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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H29U
Facility ID: 00507

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/27/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **57** (L18)
13. Total Certified Beds **57** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE: Chris Campbell, Unit Supervisor — Date: 01/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL: Mark Meath, Enforcement Specialist — Date: 01/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/20/2016** (L33)

DETERMINATION APPROVAL

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 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

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)

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245421	A. Building B. Wing	1/27/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 01/12/2016	ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 01/12/2016	ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 01/12/2016
ID Prefix F0244 Reg. # 483.15(c)(6) LSC	Correction Completed 01/12/2016	ID Prefix F0272 Reg. # 483.20(b)(1) LSC	Correction Completed 01/12/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 01/12/2016
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 01/12/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 01/12/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 01/12/2016
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/12/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 01/12/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 01/12/2016
ID Prefix F0411 Reg. # 483.55(a) LSC	Correction Completed 01/12/2016	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 01/12/2016	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 01/12/2016

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) CC/mm	DATE 01/28/2016	SIGNATURE OF SURVEYOR 13922	DATE 01/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
245421 (Y1)	(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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 12/31/2015				

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) CC/mm	DATE 01/28/2016	SIGNATURE OF SURVEYOR 13922	DATE 01/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
12/3/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245421	A. Building 01 - MAIN BUILDING 01 B. Wing	1/12/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 01/09/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/mm	DATE 01/28/2016	SIGNATURE OF SURVEYOR 12424	DATE 01/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/1/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H29U
Facility ID: 00507

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/03/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Kathie Killoran, HFE NEII — Date: 01/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Mark Meath, Enforcement Specialist — Date: 01/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

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 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

Michael R. Chies

Administrator, New Brighton Care Center

RECEIVED
JAN 13 2016
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING ______ B. WING ______	12/03/2015

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

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F 000	INITIAL COMMENTS The facility plan of correction (POC) will serve as you 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 varification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	OK 1/13/16 E	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael K Chur [signature]
TITLE: Administrator
(X6) DATE: 12/31 2015

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

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F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156		01/12/16

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

TITLE: Administrator

(X6) DATE: ~~01/07/2016~~ 12/31/15

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and 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	F 156	The facility will continue to ensure that residents are provided proper liability and appeal rights notices upon termination of Medicare skilled services. A log was developed to track liability notices to ensure the completion. The facility follows the current requirements for issuance of liability notices. Education with the employee's responsible for issuing denials occurred on 12/10 and 12/11/15. Random audits of the log for completion of liability notices will be conducted weekly for 4weeks with results reported to the facility QA committee to determine ongoing compliance. DON will be responsible for ongoing compliance. Date of compliance will be 1/12/16.	12/31/2015

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide liability notices for 1 of 3 residents (R46) reviewed for liability notices and beneficiary appeal rights. Findings include: R46's Admission Record dated 12/3/15, indicated R46 was admitted to the facility on 9/14/15, and was discharged on 9/24/15. While at the facility, R46 was receiving physical therapy services due to weakness from pneumonia. On 9/3/15, at approximately 10:30 a.m. the Notices of Medicare Non-Coverage were requested from the facility. On 9/3/15, at 2:50 p.m. the health information technologist (HIT) stated she was not able to find evidence of R46's Liability Notices and Appeal Rights forms. The HIT stated R46's services ended on 9/24/15, and	F 156		

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

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F 156	Continued From page 3 R46 discharged from the facility the same day. The facility's undated Medicare Policy and Procedure indicated social services would notify the resident and/or the responsible party 48 hours prior to discontinuation of Medicare coverage.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess and obtain a physician's order for the use of a self-release alarmed seat belt for 1 of 3 residents (R65) reviewed for accidents. Findings include: R65's 14 day Minimum Data Set (MDS) dated 10/19/15, identified R65 was admitted on 10/5/15, with diagnoses including hip fracture and Alzheimer's. In addition, R65 had one fall since admission, no physical restraints and severe cognitive impairment. R65's care plan, dated 10/29/15, indicated a fall prior to admission and at facility, remained a high risk for falls related to Alzheimer's, and impulsiveness. The care plan identified the intervention of a self-release alarmed seat belt in wheelchair to alert staff of self- transfer attempts.	F 221	Resident R 65 no longer resides at 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 was reviewed 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.	12/31/2015

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F 221	Continued From page 4 R65's multi-disciplinary progress notes, dated 11/2/15, indicated safety belt engaged and fit/use per facilities policy. R65's record did not include an assessment and a physician's order for the use of a self-release alarmed seat belt on R65's wheelchair. During interview on 12/3/15, at 12:19 p.m., the facility consultant (C)-L verified R65's record failed to include an assessment for the use of a self-release alarmed seat belt on R65's wheelchair. During interview on 12/03/2015, at 12:19 p.m., the assistant director of nursing (ADON)-C stated she did not remember the use of a self-release alarmed seat belt on [R65's] wheelchair. During interview on 12/03/2015, at 12:19 p.m., the director of nursing (DON) verified the content in R65's care plan dated 10/29/15, and multi-disciplinary notes, dated 11/2/15. The DON stated she did not remember the use of a self-release alarmed seat belt on [R65's] wheelchair. The DON verified R65's record failed to include a physician's order for the use of a self-release alarmed seat belt on [R65's] wheelchair. The DON stated she would expect to be notified right away when the self-release alarmed seat belt had been placed on [R65's] wheelchair. The DON stated an assessment should have been done at the time the self-release alarmed seat belt had been implemented and should have been monitored for effectiveness. The DON stated she did not know why the self-release alarmed seat belt was placed on [R65's] wheelchair.	F 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 221	Continued From page 5 The undated facility policy Restraints (Physical), indicated staff was to assess resident's need for restraint use, obtain informed consent for restraint use and obtain a physician's order for the restraint.	F 221		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure frequency and type of bathing preferences were honored for 3 of 3 residents (R64, R14, R75) reviewed for choices. Findings include: R64 requested two showers a week during a preferences assessment but was only receiving one. R64's Admission Record dated 12/2/15, indicated R64's diagnoses included dementia, anxiety, depression, and psychotic disorder. The quarterly Minimum Data Set (MDS) dated 10/23/15, indicated R64 was understood, was able to understand others and was cognitively	F 242	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 ongoing compliance. Date of compliance will be 1/12/16.	12/31/2015

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F 242	Continued From page 6 intact. R64 required the extensive assistance of one staff with transferring, personal hygiene and bathing. 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. The Annual Activity Evaluation for resident preferences dated 4/14/15, indicated R64 wanted a shower twice a week. The Activities of Daily Living (ADL) care plan revised on 8/1/15, indicated R64 needed the assistance of one staff for a weekly bath to wash her lower body. R64 was able to wash her face, hands and upper body after set up and staff was to complete what she was unable to finish. The Nurses Brain Board sheet dated 12/2/15, indicated R64's bath was scheduled for a shower on Wednesday and Saturday. The nursing assistant (NA) care guide dated 12/1/15, indicated R64's bath was only on Wednesday. On 12/2/15, at 1:33 p.m. NA-B verified the group sheet directed R64's bath day was on Wednesday. NA-B stated she worked every other weekend and R64 did not get a bath on Saturday, only on Wednesday. NA-B stated she gave R64 her bath today (Wednesday). On 12/2/15, at 1:48 p.m. the activity supervisor (AS)-A verified the last Annual Activity Evaluation for resident preferences was done 4/14/15. AS-A verified the assessment indicated R64 wanted a shower twice a week.	F 242		

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F 242	Continued From page 7	F 242		

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 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 sponge bath.

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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F 242	Continued From page 8 bath and soak. In an interview on 12/1/15, at 2:41 p.m., R14 stated soaking in the tub used to be a life joy. R14 continued she would sit for hours in the tub with a book. R14 did not think she had been offered a tub bath while residing at the facility. R14 did not know if taking a bath at the facility would be as relaxing as at home, but didn't even know if a tub was available. In an interview on 12/1/15, at 2:01 p.m., Nursing Assistant (NA)-A stated a bath was available on the north hall. The bath had a swing door and the resident had to sit in it while it fills. NA-A stated it takes a long time to fill and the "ladies don't like that" as it means sitting there undressed and cold. In an interview on 12/1/15 at 2:24 p.m., NA-F stated no residents on the West hall take a bath. If they wanted a bath, they would use the bath available on the North hall, as the one in the West hall is not typically used. In an interview on 12/1/15, at 10:53 a.m., NA-G stated she did not know anyone on the East or West halls that wanted a bath. In an interview on 12/3/15, at 10:53 a.m., the Activities Supervisor (AS)-A stated she asked residents upon admission if they want a tub or shower. AS-A stated most of the time it's a shower, stating, "it's easier". AS-A stated she did 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	F 242		

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F 242	Continued From page 9 resident care conferences. The ADON felt that the Activities Supervisor and MDS Coordinator would have more answers, as the ADON did not have further information on this topic. In an interview on 12/3/15, at 3:27 p.m., Registered Nurse (RN)-B stated that the Activities Supervisor (AS) is responsible for asking residents the frequency and type of bath/shower questions. The AS would give the information to the Health Unit Coordinators and the nursing assistants have the information available on their group sheets. RN-B stated the choice between baths or a shower is asked only on an annual basis, but if a resident asked for one they could accommodate the request. In an interview on 12/3/15, at 3:33 p.m., Licensed Practical Nurse (LPN)-A stated she attended many care conferences. LPN-A stated the facility asked a resident's choice at admission, but LPN-A could not remember asking specifically about the choice of bath versus shower at care conferences. LPN-A stated resident bath or shower choices are listed on the group sheet. R14's group sheet dated 12/2/15, identified assist of one staff under bath information. The group sheet did not state preference of shower or bath for R14 or any other resident on the group sheet. R75's significant change MDS dated 11/11/15, indicated R75 had moderate cognitive impairments. The MDS indicated R57 needed extensive assistance to transfer and physical assistance to bathe. R75's care plan dated 9/23/15, indicated R75 needed an assist of one person, for showering. The care plan directed staff to provide set up and	F 242		

