 accurate. R17's annual MDS da concerns were present to identify R17 had mix On 11/30/15, at 6:01 phave some missing temissing teeth, but decomposed on 12/2/15, at 10:02 had missing teeth on lines and broken teeth R17's care plan dated cares, full upper and lone staff to clean and During interview on 1: registered nurse (RN) identified R17 had full RN-B verified R17 had full RN-B verified R17's a R17's missing and brown of the registered nurse (RN) identify R17 had miss stated she would expraccurately. Facility policy for oral,	ON) verified R16's care plan ssing and cracked teeth. S's annual MDS was not ated 1/6/15, identified no oral nt. R17's annual MDS failed issing and broken teeth. D.m., R17 was observed to be eth and R17 stated she had clined to show teeth. D.m., ADON-C verified R17 the top and bottom gum non the bottom. J. 4/23/15, identified oral lower dentures and assist of soak overnight. D.B. verified R17's care plan and purple and lower dentures. Innual MDS failed to include be be be teeth. D.J. 3/15, at 1:08 p.m., director 7's annual MDS failed to include be be teeth and leet the MDS to be filled out				
R33's 10/21/15 admis	ssion Minimum Data Set				
	COF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIER SUMMARY STI (EACH DEFICIENCY REGULATORY OR LETT) Continued From page During interview on 1: director of nursing (Duidentified R16 had minder the DON verified R16 accurate. R17's annual MDS da concerns were present to identify R17 had minder to identify R17's at 10:02 had missing teeth on lines and broken teeth R17's care plan dated cares, full upper and identified R17 had full R17's care plan dated cares, full upper and identified R17 had full R18 verified R17 had full R19 verified R17's at R17's missing and broken teeth cares in the result of the	COF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00507 ROVIDER OR SUPPLIER STREET AD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 During interview on 12/3/15, at 1:01 p.m., the director of nursing (DON) verified R16's care plan identified R16 had missing and cracked teeth. The DON verified R16's annual MDS was not accurate. R17's annual MDS dated 1/6/15, identified no oral concerns were present. R17's annual MDS failed to identify R17 had missing and broken teeth. On 11/30/15, at 6:01 p.m., R17 was observed to have some missing teeth and R17 stated she had missing teeth, but declined to show teeth. On 12/2/15, at 10:02 a.m., ADON-C verified R17 had missing teeth on the top and bottom gum lines and broken teeth on the bottom. R17's care plan dated, 4/23/15, identified oral cares, full upper and lower dentures and assist of one staff to clean and soak overnight. During interview on 12/02/15, at 2:05 p.m., registered nurse (RN)-B verified R17's care plan identified R17 had full upper and lower dentures. RN-B verified R17's annual MDS failed to include R17's missing and broken teeth. During interview on 12/3/15, at 1:08 p.m., director of nursing verified R17's annual MDS failed to identify R17 had missing and broken teeth and stated she would expect the MDS to be filled out	A BUILDING: DOSO7	Continued From page 6 2 540	TO DEFICIENCIES FORRECTION VI) PROVIDER SUPPLIER ODSO7

Minnesota Department of Health

(MDS) indicated she had severely limited

STATE FORM H29U11 If continuation sheet 7 of 52

Minnesota Department of Health

STATEMENT O AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		00507	B. WING		12/0	3/2015
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NEW BRIGH	ITON CARE CENTER		I AVENUE NOR GHTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
F to	extensive assist with presented as a chewing or swallowing assessments upon acceptation of the continued a dental reference in an interview on 12/2 assessments upon acceptation of the continued and interview on 12/2 assessments upon acceptation of broken and interview on 12/2 assessments upon acceptation of broken and interview on 12/2 assessments upon acceptation of broken and interview on 12/2 assessments were done and nursing - whichever admission work. RN-nurse (LPN)-A will officially. RN-B continued that continued that continued and are appointed as a chewing for the longular acceptance in the longular acceptance in the continued that continued that continued and are appointed as a continued that a contin	andicated R33 required bersonal hygiene. Review of no issues with oral/dental e MDS included: obvious or natural teeth. (30/15, at 6:28 p.m., to be dark in color on the nd the inside, as if decayed. If and some teeth appeared down. (2/15, at 8:40 a.m., Licensed en teeth, if a resident was a resident had dentures, grissues and if the resident ral. (2/15, at 1:20 p.m., -B stated dental en assist with MDS data term care side of the comprehensive evaluations, and dental was completed and significant changes. The comprehensive evaluation from the	2 540			

Minnesota Department of Health

STATE FORM H29U11 If continuation sheet 8 of 52

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00507	B. WING		12/03/201	5
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		805 SIXTH	AVENUE NOR	THWEST		
NEW BRIC	SHTON CARE CENTER	NEW BRIG	HTON, MN 55	112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CON	X5) IPLETE ATE
2 540	Continued From page	e 8	2 540			
	on 12/2/15, at 2:08 p. assessment note was R33 had her own teeth her own teeth on top denture. The note als dental referral. A copy referral information we received from the factors.	o indicated to provide a y of this assessment and of as requested but not ility.				
	plan indicated assist of which included brushing before bed. The care exams per facility pro R33's medical record	es of Daily Living (ADL) care of 1 staff for oral cares, ing teeth in the morning and e plan also indicated dental tocol. R33's care plan and were absent of information he condition of R33's teeth.				
	SUGGESTED METH	OD OF CORRECTION:				
	develop, review, and/ procedures to ensure are comprehensive ar physical restraints. Ec	resident MDS assessments nd include the use of ducation could be provided f and a monitoring system				
	TIME PERIOD FOR (21) Days	CORRECTION: Twenty-one				
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			
		nprehensive plan of care ersonnel involved in the				

Minnesota Department of Health

STATE FORM H29U11 If continuation sheet 9 of 52

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00507	B WING		40/00/0045	
		00507	<u> </u>		12/03/2015	
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA			
NEW BRIG	HTON CARE CENTER		AVENUE NOR 35 HTON, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 565	Continued From page	9	2 565			
	care of the resident.					
	This MN Requiremen by:	t is not met as evidenced				
	=	n, interview and document				
		ed to ensure the care plan				
		3 residents (R29) reviewed				
	for accidents.					
	Findings include:					
	R29's care plan revise	ed on 10/29/15, indicated				
		ed to diagnoses of right				
	side hemiparesis (we					
	use call light for assis	afety awareness, inability to				
	included anticipate ar					
		participate in activities,				
		nce of one to ambulate with				
		becomes restless, ensure				
	transferring, ambulati	g appropriate footwear when				
	_	cility fall protocol, physical				
	therapy to evaluate a	nd treat as ordered or as				
		ies that minimize potential				
	needs safe environme	g diversion and distraction,				
		e glare free light, a working				
		ht, the bed in low position at				
		s two as ordered, handrails				
		ms within reach. Revision of				
		/15, included staff to leave so resident is able to see				
	•	bed alarm and chair alarm				
	at all times.					
	During observation or	n 12/1/15, at 1:44, p.m., the				

Minnesota Department of Health

STATE FORM H29U11 If continuation sheet 10 of 52

Minnesota Department of Health			_		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00507	B. WING		12/03/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
NEW BRIG	SHTON CARE CENTER		I AVENUE NOR		
	-	NEW BRIG	GHTON, MN 55	112	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(/
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
2 565	Continued From page	10	2 565		
2 303	Continued From page	: 10	2 303		
		de of R29's room. R29 was			
		the bed, stood up and			
		cliner, sitting down in the			
		unded on R29's bed when			
		ord to the alarm box for			
		etached. Licensed practical			
	, ,	d into R29's room to answer			
	•	ached the cord to the alarm			
		g the cord to the alarm,			
		as non-compliant with the			
		stated R29 just recently rm was put back into place			
		5. LPN-A stated R29 tried to			
	_	ontinent and had a hard time			
		ent product. LPN-A stated			
		with the use of the call light.			
	1125 Was inconsistent	with the use of the can light.			
	During observation or	n 12/2/15 at 7:10 a.m., R29			
	•	regular socks on both feet			
		in R29's room. In addition,			
		served to be on R29's bed.			
	At 7:38 a.m., LPN-C	entered R29's room,			
	assisted R29 to stand	l and transfer from sitting on			
		walking a few steps and R29			
		9 had regular socks on feet			
	•	PN-C verified at the time she			
		with regular socks on feet,			
		229's room and there were			
		s bed. LPN-C walked out of			
		ntinued to have only regular			
	socks on both feet.				
	An incident note ident	tified on 10/29/15, R29 was			
		ner room, having slipped			
		"root cause" of the fall was			
	identified as footwear				
	identified as footweat	•			
	On 11/29/15. an incid	ent report indicated R29			
		or in her room. The "root			

