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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: N88X

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **07/31/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 07/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/12/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/09/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/07/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245164
August 14, 2017

Mr. Kurtis Rollin, Administrator
Health and Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

Dear Mr. Rollin:

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 July 19, 2017 the above facility is certified for or recommended for:

100 Skilled Nursing Facility/Nursing Facility Beds

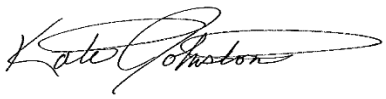
Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us

DEPARTMENT OF HEALTH

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 14, 2017

Mr. Kurtis Rollin, Administrator
Health and Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: Project Numbers: S5164027, H5164123, H5164125, H5164126, H5164127 & H5164128

Dear Mr. Rollin:

On June 28, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2017 that included an investigation of complaint numbers H5164123, H5164125, H5164126, H5164127 & H5164128. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 31, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 11, 2017, 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 June 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 19, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2017, effective July 19, 2017 and therefore remedies outlined in our letter to you dated June 28, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us

DEPARTMENT OF HEALTH

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: N88X

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

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(L1) **245164**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2015**

6. DATE OF SURVEY **06/09/2017** (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

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From (a) :
To (b) :

12.Total Facility Beds **100** (L18)
13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Cynthia Wentkiewicz, HFE NE II 07/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/04/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/09/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS
Posted 08/07/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 28, 2017

Mr. Kurtis Rollin, Administrator
Health And Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: Project Number S5164027, H5164123, H5164125, H5164126, H5164127 & H5164128

Dear Mr. Rollin:

On June 9, 2017, 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. In addition, at the time of the June 9, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5164123, H5164125, H5164126, H5164127, H5164128. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 19, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 9, 2017 (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 December 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. 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
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH AND REHABILITATION OF NEW BRIGHTON	**825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On June 5, 6, 7, 8, and 9, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Investigations of complaints H5164123, H5164125, H5164126, H5164127 and H5164128 were completed which resulted in: H5164123: Substantiated at F279, F282, F312 H5164125: Substantiated at F282, F312 H5164126: Substantiated at F279, F282, F312 H5164127: Substantiated at F282, F314 H5164128: Substantiated at F176, F282, F312, F314	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this	F 176		7/19/17

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

Electronically Signed | 07/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 06/09/2017

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) COMPLETION DATE
F 176	Continued From page 1 practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe administration of medications for 1 of 1 resident (R23), who had not been assessed to self-administer medications and who had medications left at the bedside. R23's admission record dated 9/27/16, included diagnoses of dysphasia, colon cancer and depression. On 6/7/17, at 8:54 a.m. the licensed practical nurse (LPN-C) entered room and placed a medication cup with several white tablets onto the bedside table. LPN -C spoke to R23 about taking medications and R23 attempted to swallow one medication. R23 started to cough, however drank some water and soon coughing stopped. R23 indicated it took time to swallow the pills. Staff left the room, and the medication cup remained on the bedside table. At 9:15 a.m. the nursing assistant removed the breakfast tray and indicated the medications remained on the bedside table. On 6/7/17, at approximately 7:30 a.m. LPN-C reported R23 takes a really long time to take medications, sometimes hours. At 1:30 p.m. LPN-C verified R23 had taken the morning medications and again explained R23 was really slow at taking medications and reported having to check on R23 during the day to ensure all medicaations were taken. On 6/8/17, at 10:20 a.m. the registered nurse (RN-B) reported not being aware of the time it took R23 to take medications and would look into it. RN-B verified R23 did not have an order to	F 176	Resident (R23) no longer resides at Health and Rehabilitation of New Brighton. Residents at Health and Rehabilitation of New Brighton who are administered medication have the potential to be affected by this practice. Residents who are able to self administer medication will have an assessment to determine ability to self administer medication. Review of assessment outcome to be implemented. Self Administration of Medication assessment/care plan to be documented as able to self administer medications or resident unable to safely self administer medications at this time. Licensed Nurses/TMA's and IDT team were educated on following resident's self administration of medication care plan and assessment by DON/Designee. Resident Self Administration of Medication Care Plan will be reviewed quarterly and PRN at Comprehensive Care Plan Review (CCPR) meetings held weekly to assure care plan assessments are appropriate and current. DON/Designee will audit results from CCPR meetings to ensure care plan accuracy x3 charts weekly for one month, then x1 chart weekly for an additional two months. Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components. Date Certain: 7/19/17	