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F 242	Continued From page 10 cues to have resident wash face, hands and upper body as able. The care care plan further directed staff to finish what the resident is unable to complete. The East Wing aid assignment sheet dated 12/2/15, indicated R75's bath day was Wednesdays. When interviewed on 12/1/15, at 10:35 a.m. R75 stated she got a shower one time a week, but would really like to have two showers per week. On 12/2/15, at 7:39 a.m. NA-B was observed getting R75 prepared to go take her shower. When interviewed NA-B stated that R75 received one shower a week on Wednesdays. NA-B stated that R75 had never requested more than one shower a week but if a resident did, then it would be reported to the nurse on duty. When interviewed on 12/2/15, at 11:04 a.m. LPN-A stated the activity department assessed residents for the frequency of bathing. LPN-A further stated that nursing schedules the frequency of baths from resident requests and placed it on the aid assignment sheets. When interviewed on 12/2/15, at 1:48 p.m. the activity supervisor (AS)-A stated she asked the resident's bathing frequency preferences on admission and annually. She also stated residents can request more showers at any time. AS-A stated during the MDS assessment she let residents know they would be scheduled for one shower a week and then asked them if that was enough for them. AS-A stated residents bathing frequency is not brought up in care conferences unless the resident initiated the conversation.	F 242		

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	245421	A. BUILDING ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 242	Continued From page 11 AS-A further stated she recorded on the MDS how many times a week the resident wanted to shower and let nursing know. Due to a change in the documentation process, AS-A could not provide evidence that R75 had ever been asked how often she wanted to shower.	F 242		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to resolve resident council grievances in regards to nursing, dietary, laundry and maintenance department concerns reported to the facility by the resident council. Findings include: Review of the Resident Council meeting minutes revealed the following grievances: 6/3/15 - resident council meeting minutes indicated a nursing department concern included getting ready for bed too early, and maintenance concerns for two resident's wheelchairs. 7/1/15 - resident council meeting minutes indicated dietary concerns included different types of salad and two residents wanted a table	F 244	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 brought 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. Date of compliance will be 1/12/16	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 244	Continued From page 12 change, maintenance concerns were one resident bed squeaked and outdoor areas needed to be cleaned up, and activities concerns included a resident request for more music. 8/5/15 - resident council meeting minutes indicated nursing concerns included not enough aides and going to bed too early, dietary concerns were tough meat, too much fish, vegetable complaints and laundry concerns were missing pants. 9/2/15 - resident council meeting minutes identified nursing concerns including rude pool aides do not know how to do their job, dietary concerns raised related to multiple resident food complaints, laundry concern related to shrinking shirts, and maintenance concerns related to dry air. 10/7/15 - resident council meeting minutes indicated nursing concerns related to a rough night shift aide, dietary had multiple food complaints, laundry concerns because of missing laundry and maintenance concerns for heat/temperature. 11/4/15 - resident council meeting minutes identified nursing concerns due to requests for physician contacts were not timely, overnights take too long for call light response and trouble with being able to go to the bathroom on time, and dietary concerns related to multiple food complaints and rotating tables. The resident council meeting minutes failed to include documentation of follow up for the concerns identified from 6/3/15 through 11/14/15.	F 244		

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F 244	Continued From page 13 On 11/4/15, the nursing department had documented the concerns with night staff were addressed by the director of nursing and social service. However, there had been no documentation of how the concern had been addressed and resolved. On 12/2/15, at 1:36 p.m., the activities supervisor (AS)-A and the facility consultant (C)-L verified the resident council meeting minutes from 6/3/15 through 11/4/15 failed to include documentation of follow up regarding the grievances expressed by residents during the resident council meetings. On 12/3/15, at 8:45 a.m., AS-A stated she had given a copy to each department separately for the resident concerns expressed every month from 6/3/15 through 11/4/15. AS-A stated she had not received any documented follow up reports back from the departments, except the nursing department one dated 11/4/15. On 12/3/15, at 8:59 a.m., the director of nursing (DON) provided documentation dated 11/4/15, regarding follow up of a resident concern rough handling and quickness of cares at night. The DON confirmed she had addressed the issue, but had not documented the information until 12/3/15, when she provided the information to the surveyor. On 12/3/15, at 10:43 a.m., AS-A stated the facility system was to forward the concerns by copy to each department after the monthly meeting. The departments were to return the documented follow up to her. AS-A stated she did bring up the previous months concerns at each meeting, some might take longer to get resolved, but most are resolved. AS-A stated the resolution of	F 244		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 244	Continued From page 14 concerns was addressed as well as resident satisfaction, but the information was not documented. On 12/3/15, at 12:38 p.m., the facility temporary social worker (SW)-A stated social service had received no grievances since 6/15. In addition, SW-A stated she had spoken to the administrator and he was not aware of any grievance file as grievances were dealt with as they came up. The undated facility Resident Council Bylaws indicated resident concerns and suggestions shall be documented and forwarded to department supervisors for follow through.	F 244		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	R33 no longer resides at the facility. An oral assessment was completed on residents R17 and R 16. The MDS assessments were corrected to include R 17 and R 16 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.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 15 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess oral status for 3 of 3 residents (R16, R17, R33) reviewed for dental services. Findings include: R16's annual Minimum Data Set (MDS) dated 4/7/15, had identified no oral concerns were present. R16's annual MDS failed to identify R16 had missing and broken teeth. During observation on 11/30/15, at 5:20 p.m., surveyor viewed R16's teeth and noted R16 had full upper dentures and no teeth on the bottom gum line. R16 stated she had the last tooth pulled and an impression was done for lower dentures. On 12/2/15, at 10:02 a.m., assistant director of	F 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.	

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

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F 272	Continued From page 16 nursing (ADON)-C verified R16 had no lower teeth. ADON-C stated R16 had her last tooth pulled and an impression done for lower dentures on 11/13/15. R16's care plan date initiated 1/13/15, identified R16 had two lower teeth with the left lower tooth cracked and right lower tooth intact. R16's dental notes dated 8/10/15, 9/10/15 and 11/13/15, identified R16 had extractions of teeth and on 11/13/15, initial impression for dentures. 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.	F 272		

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F 272	Continued From page 17	F 272		

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 accurately.

Facility policy for oral/MDS assessment was requested, but not provided.
R33's 10/21/15 admission Minimum Data Set (MDS) indicated she had severely limited cognition. The MDS indicated R33 required extensive assist with personal hygiene. Review of R33's MDS identified no issues with oral/dental status. Choices on the MDS included: obvious or likely cavity or broken natural teeth.

An observation on 11/30/15, at 6:28 p.m., revealed R33's teeth to be dark in color on the outside of the teeth, and the inside, as if decayed. R33 had teeth missing and some teeth appeared to be broken or worn down.

In an interview on 12/2/15, at 8:40 a.m., Licensed Practical Nurse (LPN)-A stated she did dental assessments upon admission to include determination of broken teeth, if a resident was experiencing pain, if a resident had dentures, chewing or swallowing issues and if the resident needed a dental referral.

In an interview on 12/2/15, at 1:20 p.m., registered nurse (RN)-B stated dental assessments were done by the dietary manager and nursing - whichever nurse is completing the admission work. RN-B stated licensed practical nurse (LPN)-A will often assist with MDS data gathering for the long term care side of the facility.

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F 272	Continued From page 18 RN-B continued that comprehensive evaluations, which included oral and dental was completed upon admission, annual and significant changes. RN-B stated she did not do the dental examinations, but gathered this information from the admitting floor nurse or LPN-A. RN-B stated she had information that R33 had her own teeth on the bottom and couple of her own teeth on top. RN-B did not reply when directly asked if the 10/21/15 MDS was an accurate assessment of R33's oral/dental needs. During an interview and observation with LPN-A on 12/2/15, at 2:08 p.m., the 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 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	R 29 was comprehensively reassessed on 12/3/15 for falls and physical devices and care plan was updated.	12/31/2015

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F 280	Continued From page 19 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to include interventions implemented related to falls for 1 of 3 residents (R29) reviewed for accidents. 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	F 280	All residents care plans are updated with changes and reviewed following the RAI process. The policy for care plans and physical devices was reviewed and is current. Education for the staff responsible for the revision of a care plan were educated on 12/10 and 12/11/15 to include the care plan policy and revision. 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. Date of compliance will be 1/12/16.	

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F 280	Continued From page 20 potential for falls while providing diversion and distraction, needs safe environment with floors free of clutter/spills, adequate glare free light, a working and reachable call light, grab bars times two as ordered, handrails on walls, and personal items within reach. During observation on 12/1/15, at 1:44, p.m., R29 was observed to have an alarm on R29's recliner. Licensed practical nurse (LPN)-A stated the alarm was implemented for safety on 11/29/15, after a fall. The use of an alarm failed to be on R29's care plan. During observation on 12/2/15 at 7:10 a.m., R29 was lying in bed and no grab bars were observed to be on R29's bed. On 12/1/15, at 3:08 p.m., LPN-C stated she was working when R29 fell on 11/29/15, and had implemented the use of an alarm on R29's bed and chair. On 12/3/15, at 2:05 p.m., the director of nursing stated the care plan should be updated with changes when interventions are discontinued and implemented and the nursing assistant care sheets should also be updated. The facility Care Plan Policy And Procedure, dated 8/10, indicated the care plan was to be changed and updated as the care changed for the resident. It was to be current at all times.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282	R 29 was comprehensively re assessed on 12/3/15 for falls and physical devices and care plan was updated.	12/31/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 21 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1of 3 residents (R29) reviewed for accidents. Findings include: R29's care plan revised on 10/29/15, indicated high risk for falls related to diagnoses of right side hemiparesis (weakness), dementia, incontinences, poor safety awareness, inability to use call light for assistance. Interventions included anticipate and meet the resident's needs, encourage to participate in activities, 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, 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 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 at all times. During observation on 12/1/15, at 1:44, p.m., the	F 282	All residents care plans are updated with changes and reviewed following the RAI process. The policy for care plans and physical devices was reviewed and is current. Education for the staff responsible for the care of the residents was done on 12/10 and 12/11/15 to include following the care plan. Audits will be completed weekly for 4 weeks on following the care plan 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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	245421	A. BUILDING ____ B. WING ____	12/03/2015

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

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F 282	Continued From page 22	F 282		

call light was on outside of R29's room. R29 was sitting on the edge of the bed, stood up and walked over to the recliner, sitting down in the recliner. No alarm sounded on R29's bed when R29 stood up. The cord to the alarm box for R29's recliner was detached. Licensed practical nurse (LPN)-A walked into R29's room to answer the call light and reattached the cord to the alarm box. While reattaching the cord to the alarm, LPN-A stated R29 was non-compliant with the use of alarms. LPN-A stated R29 just recently had a fall and the alarm was put back into place for safety on 11/29/15. LPN-A stated R29 tried to toilet herself, was incontinent and had a hard time changing the incontinent product. LPN-A stated R29 was inconsistent with the use of the call light.