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cause" of the fall was determined to be vision due

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
			P WING			
		00507	B. WING		12/0	3/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
NEW BRIG	HTON CARE CENTER		AVENUE NOR			
			HTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 565	Continued From page	: 11	2 565			
	to the light being off.					
	On 12/1/15, at 3:23 p.m., when queried regarding what fall interventions were in place for R29, nursing assistant (NA)-K stated she didn't know, as she was new.					
	what fall interventions stated staff check on R29 the call light, "bu	.m., when queried regarding s were in place for R29, NA-I R29 every 30 minutes, give t she forgets to use it" and ach. NA-I stated R29 did not				
	what fall interventions NA-J stated she had chair. R29 did not like	.m., when queried regarding s were in place for R29, an alarm on the bed and to use the call light. Staff ep the walker in reach.				
	(LPN)-C stated she had an alarm on R29's be	.m., licensed practical nurse ad implemented the use of d and chair on 11/29/15. rsing assistant care sheets s alarms.				
	•	.m., director of nursing uld expect the care plan to				
	The director of nursin train all staff to follow The DON or designed	OD OF CORRECTION: g (DON) or designee could each resident's care plan. e could then perform random residents care plan is being				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. BOILDING				
	00507		B. WING		12/03/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NEW BRIG	SHTON CARE CENTER		AVENUE NOR			
NEW BRIG		GHTON, MN 55	112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 570	Continued From page	2 12	2 570			
2 570	MN Rule 4658.0405 S Plan of Care; Revision	Subp. 4 Comprehensive n	2 570			
	care must be reviewe interdisciplinary team physician, a registere for the resident, and odisciplines as determined, to the extent praparticipation of the reguardian or chosen requarterly and within s	that includes the attending d nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, with the sident, the resident's legal epresentative at least even days of the revision of esident assessment required				
	by: Based on observation review the facility fails include interventions for 1 of 3 residents (R	t is not met as evidenced n, interview and document ed to revise the care plan to implemented related to falls (29) reviewed for accidents.				
	high risk for falls relatincontinence's, poor sinability to use call lighterventions included resident's needs, conto ambulate with walk restless, ensure the reappropriate footwear ambulating or mobiliz facility fall protocol, up physical therapy to every some suppression of the protocol of the protocol of the physical therapy to every some suppression of the protocol of the physical therapy to every some suppression of the protocol of the physical therapy to every some suppression of the protocol of the physical therapy to every suppression of the protocol of the physical therapy to every suppression of the protocol of the physical therapy to every suppression of the physical therapy the physical therapy the physical therapy the physical therapy therapy the physical therapy	safety awareness, and ht for assistance. If anticipate and meet the tact guard assistance of one her when resident becomes esident is wearing				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				B WING		
		00507	B. WING		12/0	3/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
NEW BRI	GHTON CARE CENTER		I AVENUE NOR SHTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	distraction, needs saffree of clutter/spills, a working and reachabl two as ordered, hand items within reach. During observation or was observed to have Licensed practical nuralarm was implement after a fall. The use of R29's care plan. During observation or was lying in bed and to be on R29's bed. On 12/1/15, at 3:08 p working when R29 fel implemented the use and chair. On 12/3/15, at 2:05 p stated the care plan schanges when interve implemented and the sheets should also be The facility Care Plan dated 8/10, indicated changed and updated the resident. It was to SUGGESTED METHOTHE director of nursin train all staff to follow The DON or designeed.	e providing diversion and le environment with floors dequate glare free light, a le call light, grab bars times rails on walls, and personal on 12/1/15, at 1:44, p.m., R29 e an alarm on R29's recliner. It is a considered for safety on 11/29/15, and alarm failed to be on an 12/2/15 at 7:10 a.m., R29 no grab bars were observed of an alarm on R29's bed on R29's bed on R29's are discontinued and nursing assistant care	2 570	DEFICIENCY)		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
00507		B. WING		40	/00/004 =	
		00507	B. WIIVO		12	/03/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
NEW BRIG	GHTON CARE CENTER		H AVENUE NOR GHTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 570	Continued From page	2 14	2 570			
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty One				
2 830	MN Rule 4658.0520 S Proper Nursing Care;		2 830			
	receive nursing care a custodial care, and su individual needs and the comprehensive replan of care as descr 4658.0405. A nursing of bed as much as powritten order from the	preferences as identified in esident assessment and ribed in parts 4658.0400 and phome resident must be out essible unless there is a stending physician that the in bed or the resident				
	by: Based on observation review the facility faile dialysis center in a tin laboratory results and	t is not met as evidenced n, interview and document ed to communicate with the nely manner regarding I a physician's order for diet ed49) reviewed with dialysis				
	Findings include:					
	11/16/15, identified di	mum data set (MDS) dated agnoses of renal disease, d therapeutic diet. The MDS gnitively intact.				
	During observation or	n 12/2/15, at 8:24 a.m., R49				

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00507 B. WING	12/03/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON CARE CENTER	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) NEW BRIGHTON, MN 55112 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
2 830 Continued From page 15 was delivered a breakfast tray, which contained 120 cc (cubic centimeters) of apple juice, 240 cc of hot water for tea, 240 cc of milk, yogurt, oatmeal, blueberry bake, two bacon strips and scrambled eggs. On 12/2/15, at 1:39 p.m., R49 stated she was on a diabetic diet but was unsure about the diet required for dialysis. R49 stated she watched how much she drank. R49's care plan, dated 11/25/15, indicated R49 required dialysis related to diagnosis of chronic kidney disease stage four. Interventions included dialysis three times a week, monitor labs and report to physician as needed, explain and re-enforce importance of maintaining diet as ordered, RD (registered dietician) to evaluate and make diet change recommendations and intake monitoring as ordered. R49's medication administration record (MAR) dated 11/15, indicated a regular diet and the MAR dated 12/15, identified a physician's ordered ated 11/11/15, for dialysis draw (blood draw) CBC (complete blood count) and renal panel today, send results to NBCC (New Brighton Care Center). However, R49's record failed to include a physician's order to address the diet to be provided to R49 and failed to include lab results from the ordered blood draw on 11/11/15. On 12/2/15, at 2:16 p.m., registered nurse (RN)-B veriffied R49's record failed to include lab results from the physician's order dated 11/11/15. Se also stated there was no communication from the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12/03/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA		
NEW BRIG	SHTON CARE CENTER		AVENUE NOR' HTON, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 830	Continued From page	e 16	2 830		
	dialysis center on R48 since admission. In accreding failed to includ diet to be provided to On 12/3/15, at 3:59 p (DS)-D stated upon a pink slip from the unit what diet the resident stated R49 was provided the days of dialysis a for R49.	P's status on dialysis days ddition, RN-B verified R49's e a physician's order for the R49. .m., the dietary supervisor dmission he usually got a coordinator informing him was to be provided. DS-D ded a diabetic diet and on sack lunch was being sent			
	record on 12/1/15. RE contacted the dialysis was adequate. RD-K fluid restriction at that not aware R49 had no	dietician and a diabetic diet stated R49 did not require a time. RD-K stated she was physician's order for a diet t an order from the physician			
	(DON) stated lab resulthe next day and the part the DON verified R45 documentation of condialysis center for the dialysis treatment. The expect the dialysis cedocumentation to the dialysis treatments. The cord failed to include the dialysis treatments. The cord failed to include the provided to Policies regarding obtained to the provided to the pro	days R49 had received e DON stated she would nter to provide facility regarding R49's he DON verified R49's e a physician's order for the R49. taining diet orders, obtaining unication with the dialysis			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12/0	3/2015
	ROVIDER OR SUPPLIER	805 SIXTH	RESS, CITY, STA AVENUE NOR HTON, MN 55	THWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	The director of nursin and revise policies recare with the dialysis education for respons nursing or designee of to ensure ongoing conwith the quality assura	OD OF CORRECTION: g or designee could review ated to the coordination of facility and provide ible staff. The director of ould conduct periodic audits mpliance, and review results	2 830			
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.		2 905			
	by: Based on observation review, the facility fail development of press residents (R33). Findings include: R33 was admitted wit developed pressure u addition, observations	ure ulcers for 1 of 1 hout pressure ulcers, but lcers on both heels. In				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		00507	B. WING		12	2/03/2015
	ROVIDER OR SUPPLIER	805 SIXT	DDRESS, CITY, STATE H AVENUE NORTH	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 905	diagnoses that includ hypertension, edema R33's 10/21/15 admis (MDS) indicated she cognition, a reduction a poor appetite. The lextensive assist of bed dressing, toileting and MDS indicated R33 wilcers and did not have that time. A 10/16/15 Skin Risk reposition R33 every accompanying 10/16/15 risk. The Skin Risk Evrisk for pressure ulcer to use a pressure redicushion in wheelchair R33 was occasionally staff are to provide perincontinence and appreneded. R33's heels the bed with proper firelief for heels. An 11/19/15 Skin Risk was at high risk of pressure ulcer to use a pressure redicushion in wheelchair R33 was occasionally staff are to provide perincontinence and appreneded. R33's heels the bed with proper firelief for heels. An 11/19/15 Skin Risk was at high risk of pressure and was a dark fluid firely heel measured 4 and was a dark fluid firely heel had a 2 cm by 3 and dry. The narrative cleansed, skin prep adressings applied. Bi-	ession record identified ed Alzheimer's disease, and muscle weakness. sion Minimum Data Set had severely limited in interest for activities and MDS indicated R33 required and mobility, transfers, dipersonal hygiene. The ras not at risk of pressure we any pressure ulcers at Evaluation recommended to 3 hours and as needed. An 15 Braden identified low valuation stated R33 was at rs. Recommendations were uction mattress on bed and rincontinent of bladder and rincontinent of bladder and rincontinent of bladder and rincal care after ly barrier creams as were also to be elevated off thing footwear that provided as Evaluation indicated R33 resure ulcers. The 11/19/15 restated R33 was noted on the centimeters (cm) by 3 cm illed blister and the right cm brown area, that was flat a stated both areas were	2 905			