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 176	Continued From page 2 have medications left at the bedside, nor had R23 been assessed to have medications left at the bedside. The policy for Self Medication Assessment and Management, effective July 2015 indicated Bullet 2 as "Review and analyze interdisciplinary assessment to determine the resident's ability to self-medicate. Bullet 4. Explain to the resident and resident representative that a self medication assessment to determine safety and ability to self medicate is required. Bullet 5. Complete the Self-Medication Data Collection and Assessment. Bullet 7 Determine outcome of assessment. a. Resident able to safely self-administer medications, all questions must be marked "able" for the resident to safely self-administer b. Resident unable to safely self-administer medications at this time. Document the reasons and plan for re-evaluations as applicable. Bullet 8. Explain outcome for assessment and analysis with resident and resident representative." .	F 176		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State	F 225		7/19/17

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F 225	Continued From page 3 nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated.	F 225		

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F 225	Continued From page 4 (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation that ensured an allegation of abuse was reported to the state agency immediately, but not later than two hours after the allegation was made for 1 of 3 residents (R59) reviewed for incidents. Findings include: Review of an incident submitted by the facility to the state agency revealed R59 made an allegation of verbal abuse by staff. According to the report, the incident occurred on 4/6/17, and was reported by the facility to the state agency on 4/7/17. Undated internal investigative documentation revealed that R59 was interviewed "on 4/7/17 at 2:30 pm about an incident that resident reported 4/6/17." The investigation documentation did not specify the date and time that the facility first became aware of the allegation, or the time that the facility reported the incident to the state agency on 4/7/17. In an interview on 6/8/17, at 2:45 p.m. the director of nursing (DON) was aware of the requirement	F 225	Resident grievances have been reviewed and reported to state agency. Resident allegations are being reported to the Executive Director, Director of Nursing Services, and reported to the state agency as required. Licensed/unlicensed staff and IDT will be re-educated regarding reporting and investigating allegations of mistreatment, neglect, abuse, injuries of unknown origin, and misappropriation of resident property by date of compliance. NHA/Designee will audit 3 allegations per week for implementation of policy and audit 3 staff members per week to assure policy understanding for one month. NHA/Designee will audit 2 allegations per week x 2 months. Results of audits will be reviewed at monthly QAPI meeting x3 months. Date Certain: 7/19/17	

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F 225	Continued From page 5 to report abuse allegations to the state agency immediately, but not later than two hours after the allegation is made. The DON said as soon as she is made aware of a reportable incident, she ensures the resident is safe then "immediately" files the report. When asked whether the investigative documentation included any report times to show that the alleged verbal abuse was reported to the state agency within two hours after the facility became aware, the DON confirmed that the investigative record did not include documented reporting times. Review of the facility procedure for Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revised December 2016, revealed under 1.1.2 Section A, part (i), the facility was required to "Ensure that all alleged violations are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury."	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226		7/19/17

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F 226	Continued From page 6 (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies and procedures that ensured an allegation of abuse was reported to the state agency immediately, but not later than two hours after the allegation was made for 1 of 3 residents (R59) reviewed for incidents. Findings include: Review of the facility procedure for Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revised December 2016, revealed under 1.1.2 Section A, part (i), the facility was required to	F 226	The facility has implemented its abuse prevention policy including immediate notification, immediate intervention, and immediate reporting of allegations to the state agency. Potential allegations are being reported to the Executive Director or Director of Nursing Services promptly and reported to the State Agency as needed. Licensed/unlicensed staff and IDT will be educated regarding policy implementation by Date Certain. NHA/Designee will audit 3 allegations per week for implementation of policy and audit 3 staff members per week to assure policy understanding for one month.	