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 walked out of the room and R29 continued to have only regular socks on both feet.

An incident note identified on 10/29/15, R29 was found on the floor in her room, having slipped when getting up. The "root cause" of the fall was identified as footwear.

On 11/29/15, an incident report indicated R29 was found on the floor in her room. The "root

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	245421	A. BUILDING ______ B. WING ______	12/03/2015

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

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F 282	Continued From page 23 cause" of the fall was determined to be vision due 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. On 12/1/15, at 3:24 p.m., when queried regarding what fall interventions were in place for R29, NA-I stated staff check on R29 every 30 minutes, give R29 the call light, "but she forgets to use it" and keep walker within reach. NA-I stated R29 did not have alarms in place. On 12/1/15, at 3:27 p.m., when queried regarding what fall interventions were in place for R29, NA-J stated she had an alarm on the bed and chair. R29 did not like to use the call light. Staff check on R29 and keep the walker in reach. On 12/1/15, at 3:08 p.m., licensed practical nurse (LPN)-C stated she had implemented the use of an alarm on R29's bed and chair on 11/29/15. LPN-C verified the nursing assistant care sheets failed to include R29's alarms. On 12/3/15, at 2:05 p.m., director of nursing (DON) stated she would expect the care plan to be followed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	Resident R 49 no longer resides in the facility.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 24 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to communicate with the dialysis center in a timely manner regarding laboratory results and a physician's order for diet for 1 of 1 residents (R49) reviewed with dialysis services. Findings include: R49's admission minimum data set (MDS) dated 11/16/15, identified diagnoses of renal disease, diabetes, dialysis, and therapeutic diet. The MDS identified R49 was cognitively intact During observation on 12/2/15, at 8:24 a.m., R49 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	F 309	It is the policy of New Brighton Care Center to communicate with the dialysis center attended by its 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 on 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 will be 1/12/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 25	F 309		

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 renal diet.

Review of R49's record on 12/2/15, identified a physician's order dated 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 the lab results from the ordered blood draw on 11/11/15.

On 12/2/15, at 2:16 p.m., registered nurse (RN)-B verified R49's record failed to include lab results from the physician's order dated 11/11/15. She also stated there was no communication from the dialysis center on R49's status on dialysis days since admission. In addition, RN-B verified R49's record failed to include a physician's order for the diet to be provided to R49.

On 12/3/15, at 3:59 p.m., the dietary supervisor (DS)-D stated upon admission he usually got a pink slip from the unit coordinator informing him what diet the resident was to be provided. DS-D stated R49 was provided a diabetic diet and on the days of dialysis a sack lunch was being sent for R49.

On 12/3/15, at 4:11 p.m., the facility registered dietician (RD)-K stated she reviewed R49's record on 12/1/15. RD-K stated she had contacted the dialysis dietician and a diabetic diet

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 26 was adequate. RD-K stated R49 did not require a fluid restriction at that time. RD-K stated she was not aware R49 had no physician's order for a diet and she would expect an order from the physician to address what diet was to be provided. On 12/3/15, at 1:10 p.m., the director of nursing (DON) stated lab results should be followed up the next day and the physician should be notified. The DON verified R49's record failed to include documentation of communication from the dialysis center for the days R49 had received dialysis treatment. The DON stated she would expect the dialysis center to provide documentation to the facility regarding R49's dialysis treatments. The DON verified R49's record failed to include a physician's order for the diet to be provided to R49. Policies regarding obtaining diet orders, obtaining lab results and communication with the dialysis center were requested, but not provided.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	R 33 no longer resides at the facility. All residents with wounds that currently reside in the facility have been comprehensively re assessed and care plans revised as needed. A new ulcer checklist was initiated.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 27 Based on observation, interview and document review, the facility failed to prevent the development of pressure ulcers for 1 of 1 residents (R33). Findings include: R33 was admitted without pressure ulcers, but developed pressure ulcers on both heels. In addition, observations on 12/2/15 revealed reddened areas on R33's coccyx and the top of her right foot. R33's 10/14/15, admission record identified diagnoses that included Alzheimer's disease, hypertension, edema, and muscle weakness. R33's 10/21/15 admission Minimum Data Set (MDS) indicated she had severely limited cognition, a reduction in interest for activities and a poor appetite. The MDS indicated R33 required extensive assist of bed mobility, transfers, dressing, toileting and personal hygiene. The MDS indicated R33 was not at risk of pressure ulcers and did not have any pressure ulcers at that time. A 10/16/15 Skin Risk Evaluation recommended to reposition R33 every 3 hours and as needed. An accompanying 10/16/15 Braden identified low 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 staff are to provide perineal care after incontinence and apply barrier creams as needed. R33's heels were also to be elevated off the bed with proper fitting footwear that provided relief for heels.	F 314	All residents are comprehensively assessed for skin risk in conjunction with the RAI process and with new onset of wounds. The care plan policy, pressure ulcer policy and skin risk policy was reviewed and is current. Education for staff responsible for updating the care plan and policy for pressure ulcers and evaluation of skin risk were educated on 12/10 and 12/11/15 to include the new checklist, pressure ulcer policy and care plan policy. Audits will be completed weekly for 4 weeks on pressure ulcers and following the care plan and 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.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING ______ B. WING ______	12/03/2015

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F 314	Continued From page 28 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 11/19/15. 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 11/301/5. 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	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 29 2x3 cm dry and brown, thin eschar area. An 11/28/15 progress note indicated the right heel was a 2 x 2 cm dry area with eschar. The left heel was described as 2 x 3 cm with thick dry eschar. In an interview on 12/1/15, at 9:47 a.m., LPN-A said R33 had blisters on her heels. Licensed Practical Nurse (LPN)-A stated they were currently dry, dark, healing Stage II ulcers, hard to the touch. During an observation on 12/2/15, at 9:44 a.m., LPN-C and Trained Medical Assistant (TMA)-A entered R33's room to change the dressings on the heels. LPN-C removed the Restorative Medical boots. Under the boots, R33 did not have on socks and the top of her right foot had a red mark which correlated to the edge of the boot's strap. LPN-C described the wound on R33's left heel as necrotic (dead tissue), dry, with no drainage and spongy. LPN-C stated the wounds did not need to be measured today. LPN-C described the right heel wound as dry, necrotic, and not as spongy as the left. During the observation, both wounds were observed to be dark brown to purple in color. LPN-C applied skin prep and a dry dressings to both heels. LPN-C also added kerlex around the feet to prevent further redness to the top of the feet. LPN-C stated she put the blue boots on more loosely so they would not rub on the top of R33's feet. LPN-C checked to ensure the boots were on properly, and TMA-A put a pillow under R33's knees to ensure the heels were floated off the bed. Continuous observations on 12/2/15 from 7:50	F 314		

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F 314	Continued From page 30 a.m. until 10:20 a.m., revealed R33 was lying in bed on her back and was not repositioned from 7:30 a.m. (per interview below) until 10:20 a.m. Staff was in and out of R33's room during this time, including the dressing changes. In an interview on 12/2/15, at 10:09 a.m., nursing assistant (NA)-E stated she and a colleague dressed R33 at 6:30 a.m., and NA-E repositioned her at 7:30 a.m. NA-E stated she assumed NA-D repositioned R33 when passing breakfast trays, but did not observe this. On 12/2/15, at 10:14 a.m., NA D stated she did not reposition R33's body when offering breakfast. NA-D stated she readjusted the pillow under her head, but did not readjust her body. During an observation on 12/2/15, at 10:20 a.m., NA-D and NA-E checked, changed, and repositioned R33. R33's incontinent brief was dry but had a small amount of stool, according to NA-D. Observations of R33's buttocks revealed a large reddened area 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's 11/3/15 pressure ulcer care plan indicated R33 had the potential for pressure ulcer development. The goal was to keep R33's skin intact, free of redness, blisters or discoloration. Interventions included skin checks daily by nursing assistants during cares and a weekly full body skin check on shower day. The care plan read to turn/reposition R33 at least every 3 hours. The care plan did not indicate the presence of	F 314		

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

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	245421	A. BUILDING ____ B. WING ____	12/03/2015

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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 schedule.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess the root cause of falls, implement appropriate interventions and evaluate effectiveness of interventions for 1 of 3 residents (R29) reviewed for accidents. Findings include: R29's annual minimum data set (MDS) dated 10/13/15, identified diagnoses of dementia, one fall no injury, two falls with injury, unsteady balance during transitions and walking, limited assist of one for transfers and ambulation and walker for mobility.	F 323	R 29 was comprehensively re assessed on 12/3/15 for falls and physical devices and care plan and group sheet was updated. The IDT reviews the falls for root cause analysis. All residents are comprehensively assessed for falls in conjunction with the RAI process and care plans are updated with changes and reviewed following the RAI process. The policy for care plans and physical devices was reviewed and is current. Audits will be completed weekly for 4 weeks on following the care plan and fall risk 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 will be 1/16/15	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING ______ B. WING ______	12/03/2015

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

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F 323	Continued From page 32	F 323		

During observation on 12/1/15, at 1:44, p.m., the call light was on outside of R29's room. R29 was sitting on the edge of the bed, stood up and walked over to the recliner, sitting down in the recliner. No alarm sounded on R29's bed when R29 stood up. The cord to the alarm box for R29's recliner was detached. Licensed practical nurse (LPN)-A walked into R29's room to answer the call light and reattached the cord to the alarm box. While reattaching the cord to the alarm, LPN-A stated R29 was non-compliant with the use of alarms. LPN-A stated R29 was throwing the alarms in the garbage. LPN-A told R29 it was her choice if she did not want the alarm. R29 stated "I don't." LPN-A stated R29 just recently had a fall and the alarm was put back into place for safety on 11/29/15. LPN-A stated R29 tried to toilet herself, was incontinent and had a hard time changing the incontinent product. LPN-A stated R29 was inconsistent with the use of the call light.