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Minnesot	a Department of Healtr	<u>n</u>				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			_			
			B. WING			
		00507			12/0	3/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		AUX SIXTH	AVENUE NOR	THWEST		
NEW BRIG	CHTON CARE CENTER					
		NEW BRIG	HTON, MN 55	112		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
1/10	··	,	IAG	DEFICIENCY)		
			+			
2 905	Continued From page	∍ 19	2 905			
	new recommendation	a stated to turn and				
		2 hours and as needed.				
		provide perineal care after				
		rrative concluded "resident				
		d family is planning to sign				
		s oral intake was noted to be				
		ed to anticipate R33's needs				
	and provide total care					
		te directed bilateral heel lift				
	boots be worn at all ti	imes to relieve pressure.				
		ekly Wound documentation			ļ	
	. •	ated R33's had bilateral heel				
		essure acquired and first				
	noted on 11/19/15. T	he right heel wound was				
	identified as a deep ti	issue injury and the left heel				
	wound was described	d as a Stage II pressure				
	ulcer. R33's right hee	l was noted to have no			ļ	
	change on 11/23/15,	but to have improved when				
	assessed on 11/301/5	5. R33's left heel was noted				
	to not have changed	on 11/23/15, and was				
	identified as "Stable"	•				
	An 11/23/15 progress	s note described the right				
		d filled blister, dark purple				
	and mushy. The note	e described the left heel as a				
	2x3 cm dry and brown					
	,	,				
	An 11/28/15 progress	s note indicated the right heel				
		rea with eschar. The left				
		is 2 x 3 cm with thick dry				
	eschar.	o z x o om mar anon ary				
	In an interview on 12/	/1/15, at 9:47 a.m., LPN-A				
		on her heels. Licensed				
	Practical Nurse (LPN)					
		ealing Stage II ulcers, hard to				
	the touch.	saling Stage if dicers, flatd to				
	the touch.					
			1	1	,	

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During an observation on 12/2/15, at 9:44 a.m.,

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Minnesota Department of Health				(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		
AIND LEWIN (OF CONNECTION	IDENTIFICATION NOWDER.	A. BUILDING: _		COMPLETED
		00507	B. WING		12/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE	
		805 SIXT	H AVENUE NOR	THWEST	
NEW BRIG	GHTON CARE CENTER	NEW BR	RIGHTON, MN 55	112	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 905	Continued From page	e 20	2 905		
	L DN C and Trained M	Andical Assistant (TMA) A			
		Medical Assistant (TMA)-A o change the dressings on			
	the heels. LPN-C rem	-			
		the boots, R33 did not have			
		of her right foot had a red			
	mark which correlated	d to the edge of the boot's			
		ed the wound on R33's left			
	heel as necrotic (dead	,, ,,			
		. LPN-C stated the wounds			
		easured today. LPN-C			
	_	eel wound as dry, necrotic,			
	and not as spongy as	unds were observed to be			
		in color. LPN-C applied skin			
		ngs to both heels. LPN-C			
		ound the feet to prevent			
		top of the feet. LPN-C			
	-	le boots on more loosely so			
	l -	the top of R33's feet.			
		sure the boots were on			
		put a pillow under R33's neels were floated off the			
	bed.	icels were moated on the			
	Continuous observati	ons on 12/2/15 from 7:50			
		revealed R33 was lying in			
		was not repositioned from			
		ew below) until 10:20 a.m.			
		of R33's room during this			
	time, including the dre	essing changes.			
	In an interview on 12/	/2/15, at 10:09 a.m., nursing			
		ed she and a colleague			
		a.m., and NA-E repositioned			
		E stated she assumed NA-D			
		en passing breakfast trays,			
	but did not observe th	nis.			
	The state of the s	a.m., NA D stated she did			
	not reposition R33's b	ouy when oπering			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		, , ,	E SURVEY PLETED	
		00507	B. WING		1.	2/03/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE		103/2013
			H AVENUE NORTH			
NEW BRI	GHTON CARE CENTER		IGHTON, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 905		e 21 ed she readjusted the pillow lid not readjust her body.	2 905			
	NA-D and NA-E chec repositioned R33. R3 but had a small amou NA-D. Observations large reddened area	33's incontinent brief was dry int of stool, according to of R33's buttocks revealed a around the coccyx.				
	Review of the nursing assistant group sheet did not provide any guidance on when to check and change R33. It also did not provide information on the use of the blue boots.					
	R33 had the potential development. The go intact, free of redness Interventions included nursing assistants du body skin check on si read to turn/reposition. The care plan did not existing ulcers or the protect the heels. R33	al was to keep R33's skin s, blisters or discoloration. d skin checks daily by ring cares and a weekly full hower day. The care plan n R33 at least every 3 hours. indicate the presence of use of bilateral boots to 3's care plan printed on de interventions for the				
		g assistant group sheet ed no direction to staff about oots or repositioning				
	The Director of Nursii develop, review, and/ procedures to ensure	or revise policies and all residents are g to their plan of care.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12/0	3/2015
	ROVIDER OR SUPPLIER	STREET ADD 805 SIXTH	DRESS, CITY, STA AVENUE NOR SHTON, MN 55	THWEST	1 1270	0/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 905	systems to ensure on	priate staff on the nd could develop monitoring	2 905			
21095	Storage of Nonperish Subp. 4. Storage of r Containers of nonperi a minimum of six inch manner that protects other contamination, cleaning of the storag stored on equipment pallets, provided the e and constructed to all Nonperishable food a nonperishable food m exposed or unprotect	nonperishable food. ishable food must be stored hes above the floor in a the food from splash and and that permits easy ge area. Containers may be such as dollies, racks, or equipment is easily movable ow for easy cleaning. Ind containers of hust not be stored under ed sewer lines or similar ontamination. The storage d in toilet rooms or	21095			
	by: Based on observation review, the facility fail handled in sanitary methawing uncovered in placed on the floor duwere stored undated. These practices had residents residing in the Findings include:	t is not met as evidenced n, interview and document ed to ensure food was ethods: sausages were the cooler, bread was uring rotation task, and foods in the basement freezer. the potential to affect all 47 he facility. with the facility Dietary				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	· '	E SURVEY PLETED
		00507	B. WING		12	2/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE		
NEW BRIG	GHTON CARE CENTER		TH AVENUE NOR [*] RIGHTON, MN 55 ²			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21095	sausages were obser refrigerator thawing under policies observed in the task of the older loaves of briting the back). Whe put the loaves of briting the back of the put the loaves of briting the back of the put the loaves of briting the back of the put the loaves of briting the back of the put the floor during the roll of the basement freed chicken was observed not dated. DS stated opened and the content order to fit into the space. DS stated he last Friday, but confining the dietary director of storage policies and provide education to a develop a monitoring compliance.	1/30/15, at 2:29 p.m., link ved in the cooks' ncovered on a sheet pan. Try Aide (DA)-A was of rotating breads (putting lead in the front, the newer lead in the front, the newer lead, which were packaged ly on the floor of the kitchen leack in the cupboard. The lead was not to be placed on tation task. The lead was not to be placed on tation task. The lead was not to be placed on the lead potatoes and lead in bags, but the bags were lead the original boxes were lead the original boxes were lead the lead of	21095			
21325	Subpart 1. Routine of home must provide, resource, routine den	dental services. A nursing or obtain from an outside tal services to meet the	21325			
		nt. Routine dental services nations and cleanings,				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		00507	B. WING		12/0	3/2015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
NEW BRIC	HTON CARE CENTER		I AVENUE NOR GHTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
21325	Continued From page	e 24	21325			
	fillings and crowns, ro oral surgery, bridges orthodontic procedure that are provided for s	oot canals, periodontal care, and removable dentures, es, and adjunctive services similar dental patients in the is limited by third party				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine dental services for 1 of 3 residents (R33) reviewed for dental services. Findings include: R33's 10/14/15, admission record identified diagnoses that included Alzheimer's disease. R33's 10/21/15, admission Minimum Data Set (MDS) indicated she had severely limited cognition, and a poor appetite. The MDS indicated R33 required extensive assist of bed mobility, transfers, dressing, toileting and personal hygiene.					
	are present." Choices	1/15, admission MDS indicated "none of the above on the MDS included: y or broken natural teeth.				
	outside of the teeth, a	to be dark of color on the and dark on the inside, as if eth missing and some teeth				
	In an interview on 12/2/15, at 8:40 a.m., Licensed Practical Nurse (LPN)-A stated she does dental assessments upon admission to include determination of broken teeth, if a resident is experiencing pain, if a resident had dentures,					

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, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		, ,	E SURVEY PLETED
		00507	B. WING		12	2/03/2015
	ROVIDER OR SUPPLIER	805 SIXT	DDRESS, CITY, STATE TH AVENUE NORTH	IWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21325	In an interview on 12 registered nurse (RN assessments are don and nursing-whicheve admission work. RN-nurse (LPN)-A will off gathering for the long facility. RN-B continued that which included oral a admission, annual an stated she does not obut gathers this information that R33 bottom and couple of did not reply when as was accurate. During an interview a on 12/2/15, at 2:08 p. assessment note was R33 had her own teether own teeth	g issues and if the resident ral. (2/15, at 1:20 p.m.,)-B stated dental re by the dietary manager er nurse is completing respectively. Be stated licensed practical renassist with MDS data remarks are side of the comprehensive evaluations, and dental is completed upon disignificant changes. RN-B to the dental examinations, mation from the admitting RN-B stated she had had her own teeth on the her own teeth on top. She sked if the 10/21/15 MDS and observation with LPN-A m., a 10/14/15 admission is reviewed which indicated the onthe bottom, a couple of and an upper partial representation indicated to provide a requested but not illity. The ses of Daily Living (ADL) care of 1 staff for oral cares, ing teeth in the morning and replan also indicated dental	21325			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
		00507	B. WING		12	/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
NEW BRIG	GHTON CARE CENTER		H AVENUE NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21325	condition of R33's tee SUGGESTED METH Suggested Method of nursing or designee of ensure residents rece Facility staff could be The director of nursin monitoring systems to compliance.	on dental exams or the eth. OD OF CORRECTION: Correction: The director of could establish systems to eive routine dental services. educated on that system. g or designee could develop	21325			
21530	A. The drug regimer reviewed at least mor currently licensed by This review must be of Appendix N of the State Surveyor Procedures Requirements in Long the Department of He Health Care Financin This standard is inco available through the system. It is not subjustem. It is not subjustements to the diand the attending phymust be acted upon be physician visit, or soo pharmacist. For purpupon" means the accreport and the signing	A.B.C Drug Regimen Review of each resident must be anthly by a pharmacist the Board of Pharmacy. Hone in accordance with ate Operations Manual, for Pharmaceutical Service g-Term Care, published by eath and Human Services, g Administration, April 1992. In a proposed by reference. It is Minitex interlibrary loan eet to frequent change. It is must report any rector of nursing services resician, and these reports by the time of the next mer, if indicated by the oses of this part, "acted eptance or rejection of the gor initialing by the director and the attending physician.	21530			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
00507		00507				102/2045
		00507	D. WIITO		12	2/03/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
NEW BRIC	HTON CARE CENTER		1 AVENUE NOR GHTON, MN 55			
OUR MARY OTATEMENT OF RESIDENCES					CORRECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From page	27	21530			
	C. If the attending with the pharmacist's not provide adequate pharmacist believes t being adversely affect refer the matter to the if the medical director physician. If the med the attending physicia justification for the ord physician does not characteristic physician does no	g physician does not concur recommendation, or does justification, and the he resident's quality of life is ted, the pharmacist must e medical director for review is not the attending ical director determines that an does not have adequate der and if the attending lange the order, the matter eview to the quality urance committee required the attending physician is the consulting pharmacist directly to the quality				
	by: Based on interview and consultant pharmacis was not monitoring blues as ordered prior to me 2 of 5 residents (R10, unnecessary medicate) Findings include: R10's quarterly Minim 9/15/15, indicated R1 MDS included the diate R10's physician order the staff to administer antihypertensive (for emedications:	num Data Set (MDS) dated 0 was cognitively intact. The gnosis of hypertension. rs dated 10/30/15, directed the following decreasing blood pressure)				
	medications:	ns (mg) 1 tablet orally daily				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		00507	B. WING		12/03/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NEW DDI	0.110N 04DE 0ENTED	805 SIXTH	AVENUE NOR	THWEST		
NEW BRIG	GHTON CARE CENTER	NEW BRIG	HTON, MN 55	112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
21530	Continued From page	28	21530			
	for hypertension. Instruction Atenolol for a systolic 100. An original order - Diltiazem 240 mg 1 hypertension. Instruct Diltiazem for a systoli	ructions provided to hold the blood pressure of less than date of 6/12/15 was listed. capsule orally daily for tions provided to hold the c blood pressure of less order date of 6/12/15 was				
		nacist monthly medication conducted on 6/18/15, 6/15, 10/22/15, and				
	On 12/2/15, at 7:08 a.m. licensed practical nurse (LPN)- C was observed administering R10 her morning medications. LPN-C was not observed to take R10's blood pressure prior to the administration of Atenolol and Diltiazem.					
	R10's Medication Administration Record (MAR) was reviewed for 10/15, 11/15, and 12/15. The MAR lacked documentation of blood pressures taken prior to the administration of Atenolol and Diltiazem.					
	LPN-C stated she che pressure's prior to add	ministering R10's Atenolol s not been documenting the ere is not a place to				
	When interviewed via telephone on 12/3/15, at 3:28 p.m. the consultant pharmacist stated she failed to identify the facility was not documenting blood pressures for the Atenolol and Diltiazem prior to the administration of the medications.					