During observation on 12/1/15, at 3:18 p.m., the alarm on R29's recliner was sounding and R29 was not sitting in the recliner. The alarm continued to sound until R29 sat back down in the recliner at 3:22 p.m. During the four minutes of the alarm sounding, no staff was observed to walk from the end of the hallway by the nurse's station toward R29's room. In addition, the alarm was softly sounding in the hallway, and was difficult to hear due to other noise such as televisions on, visitors talking with other residents and staff talking by the nurse's station.

During observation of the alarm sounding from R29's recliner, on 12/1/15, at 3:36 p.m., licensed practical nurse (LPN)-C verified the alarm was softly sounding and was unable to be heard near

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 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, physical therapy to evaluate and treat as ordered or as needed, adequate glare free light, a working and reachable call light, grab bars times two as ordered.

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

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F 323	Continued From page 34 the "root cause of the fall" to be "item was not within reach." Initial interventions to prevent future falls included items placed within reach and remind to use call light. In addition, progress notes identified a bed alarm was placed. No information was documented from the fall team meeting regarding this incident. On 12/3/15, at 2:05 p.m., director of nursing (DON) verified there was no follow up team meeting documentation. On 8/12/15, R29 was found on the floor in her room, with no injury. The "root cause" of the fall was identified as poor lighting, standing up quickly creating dizziness and bare feet. Initial interventions to prevent future falls included gripper socks, bed alarm and chair alarm, and keep a light on. The fall team meeting notes identified use non slip socks or shoes, anticipate needs, bed and chair alarms at all times, call light close to resident at all times, redirect or encourage to use call light and not get up. On 8/31/15, R29 was found on the floor in her room, with an abrasion to her back and hit her head on the wall. The "root cause" of the fall was identified as "slipped." Initial interventions to prevent future falls included needs to wear shoes or non-skid socks, use walker, and call for assist. No information was documented from the fall team meeting regarding this incident. On 12/3/15, at 2:05 p.m., the DON verified there was no follow up fall team meeting documentation and no new interventions had been implemented. On 9/3/15, R29 was carrying a tray in the hallway, turned quickly and fell. The fall was witnessed. There was bruising and a cut by the right eye, swollen right shoulder, bruise to her right arm,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING ______ B. WING ______	12/03/2015

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

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F 323	Continued From page 35	F 323		

and bruised right hand. There was no "root cause", no initial interventions and no fall meeting notes documented. On 12/3/15, at 2:05 p.m., the DON verified there was no documentation regarding root cause, interventions implemented and follow up team meeting.

On 9/16/15, R29 was on the floor in her room. She fell attempting to reach the television remote. She received multiple skin tears to her right arm. The "root cause" of the fall was identified to be inappropriate foot wear and items not within reach. Initial interventions to prevent future falls included re-educate about call light use, physical therapy evaluate and treat as ordered, fall alarms initiated, and frequent safety checks. The fall team meeting identified alarm initiated and remind resident to use call light for assist, however these interventions had been previously implemented and their efficacy was not addressed. On 12/3/15, at 2:05 p.m., the DON verified no new interventions had been implemented.

R29's quarterly care conference note dated 10/29/15, indicated the last fall was on 9/16/15, when a bed alarm was added however it was creating more issues as R29 was crawling to take it off.

On 10/29/15, R29 was found on the floor in her room, having slipped when getting up. R29 complained of a sore butt. The "root cause" of the fall was identified as footwear. Initial interventions included keep shoes on at all times, gripper socks, and added bed and chair alarm. The fall team meeting
identified make sure resident has appropriate footwear on at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING ______ B. WING ______	12/03/2015

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F 323	Continued From page 36	F 323		

On 11/29/15, R29 was found on the floor in her room. She had a bruise above her right eye, skin tear right arm, and she reported she hit her head. An alarm was being used at the time of the fall, but the sound was too low and staff was unable to hear the alarm. The "root cause" of the fall was determined to be vision due to the light being off. The initial interventions to prevent future falls included checking the alarm, resident encouraged to use call light, and staff to leave the lights on in the room. The fall team meeting identified staff was to leave on the light to assist with transferring so resident can see, make sure alarms in place, resident will try to disarm alarms. Although these interventions had been previously initiated, there was no evidence of review for efficacy and ongoing need.

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.

On 12/1/15, at 3:24 p.m., when queried regarding what fall interventions were in place for R29, NA-I stated staff check on R29 every 30 minutes, give R29 the call light, "but she forgets to use it" and keep walker within reach. NA-I stated R29 did not have alarms in place.

On 12/1/15, at 3:27 p.m., when queried regarding what fall interventions were in place for R29, NA-J stated she had an alarm on the bed and chair. R29 did not like to use the call light. Staff check on R29 and keep the walker in reach.

On 12/1/15, at 3:08 p.m., licensed practical nurse (LPN)-C stated she was working when R29 fell on

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F 323	Continued From page 37	F 323		

11/29/15, and had implemented the use of an alarm on R29's bed and chair. LPN-C stated R29 turns off the alarms, monkeys with them and is non-compliant. Staff encourage R29 to use the call light, but she doesn't. The alarms are pressure pad alarms for the bed and chair. LPN-C verified the nursing assistant care sheets failed to include R29's alarms. LPN-C stated the nursing assistants would have known through report the alarms were put into place for R29. LPN-A stated we use a daily shift to shift report to update staff on changes. LPN-A showed provided the report sheet from 11/29/15, and verified there was no documentation R29 had a fall and the use of alarms was implemented.

On 12/1/15, at 3:30 p.m., LPN-A stated R29's alarms were stopped on 9/21/15, but they were put back into place "this weekend." LPN-A stated the alarms had been discontinued with R29 as the alarms were causing R29 more stress and were more of a hazard to have the alarms as R29 was bending over to shut the alarms off.

On 12/3/15, at 2:05 p.m., the assistant director of nursing (ADON)-C stated the alarms were discussed and the fall team felt it was more beneficial to have the alarms in place. ADON-C verified the team had not documented the discussion.

On 12/3/15, at 2:05 p.m., director of nursing (DON) stated she would have to ask nursing why the alarm was re-implemented when they were previously identified to be a hazard. The DON stated she did not know when the alarms were stopped after the date of 10/29/15, when the alarms were to be in place due to a fall. The DON had LPN-C come into the office during interview

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F 323	Continued From page 38 and LPN-C stated she had implemented the alarms on 11/29/15. The DON stated if the sound of the alarm was not loud enough she would expect staff to replace the alarm with one that was loud enough to be heard. The DON stated she would expect the care plan to be followed. The DON stated the facility system for falls was assess the resident for injury, and take vitals/neuro's if needed. If there was an injury, notify the physician and provide first aid. Fill out the fall incident report of head trauma or no injury or injury of unknown origin. Continue to monitor per facility protocol. Notify the family, physician, and supervisor when a fall occurs. Immediately implement an intervention and if questions about what to do the DON is to be called. The team reviews for follow up during the daily meeting. The undated facility policy Resident Incident Report, corresponded with the DON's description.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329	R 10 and R 29 medication sheet was updated to include monitoring of Bp and/or BP and P. The care plan for R29 was updated to include risk of anticoagulation therapy. The consultant pharmacist completed and audit of all current residents to assure monitoring was in place. An audit was completed on all residents on anticoagulation therapy to assure	12/31/2015

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F 329	Continued From page 39 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor blood pressures and/or pulses as ordered prior to the medication administration for 2 of 5 residents (R10, R29) and failed to develop a plan of care that included monitoring for side effects of an anti-coagulant medication (Coumadin) for 1 of 5 residents (R29) reviewed for unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 9/15/15, indicated R10 was cognitively intact The MDS included the diagnosis of hypertension. R10's physician orders dated 10/30/15, directed the staff to administer the following antihypertensive (to lower blood pressure) medications: - 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.	F 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 care plans 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 care plans and checking the medication 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 therapy to assure potential risk factors are 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 will be 1/12/16.	

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F 329	Continued From page 40 - Diltiazem 240 mg 1 capsule orally daily for hypertension. Instructions provided to hold the Diltiazem for a systolic blood pressure of less than 90. 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. When interviewed on 12/3/15, at 10:59 a.m. LPN-C stated she checked R10's blood pressure's prior to administering R10's Atenolol and Diltiazem, but had not been documenting the blood pressure as there was not a place to document them on the MAR. When interviewed on 12/3/15, at 3:37 p.m. the director of nursing (DON) stated she expected the nurses to obtain, document and monitor blood pressures as ordered by the physician. R29's annual MDS dated 10/13/15, included diagnoses of dementia, atrial fibrillation, hypertension and had received anticoagulation medication. 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	F 329		

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F 329	Continued From page 41 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. During interview on 12/03/15, at 2:23 p.m., the 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. The facility policy Medication Administration, dated 1/15, indicated medications would be administered as ordered by the attending physician.	F 329		

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F 371	Continued From page 42	F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was handled in sanitary methods: sausages were thawing uncovered in the cooler, bread was placed on the floor during rotation task, and foods were stored undated in the basement freezer. These practices had the potential to affect all 47 residents residing in the facility. Findings include: During a kitchen tour with the facility Dietary Supervisor (DS) on 11/30/15, at 2:29 p.m., link sausages were observed in the cooks' refrigerator thawing uncovered on a sheet pan. During the tour, Dietary Aide (DA)-A was observed in the task of rotating breads (putting the older loaves of bread in the front, the newer loaves in the back). As DA-A performed this task, he put the loaves of bread, which were packaged in plastic bags, directly on the floor of the kitchen before putting them back in the cupboard. The DS confirmed the bread was not to be placed on the floor during the rotation task. In the basement freezer, shredded potatoes and	F 371	The facility has taken immediate corrective actions to promptly address the concerns outline in the deficiency. All staff have been re-trained in Infection Control, including the prompt labeling of all food stored in the Refrigerators and Freezers. Staff also received additional re-training in the proper handling of food in regards to infection control procedures. The daily checklist has been modified to ensure routine compliance with these requirements. The Food Service Supervisor will be responsible for the routine monitoring of these issues to ensure consistent compliance. Facility will have all concerns addressed by January 9th, 2016.	12/31/2015

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F 371	Continued From page 43 chicken was observed in bags, but the bags were not dated. DS stated the original boxes were opened and the contents put into several freezers in order to fit into the facility's limited freezer space. DS stated he knew the food had arrived last Friday, but confirmed the bags were not labeled and dated.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This 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	F 411	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 services 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.	