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TATE FORM 6899 H29U11 If continuation sheet 29 of 52

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING:			
		00507	B. WING		12/0	3/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NEW BRIC	SHTON CARE CENTER		AVENUE NOR HTON, MN 55			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
21530	Continued From page	: 29	21530			
	director of nursing (Do the nurses to obtain a	12/3/15, at 3:37 p.m. the ON) stated she expected and document and monitor dered by the physician.				
	R29's annual MDS da diagnoses of hyperter	ated 10/13/15, included nsion.				
	order for Metoprolol (upressure) 25 mg (milli (75 mg) two times dai blood pressure) < (les	rs dated 11/15, identified an used to treat high blood igrams) take three tablets ly, hold for SBP (systolic is than) 100 or HR (heart order date of 7/6/15 was				
	Review of R29's MAR's dated 11/15 and 12/15, identified the medication was being administered. However, the 11/15 and 12/15 MAR lacked documentation of blood pressures and pulses taken prior to the administration of the Metoprolol. The consultant pharmacist monthly medication					
	review for R29 had be however the review fa	een conducted on 11/16/15, hiled to address the lack of bulses being completed for				
	registered nurse (RN) orders for metoprolol for 11/15, lacked docu	2/2/2015, at 3:08 p.m., I-B verified R29's physician medication and R29's MAR Imentation of the blood eing monitored as ordered.				
	During interview on 12/3/2015, at 3:31 p.m., the consultant pharmacist (CP)-G stated she failed to identify the facility was not documenting blood pressure and pulses for the Metoprolol prior to the administration of the medication.					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) D			
		00507	B. WING	B. WING		2/03/2015
	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
MEW BRIC	SHION CARE CENTER	NEW BRI	GHTON, MN 551	12		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21530	During interview on 1 DON stated she expetible blood pressure and padministration of the aphysician. The facility policy Medated 1/15, indicated medications as orderaphysician. The facility policy Corundated, indicated the agreed to review physician administration record documentation of medocumentation of medocumentation of medicated the supplementation of m	2/03/2015, at 2:23 p.m., the exted the staff to check the ulse prior to the metoprolol as ordered by the dication Administration, staff would administer ed by the attending a consultant Pharmacist Duties, e consultant pharmacist sician orders and medication is to ensure proper dication orders and dications to patients. OD OF CORRECTION: ng could in-service all staff cation monitoring including	21530			
21540	done also. TIME PERIOD FOR 0 (21) days. MN Rule 4658.1315 SUsage; Monitoring Subp. 2. Monitoring. monitor each resident unnecessary drug usthome's policies and pharmacist must report	for compliance needs to be CORRECTION: Twenty-one Subp. 2 Unnecessary Drug A nursing home must t's drug regimen for age, based on the nursing	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
00507		B. WING	B. WING		12/03/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	·		
NEW BRIGHTON CARE CENTER		I AVENUE NOR GHTON, MN 55				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
adequate justification believes the resident's adversely affected, the matter to the medical medical director is not the medical director of physician does not have the order and if the atchange the order, the review to the Quality (QAA) committee require attending physician the consulting pharmated directly to the QAA. This MN Requirement by: Based on observation review, the facility fail pressures and/or puls medication administration (R10, R29) and failed that included monitorianti-coagulant medications. Findings include: R10's quarterly Minimed 9/15/15, indicated R1 MDS included the diaseted and the diaseted since the residents of the re	oncur with the nursing tion, or does not provide, and the pharmacist is quality of life is being the pharmacist must refer the director for review if the it the attending physician. If the determines that the attending ave adequate justification for ittending physician does not it matter must be referred for Assurance and Assessment uired by part 4658.0070. If an is the medical director, acist shall refer the matter it is not met as evidenced in, interview and document the document and to develop a plan of care and for side effects of an action (Coumadin) for 1 of 5 wed for unnecessary	21540				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	'
00507 B. WING			12/03/20)15		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
NEW DDI	NITON CARE CENTER	805 SIXTH	AVENUE NOR	THWEST		
NEW BRIC	SHTON CARE CENTER	NEW BRIG	HTON, MN 55	112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) OMPLETE DATE
21540	Continued From page 32		21540			
	- Atenolol 50 milligrams (mg) 1 tablet orally daily for hypertension. Instructions provided to hold the Atenolol for a systolic blood pressure of less than 100.					
	hypertension. Instruct	capsule orally daily for tions provided to hold the c blood pressure of less				
	On 12/2/15, at 7:08 a.m. licensed practical nurse (LPN)- C was observed administering R10 her morning medications. LPN-C was not observed to take R10's blood pressure prior to the administration of Atenolol and Diltiazem.					
	R10's Medication Administration Record (MAR) was reviewed for 10/15, 11/15, and 12/15. The MAR lacked documentation of blood pressures taken prior to the administration of Atenolol and Diltiazem.					
	LPN-C stated she che pressure's prior to add	ministering R10's Atenolol d not been documenting the ere was not a place to				
	director of nursing (De	12/3/15, at 3:37 p.m. the ON) stated she expected document and monitor blood by the physician.				
	diagnoses of dementi	ated 10/13/15, included a, atrial fibrillation, I received anticoagulation				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (RAD FORTICINEY) MIST BE PRECIDED BY TULL RESOLATORY OR LSD (DENTIFYING INFORMATION) 21540 Continued From page 33 R29's physician orders dated 11/15, identified an order for Meloprolol (for high blood pressure) 25 mg (milligrams) take three tablets (75 mg) two times daily, hold for SSP (systolic blood pressure) 4 (less than) 100 or HR (hear trate) < 60 and Coumadin (anticoagulant) 2 mg daily. Review of R29's MAR dated 11/15 and 12/15, identified the medications were being administered. However, the 11/15 and 12/15, identified for excessive bleeding associated with the use of Coumadin. During interview on 12/2/15, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR for 11/15, laced documentation of the blood pressure and pulse being monitored as ordered. In addition, R29's care plan failed to include risk factors and interventions for the potential for excessive bleeding associated with the use of Coumadin. During interview on 12/2/15, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR for 11/15, laced documentation of the blood pressure and pulse being monitored as ordered. In addition, RN-B verified R29 was receiving Coumadin medication, had a history of bruising and R29's care plan failed to include risk factors and interventions for the use of Coumadin. During interview on 12/03/15, at 2:23 p.m., the	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON CARE CENTER C(4) D SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) PREFEX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 21540 Continued From page 33 R29's physician orders dated 11/15, identified an order for Metoprolol (for high blood pressure) < (less than) 100 or HR (heart rate) < 80 and Couradin (anticoagulant) 2 mg daily. Review of R29's MAR dated 11/15 and 12/15, identified the medications were being administered. However, the 11/15 and 12/15, identified the medications were being administered. However, the 11/15, failed to address risk factors and interventions for the potential for excessive bleeding associated with the use of Couradin. During interview on 12/2/15, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR for 11/15, lacked documentation of the blood pressure and pulse being monitored as ordered. In addition, RN-B verified R29 was receiving Couradin medication, had a history of bruising and R29's care plan failed to include risk factors and interventions for the use of Couradin.				A. BOILDING.				
SUMMARY STATEMENT OF DEFICIENCES NEW BRIGHTON, MN 5512 PROVIDERS PLAN OF CORRECTION PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION CLARCOMBRIGHT AND THE APPROPRIATE DATE			00507	B. WING		12/	03/2015	
NEW BRIGHTON CARE CENTER NEW BRIGHTON, MN 55112 (A4)ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21540 Continued From page 33 R29's physician orders dated 11/15, identified an order for Metoprolol (for high blood pressure) 25 mg (milligrams) take three tablets (75 mg) two times daily, hold for SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 60 and Coumadin (anticoagulant) 2 mg daily. Review of R29's MAR dated 11/15 and 12/15, identified the medications were being administered. However, the 11/15 and 12/15 MARTs lacked documentation of blood pressures and pulses taken prior to the administration of the Metoprolol. In addition, R29's care plan dated 12/1/15, failed to address risk factors and interventions for the potential for excessive bleeding associated with the use of Coumadin. During interview on 12/2/15, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR for 11/15, lacked documentation of the blood pressure and pulse being monitored as ordered. In addition, RN-B verified R29 was receiving Coumadin medication, had a history of bruising and R29's care plan failed to include risk factors and interventions for the use of Coumadin.	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTION SHOULD BE	NEW BRIG	GHTON CARE CENTER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21540 Continued From page 33 R29's physician orders dated 11/15, identified an order for Metoprolol (for high blood pressure) 25 mg (milligrams) take three tablets (75 mg) two times daily, hold for SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 60 and Cournadin (anticoagulant) 2 mg daily. Review of R29's MAR dated 11/15 and 12/15, identified the medications were being administered. However, the 11/15 and 12/15 MAR's lacked documentation of blood pressures and pulses taken prior to the administration of the Metoprolol. In addition, R29's care plan dated 12/1/15, failed to address risk factors and interventions for the potential for excessive bleeding associated with the use of Coumadin. During interview on 12/2/15, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR for 11/15, lacked documentation of the blood pressure and pulse being monitored as ordered. In addition, RN-B verified R29 was receiving Cournadin medication, had a history of bruising and R29's care plan failed to include risk factors and interventions for the use of Coumadin.	(V4) ID	SLIMMARY STA				OF CORRECTION	(Y5)	
R29's physician orders dated 11/15, identified an order for Metoprolol (for high blood pressure) 25 mg (milligrams) take three tablets (75 mg) two times daily, hold for SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 60 and Coumadin (anticoagulant) 2 mg daily. Review of R29's MAR dated 11/15 and 12/15, identified the medications were being administered. However, the 11/15 and 12/15 MAR's lacked documentation of blood pressures and pulses taken prior to the administration of the Metoprolol. In addition, R29's care plan dated 12/1/15, failed to address risk factors and interventions for the potential for excessive bleeding associated with the use of Coumadin. During interview on 12/2/15, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR for 11/15, lacked documentation of the blood pressure and pulse being monitored as ordered. In addition, RN-B verified R29 was receiving Coumadin medication, had a history of bruising and R29's care plan failed to include risk factors and interventions for the use of Coumadin.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETE	
order for Metoprolol (for high blood pressure) 25 mg (milligrams) take three tablets (75 mg) two times daily, hold for SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 60 and Coumadin (anticoagulant) 2 mg daily. Review of R29's MAR dated 11/15 and 12/15, identified the medications were being administered. However, the 11/15 and 12/15 MAR's lacked documentation of blood pressures and pulses taken prior to the administration of the Metoprolol. In addition, R29's care plan dated 12/1/15, failed to address risk factors and interventions for the potential for excessive bleeding associated with the use of Coumadin. During interview on 12/2/15, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR for 11/15, lacked documentation of the blood pressure and pulse being monitored as ordered. In addition, RN-B verified R29 was receiving Coumadin medication, had a history of bruising and R29's care plan failed to include risk factors and interventions for the use of Coumadin.	21540	Continued From page	2 33	21540				
DON stated she expected the staff to check the blood pressure and pulse prior to the administration of the metoprolol as ordered by the physician. In addition, the DON verified R29's care plan failed to include risk factors and interventions for the use of Coumadin and she would expect R29's care plan included the information.	21540	R29's physician order order for Metoprolol (fing (milligrams) take to times daily, hold for Significant (less than) 100 or His Coumadin (anticoagus). Review of R29's MAR identified the medicat administered. However, MAR's lacked docume and pulses taken prior Metoprolol. In addition, R29's care to address risk factors potential for excessive the use of Coumadin. During interview on 1: registered nurse (RN) orders for metoprolol for 11/15, lacked docupressure and pulse be in addition, RN-B veri Coumadin medication and R29's care plan find interventions for the rephysician. In addition, care plan failed to incinterventions for the upould expect R29's care.	rs dated 11/15, identified an for high blood pressure) 25 three tablets (75 mg) two BP (systolic blood pressure) IR (heart rate) < 60 and lant) 2 mg daily. R dated 11/15 and 12/15, ions were being er, the 11/15 and 12/15 entation of blood pressures in to the administration of the e bleeding associated with 2/2/15, at 3:08 p.m., be verified R29's physician medication and R29's MAR umentation of the blood eing monitored as ordered. Fied R29 was receiving in, had a history of bruising ailed to include risk factors the use of Coumadin. 2/03/15, at 2:23 p.m., the ected the staff to check the ulse prior to the metoprolol as ordered by the of the DON verified R29's lude risk factors and use of Coumadin and she	21540				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12/03/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE	
NEW BRIG	SHTON CARE CENTER		H AVENUE NORT		
040.15	SHIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ONI (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21540	Continued From page 34		21540		
	administered as order physician. A SUGGESTED MET The director of nursing the policies and process monitoring. She or deeducation to all involved develop a monitoring.	HOD FOR CORRECTION: g could review and revise edures related to medication esignee could provide ed staff. The facility could system to ensure ongoing t the findings to the Qualify			
21550	(21) days.	CORRECTION: Twenty one	21550		
21550	Medications; Pharma	Subp. 1 Adminiatration of cy Serv.	21550		
	Subpart 1. Pharmacy must arrange for the particles.	services. A nursing home provision of pharmacy			
	by: Based on interview ar facility failed to admin 1 of 5 residents (R10) medications. Findings include: R10's quarterly Minim 9/15/15, indicated R10 wDS indicated R10 w	t is not met as evidenced and document review the ister Tylenol as ordered for reviewed for unnecessary um Data Set (MDS) dated 0 was cognitively intact. The as on a scheduled pain R10's Admission Record			