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F 411	Continued From page 44 cognition, and a poor appetite. The MDS indicated R33 required extensive assist of bed mobility, transfers, dressing, toileting and personal hygiene. Review of R33's 10/21/15, admission MDS related to oral needs indicated "none of the above are present." Choices on the MDS included: obvious or likely cavity or broken natural teeth. An observation on 11/30/15, at 6:28 p.m., revealed R33's teeth to be dark of color on the outside of the teeth, and dark on the inside, as if decayed. R33 had teeth missing and some teeth appeared to be broken or worn down. 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, chewing or swallowing issues and if the resident needed a dental referral. In an interview on 12/2/15, at 1:20 p.m., registered nurse (RN)-B stated dental assessments are done by the dietary manager and nursing-whichever nurse is completing admission work. RN-B stated licensed practical nurse (LPN)-A will often assist with MDS data gathering for the long term care side of the facility. RN-B continued that comprehensive evaluations, which included oral and dental is completed upon admission, annual and significant changes. RN-B stated she does not do the dental examinations, but gathers this information from the admitting floor nurse or LPN-A. RN-B stated she had	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.	

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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 411		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	Medication omission was completed and the MD contacted for R10. The policy and procedure for transcription of medication orders and medication errors was reviewed and is current.	12/31/2015

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F 425	Continued From page 46 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy 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.	F 425	Education was completed for staff responsible to transcribing medications on 12/10 and 12/11/15 to include the process to assure accuracy. 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	

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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 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 12/1/15, 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, 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 orders and a nurse checked the order for	F 425		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. 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 unnecessary medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 9/15/15, indicated R10 was cognitively intact. The	F 428	The consulting pharmacist was made aware. The consulting pharmacist completed an audit on all resident MARs to assure proper monitoring is included. The consulting pharmacist will complete a comprehensive monthly chart review.	

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	245421	A. BUILDING ______ B. WING ______	12/03/2015

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

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F 428	Continued From page 49 MDS included the diagnosis of hypertension. R10's physician orders dated 10/30/15, directed the staff to administer the following antihypertensive (for decreasing blood pressure) medications: - 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. An original order date of 6/12/15 was listed. - Diltiazem 240 mg 1 capsule orally daily for hypertension. Instructions provided to hold the Diltiazem for a systolic blood pressure of less than 90. An original order date of 6/12/15 was listed. The consultant pharmacist monthly medication reviews for R10 were conducted on 6/18/15, 7/21/15, 8/29/15. 9/16/15, 10/22/15, and 11/16/15. 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. When interviewed on 12/3/15, at 10:59 a.m. LPN-C stated she checked R10's blood pressure's prior to administering R10's Atenolol and Diltiazem, but has not been documenting the	F 428	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 pharmacist will be responsible for ongoing compliance. Date of compliance will be 1/12/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 50	F 428		

blood pressures as there is not a place to document them on the MAR.

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.

When interviewed on 12/3/15, at 3:37 p.m. the director of nursing (DON) stated she expected the nurses to obtain and document and monitor blood pressures as ordered by the physician.
R29's annual MDS dated 10/13/15, included diagnoses of hypertension.

R29's physician orders dated 11/15, identified an order for Metoprolol (used to treat 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. An original order date of 7/6/15 was listed.

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 been conducted on 11/16/15, however the review failed to address the lack of blood pressures and pulses being completed for the administration of the Metoprolol.

During interview on 12/2/2015, at 3:08 p.m., registered nurse (RN)-B verified R29's physician orders for metoprolol medication and R29's MAR

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F 428	Continued From page 51 for 11/15, lacked documentation of the blood pressure and pulse being 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. During interview on 12/03/2015, at 2:23 p.m., the 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. The facility policy Medication Administration, dated 1/15, indicated staff would administer medications as ordered by the attending physician. The facility policy Consultant Pharmacist Duties, undated, indicated the consultant pharmacist agreed to review physician orders and medication administration records to ensure proper documentation of medication orders and documentation of medications to patients.	F 428		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 465	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 immediately addressed. A professional refrigeration company was brought in the day after the survey to completely clean and sanitize the ice machine.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 52 review, the facility failed to maintain the sanitary condition of the ice machine. This had the potential to affect all 47 residents residing in the facility. Findings include: On 11/30/15, at 4:51 p.m., during a dining observation, the facility ice machine was observed to have crusted lime build up on the front of the machine and under the grill tray. In addition, the tray had lime and rust on it and the nozzles for the ice and the water had dark build-up. On 12/1/15, at 8:49 a.m., Housekeeper (H)-A and Maintenance (M)-A observed the lime and rust. H-A stated that housekeepers wipe down the front of the ice machine daily. H-A stated housekeeping does not clean the nozzles or components. In an interview on 12/1/15, at 8:49 a.m., M-A stated he uses lime away on the ice machine components monthly and cleaned the filter "every couple of months". Observing the ice machine, M-A stated, "It looks pretty rough." In an interview on 12/2/15, at 2:14 p.m., M-A stated he contacted a refrigeration company and had ordered new parts, will have the grill sanded and treated with rust oleum paint. In an interview on 12/3/15, at 8:37 a.m., H-A confirmed that housekeepers clean the outside of the ice machine in the morning and at night before they leave the facility they wipe it down with a disinfectant. Policies and procedures on cleaning of the ice machine were requested but not received from the facility.	F 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 this requirement. This concern has been corrected as of Dec 21st, 2015.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000		

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

Administrator — 12/31/15 — ~~01/07/2016~~

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of construction, the building was surveyed as 1 building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. the facility has a capacity of 57 and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	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	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING **01 - MAIN BUILDING 01** B. WING	12/01/2015

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

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K 050	Continued From page 2 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.	K 050	requirements. Fire Drill policies have been reviewed with the Maintenance Person. All drills on 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.	

F5421025

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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	APPROVED By Tom Linhoff at 10:46 am, Jan 12, 2016 RECEIVED Jan 11 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

K 000 end	Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of construction, the building was surveyed as 1 building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. the facility has a capacity of 57 and had a census of 47 at the time of the survey. 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			
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805 SIXTH AVENUE NORTHWEST
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Administrator Signature

12\31\2016

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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
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, 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)

RECEIVED

JAN 12 2016

MN Dept of Health
Duluth

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,

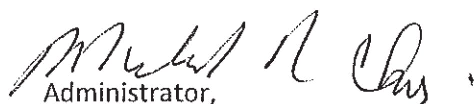
Re: Plan of Correction for Project Number: S5421026

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,



Administrator,

New Brighton Care Center &

Senior Suites of New Brighton

RECEIVED

JAN 12 2016

PRINTED: 12/17/2015
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: MN Dept of Health ~~Duluth~~ B. WING	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On November 30, 2015, through December 3, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/7/2016

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ____ B. WING ____	12/03/2015

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 535	MN Rule 4658.0300 Subp. 5 A-D Use of Restraints Subp. 5. Physical restraints. At a minimum, for a resident placed in a physical restraint, a nursing home must also: A. develop a system to ensure that the restrained resident is monitored at the interval specified in the written order from the physician; B. assist the resident as often as necessary for the resident's safety, comfort, exercise, and	2 535		

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2 535	Continued From page 2	2 535		

elimination needs;
C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and
D. release the resident from the restraint as quickly as possible.

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to comprehensively assess and obtain a physician's order for the use of a self-release alarmed seat belt for 1 of 3 residents (R65) reviewed for accidents.

Findings include:

R65's 14 day Minimum Data Set (MDS) dated 10/19/15, identified R65 was admitted on 10/5/15, with diagnoses including hip fracture and Alzheimer's. In addition, R65 had one fall since admission, no physical restraints and severe cognitive impairment.

R65's care plan, dated 10/29/15, indicated a fall prior to admission and at facility, remained a high risk for falls related to Alzheimer's, and impulsiveness. The care plan identified the intervention of a self-release alarmed seat belt in wheelchair to alert staff of self- transfer attempts.
R65's multi-disciplinary progress notes, dated 11/2/15, indicated safety belt engaged and fit/use per facilities policy.

R65's record did not include an assessment and a physician's order for the use of a self-release alarmed seat belt on R65's wheelchair.

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2 535	Continued From page 3	2 535		

Continued From page 3

During interview on 12/3/15, at 12:19 p.m., the facility consultant (C)-L verified R65's record failed to include an assessment for the use of a self-release alarmed seat belt on R65's wheelchair.

During interview on 12/03/2015, at 12:19 p.m., the assistant director of nursing (ADON)-C stated she did not remember the use of a self-release alarmed seat belt on [R65's] wheelchair.

During interview on 12/03/2015, at 12:19 p.m., the director of nursing (DON) verified the content in R65's care plan dated 10/29/15, and multi-disciplinary notes, dated 11/2/15. The DON stated she did not remember the use of a self-release alarmed seat belt on [R65's] wheelchair. The DON verified R65's record failed to include a physician's order for the use of a self-release alarmed seat belt on [R65's] wheelchair. The DON stated she would expect to be notified right away when the self-release alarmed seat belt had been placed on [R65's] wheelchair. The DON stated an assessment should have been done at the time the self-release alarmed seat belt had been implemented and should have been monitored for effectiveness. The DON stated she did not know why the self-release alarmed seat belt was placed on [R65's] wheelchair.