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00507	B. WING		1:	2/03/2015		
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE					
NEW BRIG	GHTON CARE CENTER		TH AVENUE NORTH RIGHTON, MN 5511					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
21550	Continued From pag	e 35	21550					
	included the diagnos knee.	is of osteoarthritis of the						
	chronic pain related to osteoarthritis of the le	d 7/2/15, indicated R10 had to diabetic neuropathy, eft shoulder and both knees. ed staff to administer pain ers.						
	the facility to disconti strength Tylenol orde	ers dated 10/7/15, directed inue the current extra er and resume the previous milligrams (mg) three times (po) for pain.						
	for 10/15, indicated t was discontinued (do order Tylenol 650 mg	ministration Record (MAR) he Tylenol 1000 mg po TID c'd) on 10/6/15. The new g po TID started and /15, through 10/31/15.						
	The director of nursir educate all staff resp administration to ens	HOD OF CORRECTION: and or pharmacist can consible for medicaiton cure residents received their and by the physician. Also to ce.						
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one						
21685	MN Rule 4658.1415 Housekeeping, Oper	Subp. 2 Plant ation, & Maintenance	21685					
	including walls, floors systems, and equipm continuous state of g	ant. The physical plant, s, ceilings, all furnishings, nent must be kept in a good repair and operation alth, comfort, safety, and						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00507	B. WING		12/0	3/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
NEW BRI	GHTON CARE CENTER	805 SIXTH	AVENUE NOR	THWEST		
IVEW DIG	NEW BI			112		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21685	Continued From page	2.36	21685			
21000	Continued From page 36 well-being of the residents according to a written routine maintenance and repair program.		2.000			
	by: Based on observation review, the facility fail condition of the ice m potential to affect all 4 facility. Findings include: On 11/30/15, at 4:51 observation, the facili observed to have crustront of the machine addition, the tray had nozzles for the ice an build-up. On 12/1/15, at 8:49 a Maintenance (M)-A of H-A stated that house front of the ice machin housekeeping does not components. In an interview on 12/stated he uses lime a components monthly couple of months". Of M-A stated, "It looks pure in an interview on 12/stated he contacted a had ordered new part and treated with rust in an interview on 12/confirmed that house the ice machine in the before they leave the with a disinfectant.	p.m., during a dining ty ice machine was sted lime build up on the and under the grill tray. In lime and rust on it and the d the water had dark m., Housekeeper (H)-A and baserved the lime and rust. ekeepers wipe down the ne daily. H-A stated to clean the nozzles or (1/15, at 8:49 a.m., M-A way on the ice machine and cleaned the filter "every observing the ice machine, pretty rough." (2/15, at 2:14 p.m., M-A a refrigeration company and its, will have the grill sanded				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12/03/2015	
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIR CODE	1 12/0	3/2015
			AVENUE NOR			
NEW BRIG	SHTON CARE CENTER		HTON, MN 55			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21685	Continued From page	: 37	21685			
	machine were requested but not received from the facility.					
	The Director of Nursir develop, review, and/procedures to ensure maintained in a safe, The Director of Nursir educate all appropriate procedures. The Director of Nursir develop monitoring sycompliance.	or revise policies and resident's environment is clean and sanitary manner. or or designee could the staff on the policies and				
21800	residents shall, at adrare legal rights for the stay at the facility or the treatment and mainte that these are describ written statement of the responsibilities set for case of patients adminas defined in section as tatement shall also operson 16 years old ope	Bill of Rights n about rights. Patients and hission, be told that there eir protection during their hroughout their course of nance in the community and led in an accompanying he applicable rights and the in this section. In the ted to residential programs 253C.01, the written lescribe the right of a lescribe the ri	21800			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12	2/03/2015	
NAME OF PRO	VIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	12	103/2013	
NEW BRIGH	TON CARE CENTER		HAVENUE NOR GHTON, MN 55				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
T by B fare by F R R W R to C N re p st Li H R T	peak a language other acility policies, inspectoral health authorities are written statement to patients, residents, residents with a consistent with practices Act, and second acility failed to provide esidents (R46) review a residents (R46) review and residents (R46) review and residents receiving photomassion receiving pho	rments and those who ler than English. Current ction findings of state and s, and further explanation of of rights shall be available their guardians or their es upon reasonable request rother designated staff th chapter 13, the Data ction 626.557, relating to It is not met as evidenced and document review, the le liability notices for 1 of 3 wed for liability notices and hts. Ord dated 12/3/15, indicated the facility on 9/14/15, and 24/15. While at the facility, sysical therapy services due eumonia.	21800				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00507	B. WING		12	2/03/2015
	ROVIDER OR SUPPLIER	805 SIXT	DDRESS, CITY, STATE	HWEST		
		NEW BR	IGHTON, MN 5511	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21800	Continued From page	e 39	21800			
	prior to discontinuation	e responsible party 48 hours on of Medicare coverage.				
	The director of nursin develop and impleme to ensure that resider Medicare denial and a educate all staff. The systems to ensure on					
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty one				
21830	MN St. Statute 144.69 Residents of HC Fac.	51 Subd. 10 Patients & Bill of Rights	21830			
	Subd. 10. Participat notification of family r	tion in planning treatment; nembers.				
	in the planning of thei includes the opportunity alternatives with indiv opportunity to reques care conferences, and family member or oth both. In the event that present, a family men chosen by the resider conferences. (b) If a resident who unconscious or coma communicate, the face efforts as required un either a family member.	t and participate in formal d the right to include a er chosen representative or at the resident cannot be nber or other representative nt may be included in such o enters a facility is				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00507	B. WING		40/00/0045	
		00507	B: Wiite		12/03/20	15
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		805 SIXTI	I AVENUE NOR	THWEST		
NEW BRIC	SHTON CARE CENTER		GHTON, MN 55			
	CLIMMA DV CT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
24020	0	- 10	21830			
21830	Continued From page	e 40	21030			
	an emergency that the	e resident has been				
	admitted to the facility	/. The facility shall allow the				
	family member to par	ticipate in treatment				
		acility knows or has reason				
		t has an effective advance				
		ary or knows the resident has				
		at they do not want a family				
	•	reatment planning. After				
		mber but prior to allowing a				
	family member to part	· · · · · · · · · · · · · · · · · · ·				
	•	nust make reasonable				
	efforts, consistent with					
	practice, to determine					
	•	directive relative to the				
		decisions. For purposes of				
		onable efforts" include:				
		personal effects of the				
	resident;	Dersonal effects of the				
	· ·	nedical records of the				
	resident in the posses					
	-	emergency contact or				
		cted under this section				
	•	has executed an advance				
	directive and whether					
		e resident normally goes for				
	care; and	physician to whom the				
		physician to whom the				
	resident normally goe					
		has executed an advance				
		notifies a family member or				
	•	cy contact or allows a family				
		e in treatment planning in				
		paragraph, the facility is not				
		lamages on the grounds that				
	the notification of the					
		r the participation of the				
	_	nproper or violated the				
	patient's privacy rights					
	(c) In making reaso	onable efforts to notify a	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	COMPLETED	
		00507	B. WING		12	/03/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
NEW BRIG	SHTON CARE CENTER		H AVENUE NOR				
			GHTON, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21830	Continued From page	÷ 41	21830				
	the facility shall attem members or a designal examining the person and the medical recorpossession of the facility a family memergency contact wadmission, the facility social service agency agency that the reside the facility has been unember or designate county social service enforcement agency sidentifying and notifying designated emergency service agency or locathat assists a facility subdivision is not liab damages on the grouthe family member or	ated emergency contact by all effects of the resident in the contact by all effects of the resident in the contact by all effects of the resident in the contact by the facility is unable above or designated within 24 hours after the shall notify the county or local law enforcement ent has been admitted and unable to notify a family demergency contact. The agency and local law shall assist the facility in an a family member or by contact. A county social all law enforcement agency in implementing this let to the resident for ands that the notification of emergency contact or the mily member was improper					
	by: Based on observation review, the facility fail	t is not met as evidenced i, interview and document ed to ensure frequency and ences were honored for 3 of i, R75) reviewed for					
	Findings include:						
	-	nowers a week during a ent but was only receiving					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00507	B. WING		12	2/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE	·	
NEW DDI	CUTON CARE CENTER	805 SIXT	H AVENUE NORTH	IWEST		
NEW BRI	GHTON CARE CENTER	NEW BR	IGHTON, MN 5511	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21830	Continued From page	e 42	21830			
		cord dated 12/2/15, indicated uded dementia, anxiety, shotic disorder.				
	10/23/15, indicated R able to understand of intact. R64 required t	m Data Set (MDS) dated 64 was understood, was thers and was cognitively he extensive assistance of rring, personal hygiene and				
	On 12/1/15, at 8:38 a.m. R64 stated she received a shower once a week but would like a shower twice a week. R64 stated she had not been asked how many times a week she would like a bath or shower.					
		valuation for resident 14/15, indicated R64 wanted ek.				
	revised on 8/1/15, including assistance of one state her lower body. R64 hands and upper body.	Living (ADL) care plan dicated R64 needed the ff for a weekly bath to wash was able to wash her face, ly after set up and staff was was unable to finish.				
	indicated R64's bath on Wednesday and S assistant (NA) care g	ard sheet dated 12/2/15, was scheduled for a shower Saturday. The nursing uide dated 12/1/15, was only on Wednesday.				
	sheet directed R64's Wednesday. NA-B st weekend and R64 did	.m. NA-B verified the group bath day was on ated she worked every other d not get a bath on Saturday, NA-B stated she gave R64				