The undated facility policy Restraints (Physical), indicated staff was to assess resident's need for restraint use, obtain informed consent for restraint use and obtain a physician's order for the restraint.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and

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2 535	Continued From page 4 procedures to ensure residents receive appropriate use of physical restraints. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 535		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status;	2 540		

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2 540	Continued From page 5 H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess oral status for 3 of 3 residents (R16, R17, R33) reviewed for dental services. Findings include: R16's annual Minimum Data Set (MDS) dated 4/7/15, had identified no oral concerns were present. R16's annual MDS failed to identify R16 had missing and broken teeth. During observation on 11/30/15, at 5:20 p.m., surveyor viewed R16's teeth and noted R16 had full upper dentures and no teeth on the bottom gum line. R16 stated she had the last tooth pulled and an impression was done for lower dentures. On 12/2/15, at 10:02 a.m., assistant director of nursing (ADON)-C verified R16 had no lower teeth. ADON-C stated R16 had her last tooth pulled and an impression done for lower dentures on 11/13/15. R16's care plan date initiated 1/13/15, identified R16 had two lower teeth with the left lower tooth cracked and right lower tooth intact. R16's dental notes dated 8/10/15, 9/10/15 and 11/13/15, identified R16 had extractions of teeth and on 11/13/15, initial impression for dentures.	2 540		

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2 540	Continued From page 6	2 540		

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 accurately.

Facility policy for oral/MDS assessment was requested, but not provided.

R33's 10/21/15 admission Minimum Data Set (MDS) indicated she had severely limited

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2 540	Continued From page 7	2 540		

cognition. The MDS indicated R33 required extensive assist with personal hygiene. Review of R33's MDS identified no issues with oral/dental status. Choices on the MDS included: obvious or likely cavity or broken natural teeth.

An observation on 11/30/15, at 6:28 p.m., revealed R33's teeth to be dark in color on the outside of the teeth, and the inside, as if decayed. R33 had teeth missing and some teeth appeared to be broken or worn down.

In an interview on 12/2/15, at 8:40 a.m., Licensed Practical Nurse (LPN)-A stated she did dental assessments upon admission to include determination of broken teeth, if a resident was experiencing pain, if a resident had dentures, chewing or swallowing issues and if the resident needed a dental referral.

In an interview on 12/2/15, at 1:20 p.m., registered nurse (RN)-B stated dental assessments were done by the dietary manager and nursing - whichever nurse is completing the admission work. RN-B stated licensed practical nurse (LPN)-A will often assist with MDS data gathering for the long term care side of the facility.

RN-B continued that comprehensive evaluations, which included oral and dental was completed upon admission, annual and significant changes. RN-B stated she did not do the dental examinations, but gathered this information from the admitting floor nurse or LPN-A. RN-B stated she had information that R33 had her own teeth on the bottom and couple of her own teeth on top. RN-B did not reply when directly asked if the 10/21/15 MDS was an accurate assessment of R33's oral/dental needs.

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2 540	Continued From page 8 During an interview and observation with LPN-A on 12/2/15, at 2:08 p.m., the 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident MDS assessments are comprehensive and include the use of physical restraints. Education could be provided to all appropriate staff and a monitoring system could be developed to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 540		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the	2 565		

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2 565	Continued From page 9 care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1of 3 residents (R29) reviewed for accidents. Findings include: R29's care plan revised on 10/29/15, indicated high risk for falls related to diagnoses of right side hemiparesis (weakness), dementia, incontinences, poor safety awareness, inability to use call light for assistance. Interventions included anticipate and meet the resident's needs, encourage to participate in activities, 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, 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 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 at all times. During observation on 12/1/15, at 1:44, p.m., the	2 565		

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2 565	Continued From page 10	2 565		

call light was on outside of R29's room. R29 was sitting on the edge of the bed, stood up and walked over to the recliner, sitting down in the recliner. No alarm sounded on R29's bed when R29 stood up. The cord to the alarm box for R29's recliner was detached. Licensed practical nurse (LPN)-A walked into R29's room to answer the call light and reattached the cord to the alarm box. While reattaching the cord to the alarm, LPN-A stated R29 was non-compliant with the use of alarms. LPN-A stated R29 just recently had a fall and the alarm was put back into place for safety on 11/29/15. LPN-A stated R29 tried to toilet herself, was incontinent and had a hard time changing the incontinent product. LPN-A stated R29 was inconsistent with the use of the call light.

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 walked out of the room and R29 continued to have only regular socks on both feet.

An incident note identified on 10/29/15, R29 was found on the floor in her room, having slipped when getting up. The "root cause" of the fall was identified as footwear.

On 11/29/15, an incident report indicated R29 was found on the floor in her room. The "root cause" of the fall was determined to be vision due

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2 565	Continued From page 11	2 565		

Continued From page 11

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.

On 12/1/15, at 3:24 p.m., when queried regarding what fall interventions were in place for R29, NA-I stated staff check on R29 every 30 minutes, give R29 the call light, "but she forgets to use it" and keep walker within reach. NA-I stated R29 did not have alarms in place.

On 12/1/15, at 3:27 p.m., when queried regarding what fall interventions were in place for R29, NA-J stated she had an alarm on the bed and chair. R29 did not like to use the call light. Staff check on R29 and keep the walker in reach.

On 12/1/15, at 3:08 p.m., licensed practical nurse (LPN)-C stated she had implemented the use of an alarm on R29's bed and chair on 11/29/15. LPN-C verified the nursing assistant care sheets failed to include R29's alarms.

On 12/3/15, at 2:05 p.m., director of nursing (DON) stated she would expect the care plan to be followed.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could train all staff to follow each resident's care plan. The DON or designee could then perform random audits to ensure each residents care plan is being followed by all staff.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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2 570	Continued From page 12	2 570		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to include interventions implemented related to falls for 1 of 3 residents (R29) reviewed for accidents. 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	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 13	2 570		

Continued From page 13

potential for falls while providing diversion and distraction, needs safe environment with floors free of clutter/spills, adequate glare free light, a working and reachable call light, grab bars times two as ordered, handrails on walls, and personal items within reach.

During observation on 12/1/15, at 1:44, p.m., R29 was observed to have an alarm on R29's recliner. Licensed practical nurse (LPN)-A stated the alarm was implemented for safety on 11/29/15, after a fall. The use of an alarm failed to be on R29's care plan.

During observation on 12/2/15 at 7:10 a.m., R29 was lying in bed and no grab bars were observed to be on R29's bed.

On 12/1/15, at 3:08 p.m., LPN-C stated she was working when R29 fell on 11/29/15, and had implemented the use of an alarm on R29's bed and chair.

On 12/3/15, at 2:05 p.m., the director of nursing stated the care plan should be updated with changes when interventions are discontinued and implemented and the nursing assistant care sheets should also be updated.

The facility Care Plan Policy And Procedure, dated 8/10, indicated the care plan was to be changed and updated as the care changed for the resident. It was to be current at all times.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could train all staff to follow each resident's care plan. The DON or designee could then perform random audits to ensure each residents care plan is being followed by all staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ___ B. WING ___	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 570	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to communicate with the dialysis center in a timely manner regarding laboratory results and a physician's order for diet for 1 of 1 residents (R49) reviewed with dialysis services. Findings include: R49's admission minimum data set (MDS) dated 11/16/15, identified diagnoses of renal disease, diabetes, dialysis, and therapeutic diet. The MDS identified R49 was cognitively intact. During observation on 12/2/15, at 8:24 a.m., R49	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15	2 830		

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 renal diet.

Review of R49's record on 12/2/15, identified a physician's order dated 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 the lab results from the ordered blood draw on 11/11/15.

On 12/2/15, at 2:16 p.m., registered nurse (RN)-B verified R49's record failed to include lab results from the physician's order dated 11/11/15. She also stated there was no communication from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16	2 830		

dialysis center on R49's status on dialysis days since admission. In addition, RN-B verified R49's record failed to include a physician's order for the diet to be provided to R49.

On 12/3/15, at 3:59 p.m., the dietary supervisor (DS)-D stated upon admission he usually got a pink slip from the unit coordinator informing him what diet the resident was to be provided. DS-D stated R49 was provided a diabetic diet and on the days of dialysis a sack lunch was being sent for R49.

On 12/3/15, at 4:11 p.m., the facility registered dietician (RD)-K stated she reviewed R49's record on 12/1/15. RD-K stated she had contacted the dialysis dietician and a diabetic diet was adequate. RD-K stated R49 did not require a fluid restriction at that time. RD-K stated she was not aware R49 had no physician's order for a diet and she would expect an order from the physician to address what diet was to be provided.

On 12/3/15, at 1:10 p.m., the director of nursing (DON) stated lab results should be followed up the next day and the physician should be notified. The DON verified R49's record failed to include documentation of communication from the dialysis center for the days R49 had received dialysis treatment. The DON stated she would expect the dialysis center to provide documentation to the facility regarding R49's dialysis treatments. The DON verified R49's record failed to include a physician's order for the diet to be provided to R49.

Policies regarding obtaining diet orders, obtaining lab results and communication with the dialysis center were requested, but not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies related to the coordination of care with the dialysis facility and provide education for responsible staff. The director of nursing or designee could conduct periodic audits to ensure ongoing compliance, and review results with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent the development of pressure ulcers for 1 of 1 residents (R33). Findings include: R33 was admitted without pressure ulcers, but developed pressure ulcers on both heels. In addition, observations on 12/2/15 revealed reddened areas on R33's coccyx and the top of her right foot.	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

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2 905	Continued From page 18	2 905		

R33's 10/14/15, admission record identified diagnoses that included Alzheimer's disease, hypertension, edema, and muscle weakness.

R33's 10/21/15 admission Minimum Data Set (MDS) indicated she had severely limited cognition, a reduction in interest for activities and a poor appetite. The MDS indicated R33 required extensive assist of bed mobility, transfers, dressing, toileting and personal hygiene. The MDS indicated R33 was not at risk of pressure ulcers and did not have any pressure ulcers at that time.

A 10/16/15 Skin Risk Evaluation recommended to reposition R33 every 3 hours and as needed. An accompanying 10/16/15 Braden identified low 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 staff are to provide perineal care after incontinence and apply barrier creams as needed. R33's heels were also to be elevated off the bed with proper fitting footwear that provided relief for heels.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 905	Continued From page 19	2 905		

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 11/19/15. 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 11/301/5. 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 2x3 cm dry and brown, thin eschar area.

An 11/28/15 progress note indicated the right heel was a 2 x 2 cm dry area with eschar. The left heel was described as 2 x 3 cm with thick dry eschar.

In an interview on 12/1/15, at 9:47 a.m., LPN-A said R33 had blisters on her heels. Licensed Practical Nurse (LPN)-A stated they were currently dry, dark, healing Stage II ulcers, hard to the touch.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

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2 905	Continued From page 20	2 905		

LPN-C and Trained Medical Assistant (TMA)-A entered R33's room to change the dressings on the heels. LPN-C removed the Restorative Medical boots. Under the boots, R33 did not have on socks and the top of her right foot had a red mark which correlated to the edge of the boot's strap. LPN-C described the wound on R33's left heel as necrotic (dead tissue), dry, with no drainage and spongy. LPN-C stated the wounds did not need to be measured today. LPN-C described the right heel wound as dry, necrotic, and not as spongy as the left. During the observation, both wounds were observed to be dark brown to purple in color. LPN-C applied skin prep and a dry dressings to both heels. LPN-C also added kerlex around the feet to prevent further redness to the top of the feet. LPN-C stated she put the blue boots on more loosely so they would not rub on the top of R33's feet. LPN-C checked to ensure the boots were on properly, and TMA-A put a pillow under R33's knees to ensure the heels were floated off the bed.

Continuous observations on 12/2/15 from 7:50 a.m. until 10:20 a.m., revealed R33 was lying in bed on her back and was not repositioned from 7:30 a.m. (per interview below) until 10:20 a.m. Staff was in and out of R33's room during this time, including the dressing changes.

In an interview on 12/2/15, at 10:09 a.m., nursing assistant (NA)-E stated she and a colleague dressed R33 at 6:30 a.m., and NA-E repositioned her at 7:30 a.m. NA-E stated she assumed NA-D repositioned R33 when passing breakfast trays, but did not observe this.

On 12/2/15, at 10:14 a.m., NA D stated she did not reposition R33's body when offering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ___ B. WING ___	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 21	2 905		

breakfast. NA-D stated she readjusted the pillow under her head, but did not readjust her body.

During an observation on 12/2/15, at 10:20 a.m., NA-D and NA-E checked, changed, and repositioned R33. R33's incontinent brief was dry but had a small amount of stool, according to NA-D. Observations of R33's buttocks revealed a large reddened area 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's 11/3/15 pressure ulcer care plan indicated R33 had the potential for pressure ulcer development. The goal was to keep R33's skin intact, free of redness, blisters or discoloration. Interventions included skin checks daily by nursing assistants during cares and a weekly full body skin check on shower day. The care plan read to turn/reposition R33 at least every 3 hours. The care plan did not indicate the presence of 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 schedule.

SUGGESTED METHOD FOR CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents are repositioned according to their plan of care.
The Director of Nursing or designee could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ____ B. WING ____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 22 educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 905		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was handled in sanitary methods: sausages were thawing uncovered in the cooler, bread was placed on the floor during rotation task, and foods were stored undated in the basement freezer. These practices had the potential to affect all 47 residents residing in the facility. Findings include: During a kitchen tour with the facility Dietary	21095		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21095	Continued From page 23 Supervisor (DS) on 11/30/15, at 2:29 p.m., link sausages were observed in the cooks' refrigerator thawing uncovered on a sheet pan. During the tour, Dietary Aide (DA)-A was observed in the task of rotating breads (putting the older loaves of bread in the front, the newer loaves in the back). As DA-A performed this task, he put the loaves of bread, which were packaged in plastic bags, directly on the floor of the kitchen before putting them back in the cupboard. The DS confirmed the bread was not to be placed on the floor during the rotation task. In the basement freezer, shredded potatoes and chicken was observed in bags, but the bags were not dated. DS stated the original boxes were opened and the contents put into several freezers in order to fit into the facility's limited freezer space. DS stated he knew the food had arrived last Friday, but confirmed the bags were not labeled and dated. SUGGESTED METHOD OF CORRECTION: The dietary director could review and revise food storage policies and procedures. They could provide education to appropriate staff and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings,	21325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ___ B. WING ___	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 24 fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. 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. Review of R33's 10/21/15, admission MDS related to oral needs indicated "none of the above are present." Choices on the MDS included: obvious or likely cavity or broken natural teeth. An observation on 11/30/15, at 6:28 p.m., revealed R33's teeth to be dark of color on the outside of the teeth, and dark on the inside, as if decayed. R33 had teeth missing and some teeth appeared to be broken or worn down. 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,	21325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 25	21325		

chewing or swallowing issues and if the resident needed a dental referral.

In an interview on 12/2/15, at 1:20 p.m., registered nurse (RN)-B stated dental assessments are done by the dietary manager and nursing-whichever nurse is completing admission work. RN-B stated licensed practical nurse (LPN)-A will often assist with MDS data gathering for the long term care side of the facility.

RN-B continued that comprehensive evaluations, which included oral and dental is completed upon admission, annual and significant changes. RN-B stated she does not do the dental examinations, but gathers this information from the admitting floor nurse or LPN-A. RN-B stated she had 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 26 absent of information on dental exams or the condition of R33's teeth. SUGGESTED METHOD OF CORRECTION: Suggested Method of Correction: The director of nursing or designee could establish systems to ensure residents receive routine dental services. Facility staff could be educated on that system. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21325		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.	21530		

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21530	Continued From page 27	21530		

Continued From page 27

C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

This MN 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 unnecessary medications.

Findings include:

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

R10's physician orders dated 10/30/15, directed the staff to administer the following antihypertensive (for decreasing blood pressure) medications:

- Atenolol 50 milligrams (mg) 1 tablet orally daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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21530	Continued From page 28 for hypertension. Instructions provided to hold the Atenolol for a systolic blood pressure of less than 100. An original order date of 6/12/15 was listed. - Diltiazem 240 mg 1 capsule orally daily for hypertension. Instructions provided to hold the Diltiazem for a systolic blood pressure of less than 90. An original order date of 6/12/15 was listed. The consultant pharmacist monthly medication reviews for R10 were conducted on 6/18/15, 7/21/15, 8/29/15. 9/16/15, 10/22/15, and 11/16/15. 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. When interviewed on 12/3/15, at 10:59 a.m. LPN-C stated she checked R10's blood pressure's prior to administering R10's Atenolol and Diltiazem, but has not been documenting the blood pressures as there is not a place to document them on the MAR. 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.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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21530	Continued From page 29 When interviewed on 12/3/15, at 3:37 p.m. the director of nursing (DON) stated she expected the nurses to obtain and document and monitor blood pressures as ordered by the physician. R29's annual MDS dated 10/13/15, included diagnoses of hypertension. R29's physician orders dated 11/15, identified an order for Metoprolol (used to treat 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. An original order date of 7/6/15 was listed. 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 been conducted on 11/16/15, however the review failed to address the lack of blood pressures and pulses being completed for the administration of the Metoprolol. During interview on 12/2/2015, 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. 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.	21530		

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	00507	A. BUILDING: ____ B. WING ____	12/03/2015

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21530	Continued From page 30 During interview on 12/03/2015, at 2:23 p.m., the 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. The facility policy Medication Administration, dated 1/15, indicated staff would administer medications as ordered by the attending physician. The facility policy Consultant Pharmacist Duties, undated, indicated the consultant pharmacist agreed to review physician orders and medication administration records to ensure proper documentation of medication orders and documentation of medications to patients. SUGGESTED METHOD OF CORRECTION: The Director of nursing could in-service all staff responsible for medication monitoring including consultant pharmacist on obtaining blood pressure and or pulse as ordered by the physician. Monitoring for compliance needs to be done also. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21540	Continued From page 31	21540		

physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to monitor blood pressures and/or pulses as ordered prior to the medication administration for 2 of 5 residents (R10, R29) and failed to develop a plan of care that included monitoring for side effects of an anti-coagulant medication (Coumadin) for 1 of 5 residents (R29) reviewed for unnecessary medications.

Findings include:

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

R10's physician orders dated 10/30/15, directed the staff to administer the following antihypertensive (to lower blood pressure) medications:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21540	Continued From page 32 - 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. - Diltiazem 240 mg 1 capsule orally daily for hypertension. Instructions provided to hold the Diltiazem for a systolic blood pressure of less than 90. 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. When interviewed on 12/3/15, at 10:59 a.m. LPN-C stated she checked R10's blood pressure's prior to administering R10's Atenolol and Diltiazem, but had not been documenting the blood pressure as there was not a place to document them on the MAR. When interviewed on 12/3/15, at 3:37 p.m. the director of nursing (DON) stated she expected the nurses to obtain, document and monitor blood pressures as ordered by the physician. R29's annual MDS dated 10/13/15, included diagnoses of dementia, atrial fibrillation, hypertension and had received anticoagulation medication.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. During interview on 12/03/15, at 2:23 p.m., the 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. The facility policy Medication Administration,	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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21540	Continued From page 34 dated 1/15, indicated medications would be administered as ordered by the attending physician. A SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to medication monitoring. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21540		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ____ B. WING ____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21550	Continued From page 35 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. 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. SUGGESTED METHOD OF CORRECTION: The director of nursing and or pharmacist can educate all staff responsible for medicaiton administration to ensure residents received their medication as ordered by the physician. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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21685	Continued From page 36 well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the sanitary condition of the ice machine. This had the potential to affect all 47 residents residing in the facility. Findings include: On 11/30/15, at 4:51 p.m., during a dining observation, the facility ice machine was observed to have crusted lime build up on the front of the machine and under the grill tray. In addition, the tray had lime and rust on it and the nozzles for the ice and the water had dark build-up. On 12/1/15, at 8:49 a.m., Housekeeper (H)-A and Maintenance (M)-A observed the lime and rust. H-A stated that housekeepers wipe down the front of the ice machine daily. H-A stated housekeeping does not clean the nozzles or components. In an interview on 12/1/15, at 8:49 a.m., M-A stated he uses lime away on the ice machine components monthly and cleaned the filter "every couple of months". Observing the ice machine, M-A stated, "It looks pretty rough." In an interview on 12/2/15, at 2:14 p.m., M-A stated he contacted a refrigeration company and had ordered new parts, will have the grill sanded and treated with rust oleum paint. In an interview on 12/3/15, at 8:37 a.m., H-A confirmed that housekeepers clean the outside of the ice machine in the morning and at night before they leave the facility they wipe it down with a disinfectant. Policies and procedures on cleaning of the ice	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 37 machine were requested but not received from the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's environment is maintained in a safe, clean and sanitary manner. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21800	Continued From page 38 communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide liability notices for 1 of 3 residents (R46) reviewed for liability notices and beneficiary appeal rights. Findings include: R46's Admission Record dated 12/3/15, indicated R46 was admitted to the facility on 9/14/15, and was discharged on 9/24/15. While at the facility, R46 was receiving physical therapy services due to weakness from pneumonia. On 9/3/15, at approximately 10:30 a.m. the Notices of Medicare Non-Coverage were requested from the facility. On 9/3/15, at 2:50 p.m. the health information technologist (HIT) stated she was not able to find evidence of R46's Liability Notices and Appeal Rights forms. The HIT stated R46's services ended on 9/24/15, and R46 discharged from the facility the same day. The facility's undated Medicare Policy and Procedure indicated social services would notify	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21800	Continued From page 39 the resident and/or the responsible party 48 hours prior to discontinuation of Medicare coverage. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive the required Medicare denial and appeal rights notices; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21800		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

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21830	Continued From page 40	21830		

an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21830	Continued From page 41 family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure frequency and type of bathing preferences were honored for 3 of 3 residents (R64, R14, R75) reviewed for choices. Findings include: R64 requested two showers a week during a preferences assessment but was only receiving one.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

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21830	Continued From page 42	21830		

R64's Admission Record dated 12/2/15, indicated R64's diagnoses included dementia, anxiety, depression, and psychotic disorder.