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		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLE	ETED	
		00507	B. WING		12/0	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		805 SIXTH	AVENUE NOR	THWEST		
NEW BRIG	SHTON CARE CENTER	NEW BRIG	HTON, MN 55	112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21830	Continued From page	e 43	21830			
	her bath today (Wedn	esday).				
	(AS)-A verified the last for resident preference verified the assessment shower twice a week. On 12/2/15, at 2:35 p (LPN)-C checked the verified the sheet direct bath on Wednesday at stated her family ment and received a bath of Saturdays. The LPN shave been changed.	.m. licensed practical nurse Brain Board sheet and cted R64 was to receive a and Saturday. The LPN her was in R64's bed prior on Wednesdays and stated the sheet may not The LPN stated she worked and R64 only received a The LPN had never seen				
	A policy was requeste	ed and not received.				
	R14 would like the op not know if one was a	tion to take a bath, but did vailable at the facility.				
	remain in long term careplacement surgery, rehabilitation. The care R14 had limited physical stress remains the care remains	an indicated R14 wished to are through a planned knee then return to the facility for re plan continued to identify cal mobility related to thritis, weakness and pain.				
	indicated R14 was co extensive assistant w dressing and toileting R14 required limited a	num Data Set, dated 9/1/15, gnitively intact, but required ith bed mobility, transfers, The MDS further indicated assistance with personal son to physically assist with do part of the activity.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1127 27.11	or dorate of the transfer of t	IDENTIFICATION NOMBER.	A. BUILDING:		JOHN ELTEB	
		00507	B. WING		12/03/201	5
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
NEW BRIG	GHTON CARE CENTER		AVENUE NOR SHTON, MN 55			
0/0.15	STIMMADY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ANI .	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE CON	(X5) MPLETE DATE
21830	Continued From page	e 44	21830			
	indicated it was some	vity evaluation dated 3/5/15, ewhat important for R14 to b bath, shower, bed bath or				
		30/15, at 6:48 p.m., R14 wer, but would like to take a				
	stated soaking in the R14 continued she we with a book. R14 did offered a tub bath whi R14 did not know if to	1/15, at 2:41 p.m., R14 tub used to be a life joy. ould sit for hours in the tub not think she had been ile residing at the facility aking a bath at the facility as at home, but didn't even illable.				
	Assistant (NA)-A state the north hall. The baresident had to sit in itakes a long time to fi	11/15, at 2:01 p.m., Nursing ed a bath was available on ath had a swing door and the t while it fills. NA-A stated it Il and the "ladies don't like ng there undressed and				
	stated no residents or If they wanted a bath,	71/15 at 2:24 p.m., NA-F in the West hall take a bath. It they would use the bath in hall, as the one in the West ed.				
		11/15, at 10:53 a.m., NA-G ow anyone on the East or d a bath.				
	Activities Supervisor ((3/15, at 10:53 a.m., the (AS)-A stated she asked asion if they want a tub or most of the time it's a				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12	/03/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	·			
NEW BRIG	GHTON CARE CENTER		I AVENUE NOR SHTON, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21830	In an interview on 12/Assistant Director of I "believes" bath or shore resident care confere the Activities Supervis would have more anshave further information In an interview on 12/Registered Nurse (RN Supervisor (AS) is residents the frequent questions. The AS would the Health Unit Coord assistants have the irregroup sheets. RN-B shout if a resident accommodate the reductional Nurse (LPN) many care conference asked a resident's chellen active and the choice of beconferences. LPN-A shower choices are list R14's group sheet day of one staff under bat sheet did not state profor R14 or any other resident in the choice of the conferences.	casier". AS-A stated she did ofference after admission. (3/15, at 3:22 p.m., the Nursing (ADON) stated she ower choices are reviewed in nces. The ADON felt that sor and MDS Coordinator owers, as the ADON did not on on this topic. (3/15, at 3:27 p.m., N)-B stated that the Activities sponsible for asking cy and type of bath/shower ould give the information to linators and the nursing offormation available on their stated the choice between asked only on an annual at asked for one they could guest. (3/15, at 3:33 p.m., Licensed ones. LPN-A stated the facility office at admission, but the ember asking specifically afth versus shower at care stated resident bath or sted on the group sheet. (at the coordinator of the group sheet. (b) A stated she attended on the group sheet. (c) A stated on the group sheet.	21830	DET ICIENCE			
		S indicated R57 needed					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00507	B. WING		12	2/03/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	•	
NEW BRI	GHTON CARE CENTER		HAVENUE NORT GHTON, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21830	extensive assistance assistance to bathe. R75's care plan dated needed an assist of of the care plan directed cues to have resident upper body as able. If directed staff to finish to complete. The East Wing aid as 12/2/15, indicated R7 Wednesdays. When interviewed on stated she got a show would really like to had one shower a week of that R75 had never reshower a week but if be reported to the nur When interviewed on LPN-A stated the action residents for the frequency of baths from placed it on the aid as When interviewed on activity supervisor (AS resident's bathing free admission and annual annual states as the same a	to transfer and physical 1 9/23/15, indicated R75 ne person, for showering. d staff to provide set up and wash face, hands and he care care plan further what the resident is unable signment sheet dated 5's bath day was 12/1/15, at 10:35 a.m. R75 wer one time a week, but we two showers per week. m. NA-B was observed to go take her showerB stated that R75 received n Wednesdays. NA-B stated equested more than one a resident did, then it would rese on duty. 12/2/15, at 11:04 a.m. wity department assessed uency of bathing. LPN-A resing schedules the om resident requests and essignment sheets. 12/2/15, at 1:48 p.m. the S)-A stated she asked the quency preferences on	21830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00507	B. WING		12	2/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
NEW BRI	GHTON CARE CENTER		H AVENUE NORTH IGHTON, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21830	residents know they is shower a week and the enough for them. ASfrequency is not brown unless the resident in AS-A further stated is how many times a we shower and let nursing the documentation provide evidence that how often she wanted SUGGESTED METH. The administrator colon the need for self of the develop monito ongoing compliance and quality Assurance Colon.	would be scheduled for one nen asked them if that was A stated residents bathing ght up in care conferences itiated the conversation. The recorded on the MDS seek the resident wanted to g know. Due to a change in ocess, AS-A could not to R75 had ever been asked d to shower. OD OF CORRECTION: Ald in-service all employees hoice in residents choices. Tring systems to ensure and report the findings to the	21830			
21880	Residents of HC Fac Subd. 20. Grievand shall be encouraged their stay in a facility to understand and ex patients, residents, ar residents may voice of changes in policies a and others of their changes in control interference, coercior including threat of dis- grievance procedure well as addresses an Office of Health Faci	es. Patients and residents and assisted, throughout or their course of treatment,	21880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY
		00507	B. WING		12	/03/2015
	ROVIDER OR SUPPLIER	805 SIXTI	DRESS, CITY, STA	THWEST		
(X4) ID	Г	ATEMENT OF DEFICIENCIES	GHTON, MN 55	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
21880	residential program a 253C.01, every nonar facility employing more provides outpatient measurement at a minimum, sets for followed; specifies timelimits for facility responsor resident to have the advocate; requires a grievances; and providen impartial decision otherwise resolved. Or residential programs 253C.01 which are how treatment programs, a centers with section 1 health maintenance of 62D.11 is deemed to	on 307(a)(12) shall be bus place. Inpatient facility, every as defined in section cute care facility, and every re than two people that rental health services shall all grievance procedure that, rith the process to be ne limits, including time cassistance of an written response to written des for a timely decision by maker if the grievance is not Compliance by hospitals, as defined in section	21880			
	by: Based on interview all facility failed to resolv grievances in regards	to nursing, dietary, laundry partment concerns reported				
	Findings include:					
	Review of the Reside	nt Council meeting minutes				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND I AND OF CORDECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND I AND OF CORDECTION (X1) PROVIDER/SUPPLIER/CLIA				ATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMF	PLETED
		00507	B. WING		12	/03/2015
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
NEW BRIG	GHTON CARE CENTER		H AVENUE NOR			
	OUR MARRY OF		IGHTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21880	Continued From page	e 49	21880			
	revealed the following	g grievances:				
	getting ready for bed concerns for two resident cour indicated dietary concerns of salad and two change, maintenance resident bed squeake needed to be cleaned included a resident resident resident cour indicated nursing con aides and going to be were tough meat, too	epartment concern included too early, and maintenance dent's wheelchairs. Incil meeting minutes cerns included different to residents wanted a table of concerns were one and outdoor areas all up, and activities concerns equest for more music. Incil meeting minutes cerns included not enough and too early, dietary concerns				
	aides do not know ho concerns raised relate complaints, laundry c	ncil meeting minutes cerns including rude pool w to do their job, dietary ed to multiple resident food oncern related to shrinking ace concerns related to dry				
	night shift aide, dietar	cerns related to a rough y had multiple food oncerns because of missing				
	11/4/15 - resident cou identified nursing con	incil meeting minutes cerns due to requests for				

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	a Department of Healtr OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIPLE	CONSTRUCTION	(Y3) DATE 9	21 IDVEV
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00507	B. WING		12/0	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	-	
			H AVENUE NOR			
NEW BRIG	SHTON CARE CENTER	NEW BR	IGHTON, MN 55	112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21880	Continued From page	: 50	21880			
	take too long for call li with being able to go	ere not timely, overnights ight response and trouble to the bathroom on time, related to multiple fooding tables.				
	include documentatio concerns identified fro On 11/4/15, the nursir documented the conc addressed by the dire service. However, the	om 6/3/15 through 11/14/15. Ing department had Iterrary with night staff were Iterrary of nursing and social Iterrary had been Iterrary the concern had been				
	(AS)-A and the facility the resident council m through 11/4/15 failed of follow up regarding	.m., the activities supervisor consultant (C)-L verified neeting minutes from 6/3/15 to include documentation the grievances expressed e resident council meetings.				
	given a copy to each the resident concerns from 6/3/15 through 1 not received any docu	.m., AS-A stated she had department separately for expressed every month 1/4/15. AS-A stated she had umented follow up reports nents, except the nursing 1/11/4/15.				
	(DON) provided docu regarding follow up of handling and quickne DON confirmed she h had not documented	m., the director of nursing mentation dated 11/4/15, a resident concern rough as of cares at night. The lad addressed the issue, but the information until by by ded the information to the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPL	
		00507	B. WING		12/0	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NEW BRI	GHTON CARE CENTER		AVENUE NOR HTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21880	system was to forward each department after departments were to follow up to her. AS-A previous months conditions one might take long are resolved. AS-A structure concerns was address at satisfaction, but the indocumented. On 12/3/15, at 12:38 social worker (SW)-A received no grievance SW-A stated she had and he was not award grievances were deal. The undated facility Findicated resident corbe documented and fisupervisors for follow SUGGESTED METH director of nursing correquirement to address make a good faith attegrievences. Then devensure ongoing compfindings to the Quality	a.m., AS-A stated the facility d the concerns by copy to rethe monthly meeting. The return the documented a stated she did bring up the cerns at each meeting, er to get resolved, but most ated the resolution of sed as well as resident information was not. p.m., the facility temporary stated social service had es since 6/15. In addition, spoken to the administrator er of any grievance file as the with as they came up. Resident Council Bylaws incerns and suggestions shall convarded to department through. OD OF CORRECTION: The cold in-service staff on the concerns and empt to resolve the relop monitoring systems to	21880			

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