The quarterly Minimum Data Set (MDS) dated 10/23/15, indicated R64 was understood, was able to understand others and was cognitively intact. R64 required the extensive assistance of one staff with transferring, personal hygiene and bathing.

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.

The Annual Activity Evaluation for resident preferences dated 4/14/15, indicated R64 wanted a shower twice a week.

The Activities of Daily Living (ADL) care plan revised on 8/1/15, indicated R64 needed the assistance of one staff for a weekly bath to wash her lower body. R64 was able to wash her face, hands and upper body after set up and staff was to complete what she was unable to finish.

The Nurses Brain Board sheet dated 12/2/15, indicated R64's bath was scheduled for a shower on Wednesday and Saturday. The nursing assistant (NA) care guide dated 12/1/15, indicated R64's bath was only on Wednesday.

On 12/2/15, at 1:33 p.m. NA-B verified the group sheet directed R64's bath day was on Wednesday. NA-B stated she worked every other weekend and R64 did not get a bath on Saturday, only on Wednesday. NA-B stated she gave R64

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ___ B. WING ___	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 43	21830		

Continued From page 43

her bath today (Wednesday).

On 12/2/15, at 1:48 p.m. the activity supervisor (AS)-A verified the last Annual Activity Evaluation for resident preferences was done 4/14/15. AS-A verified the assessment indicated R64 wanted a shower twice a week.

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 44	21830		

Continued From page 44

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 sponge bath.

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

In an interview on 12/1/15, at 2:41 p.m., R14 stated soaking in the tub used to be a life joy. R14 continued she would sit for hours in the tub with a book. R14 did not think she had been offered a tub bath while residing at the facility. R14 did not know if taking a bath at the facility would be as relaxing as at home, but didn't even know if a tub was available.

In an interview on 12/1/15, at 2:01 p.m., Nursing Assistant (NA)-A stated a bath was available on the north hall. The bath had a swing door and the resident had to sit in it while it fills. NA-A stated it takes a long time to fill and the "ladies don't like that" as it means sitting there undressed and cold.

In an interview on 12/1/15 at 2:24 p.m., NA-F stated no residents on the West hall take a bath. If they wanted a bath, they would use the bath available on the North hall, as the one in the West hall is not typically used.

In an interview on 12/1/15, at 10:53 a.m., NA-G stated she did not know anyone on the East or West halls that wanted a bath.

In an interview on 12/3/15, at 10:53 a.m., the Activities Supervisor (AS)-A stated she asked residents upon admission if they want a tub or shower. AS-A stated most of the time it's a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ___ B. WING ___	12/03/2015

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21830	Continued From page 45 shower, stating, "it's easier". AS-A stated she did 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 resident care conferences. The ADON felt that the Activities Supervisor and MDS Coordinator would have more answers, as the ADON did not have further information on this topic. In an interview on 12/3/15, at 3:27 p.m., Registered Nurse (RN)-B stated that the Activities Supervisor (AS) is responsible for asking residents the frequency and type of bath/shower questions. The AS would give the information to the Health Unit Coordinators and the nursing assistants have the information available on their group sheets. RN-B stated the choice between baths or a shower is asked only on an annual basis, but if a resident asked for one they could accommodate the request. In an interview on 12/3/15, at 3:33 p.m., Licensed Practical Nurse (LPN)-A stated she attended many care conferences. LPN-A stated the facility asked a resident's choice at admission, but LPN-A could not remember asking specifically about the choice of bath versus shower at care conferences. LPN-A stated resident bath or shower choices are listed on the group sheet. R14's group sheet dated 12/2/15, identified assist of one staff under bath information. The group sheet did not state preference of shower or bath for R14 or any other resident on the group sheet. R75's significant change MDS dated 11/11/15, indicated R75 had moderate cognitive impairments. The MDS indicated R57 needed	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 46	21830		

extensive assistance to transfer and physical assistance to bathe.

R75's care plan dated 9/23/15, indicated R75 needed an assist of one person, for showering. The care plan directed staff to provide set up and cues to have resident wash face, hands and upper body as able. The care care plan further directed staff to finish what the resident is unable to complete.

The East Wing aid assignment sheet dated 12/2/15, indicated R75's bath day was Wednesdays.

When interviewed on 12/1/15, at 10:35 a.m. R75 stated she got a shower one time a week, but would really like to have two showers per week.

On 12/2/15, at 7:39 a.m. NA-B was observed getting R75 prepared to go take her shower. When interviewed NA-B stated that R75 received one shower a week on Wednesdays. NA-B stated that R75 had never requested more than one shower a week but if a resident did, then it would be reported to the nurse on duty.

When interviewed on 12/2/15, at 11:04 a.m. LPN-A stated the activity department assessed residents for the frequency of bathing. LPN-A further stated that nursing schedules the frequency of baths from resident requests and placed it on the aid assignment sheets.

When interviewed on 12/2/15, at 1:48 p.m. the activity supervisor (AS)-A stated she asked the resident's bathing frequency preferences on admission and annually. She also stated residents can request more showers at any time. AS-A stated during the MDS assessment she let

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 47	21830		

residents know they would be scheduled for one shower a week and then asked them if that was enough for them. AS-A stated residents bathing frequency is not brought up in care conferences unless the resident initiated the conversation. AS-A further stated she recorded on the MDS how many times a week the resident wanted to shower and let nursing know. Due to a change in the documentation process, AS-A could not provide evidence that R75 had ever been asked how often she wanted to shower.

SUGGESTED METHOD OF CORRECTION: The administrator could in-service all employees on the need for self choice in residents choices. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21880 MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights (21880)

Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 48	21880		

Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to resolve resident council grievances in regards to nursing, dietary, laundry and maintenance department concerns reported to the facility by the resident council.

Findings include:

Review of the Resident Council meeting minutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 49	21880		

revealed the following grievances:

6/3/15 - resident council meeting minutes indicated a nursing department concern included getting ready for bed too early, and maintenance concerns for two resident's wheelchairs.

7/1/15 - resident council meeting minutes indicated dietary concerns included different types of salad and two residents wanted a table change, maintenance concerns were one resident bed squeaked and outdoor areas needed to be cleaned up, and activities concerns included a resident request for more music.

8/5/15 - resident council meeting minutes indicated nursing concerns included not enough aides and going to bed too early, dietary concerns were tough meat, too much fish, vegetable complaints and laundry concerns were missing pants.

9/2/15 - resident council meeting minutes identified nursing concerns including rude pool aides do not know how to do their job, dietary concerns raised related to multiple resident food complaints, laundry concern related to shrinking shirts, and maintenance concerns related to dry air.

10/7/15 - resident council meeting minutes indicated nursing concerns related to a rough night shift aide, dietary had multiple food complaints, laundry concerns because of missing laundry and maintenance concerns for heat/temperature.

11/4/15 - resident council meeting minutes identified nursing concerns due to requests for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ____ B. WING ____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21880	Continued From page 50	21880		

physician contacts were not timely, overnights take too long for call light response and trouble with being able to go to the bathroom on time, and dietary concerns related to multiple food complaints and rotating tables.

The resident council meeting minutes failed to include documentation of follow up for the concerns identified from 6/3/15 through 11/14/15. On 11/4/15, the nursing department had documented the concerns with night staff were addressed by the director of nursing and social service. However, there had been no documentation of how the concern had been addressed and resolved.

On 12/2/15, at 1:36 p.m., the activities supervisor (AS)-A and the facility consultant (C)-L verified the resident council meeting minutes from 6/3/15 through 11/4/15 failed to include documentation of follow up regarding the grievances expressed by residents during the resident council meetings.

On 12/3/15, at 8:45 a.m., AS-A stated she had given a copy to each department separately for the resident concerns expressed every month from 6/3/15 through 11/4/15. AS-A stated she had not received any documented follow up reports back from the departments, except the nursing department one dated 11/4/15.

On 12/3/15, at 8:59 a.m., the director of nursing (DON) provided documentation dated 11/4/15, regarding follow up of a resident concern rough handling and quickness of cares at night. The DON confirmed she had addressed the issue, but had not documented the information until 12/3/15, when she provided the information to the surveyor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: ______ B. WING ______	12/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 51	21880		

On 12/3/15, at 10:43 a.m., AS-A stated the facility system was to forward the concerns by copy to each department after the monthly meeting. The departments were to return the documented follow up to her. AS-A stated she did bring up the previous months concerns at each meeting, some might take longer to get resolved, but most are resolved. AS-A stated the resolution of concerns was addressed as well as resident satisfaction, but the information was not documented.

On 12/3/15, at 12:38 p.m., the facility temporary social worker (SW)-A stated social service had received no grievances since 6/15. In addition, SW-A stated she had spoken to the administrator and he was not aware of any grievance file as grievances were dealt with as they came up.

The undated facility Resident Council Bylaws indicated resident concerns and suggestions shall be documented and forwarded to department supervisors for follow through.

SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the requirement to address resident concerns and make a good faith attempt to resolve the grievences. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.