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F 226	Continued From page 7 "Ensure that all alleged violations are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury." Review of an incident submitted by the facility to the state agency revealed R59 made an allegation of verbal abuse by staff. According to the report, the incident occurred on 4/6/17, and was reported by the facility to the state agency on 4/7/17. Undated internal investigative documentation revealed that R59 was interviewed "on 4/7/17, at 2:30 pm about an incident that resident reported 4/6/17." The investigation documentation did not specify the date and time that the facility first became aware of the allegation, or the time that the facility reported the incident to the state agency on 4/7/17. In an interview on 6/8/17, at 2:45 p.m. the director of nursing (DON) was aware of the requirement to report abuse allegations to the state agency immediately, but not later than two hours after the allegation is made. The DON said as soon as she is made aware of a reportable incident, she ensures the resident is safe then "immediately" files the report. When asked whether the investigative documentation included any report times to show that the alleged verbal abuse was reported to the state agency within two hours after the facility became aware, the DON confirmed that the investigative record did not include documented reporting times.	F 226	NHA/Designee will audit 2 allegations per week x 2 months. Results of audits will be reviewed at monthly QAPI meeting x3 months. Date Certain: 7/19/17	
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services	F 253		7/19/17

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F 253	Continued From page 8 necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were free from safety hazards for 2 of 24 residents (R169, R4) on the transitional care unit. Findings include: On 6/5/17, at 4:20 p.m. during random observation of the transitional care unit room, R169's bathroom had a warped discolored ceiling tile hanging down from stabilizer track and had a gap of approximately 1-1/2 foot out of the ceiling. A chair and bedside table were placed near the window. Under the window, was a metal vent with an open area with bent and shortened vent slats of approximately 3 -4 inches. The bent and snapped off slats were sharp to the touch. R169 indicated liking to sit on chair looking out window and was near the sharp slats. R4's bedroom lower cabinet doors had layers of wood missing and had marred and sharp edges on the lower cabinet doors. During environmental tour on 6/8/17, at 1:15 p.m. with the maintenance director (MD) and the director of nursing (DON), these concerns were addressed. The MD indicated the building was old and they were going through room after room to do some remodeling. The MD was not aware of the ceiling tile being warped and loose. Cabinet bids, dated 10/12/16, had been received and provided for review. The most current bid was dated 10/12/16, however, no replacements had been ordered. The MD also indicated the cover	F 253	R169's ceiling tile was replaced and metal vent was fixed on 6/09 by facility Maintenance staff. R4's cabinet doors have been replaced by facility Maintenance staff. Resident rooms will be audited x5 weekly by ED/Designee for 3 months to ensure they are free from safety hazards. Licensed/unlicensed staff and IDT will receive education regarding process for submitting a work order for Maintenance issues. Audit results will be reviewed at the monthly QAPI meeting for 3 months. Date Certain: 7/19/17	

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F 253	Continued From page 9 for the vent on the lower vent was no longer available and was unsure how to repair. The DON verified items should be repaired. On 6/9/17, at approximately 12:00 p.m. the DON reported the vent had been repaired and the ceiling title repaired.	F 253		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 279		7/19/17

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F 279	Continued From page 10 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for 1 of 1 resident (R93) reviewed for activities of daily living (ADL's). Findings include: The care plan dated 4/17/17, identified R93 had	F 279	R93's care plan was immediately developed to include "resident requires assistance with shaving" and the residents right to refuse treatment. Resident care plans were reviewed and updated regarding assistance with activities of daily living (ADL's). Licensed staff educated on the	

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F 279	Continued From page 11 alteration in ADL's and directed staff, "potential or Actual ADL/Mobility deficit, poor oral hygiene, oral infection r/t Arthritis (osteo)... "the care plan lacked resident requires assistance with shaving." Review of R93's medical record, revealed medical record lacked documentation of R93's refusal to be shaved daily as part of daily grooming. Quarterly nursing data collection and assessment sheet dated 5/2/17, indicated, "Personal Hygiene Assist 1A (assist)". R93 was observed to have several facial hairs the evening of 6/5/17, and during subsequent days of the survey on 6/6/17, and 6/7/17. On 6/5/17, at 6:19 p.m., R93 was observed to have several gray/white facial hairs to the chin area approximately one inch long. When asked if staff assisted with shaving, R93 laughed and stated, "Shave me, no". On 6/6/17, at 9:23 a.m., R93 was observed lying in bed and again had numerous gray/white facial hairs. On 6/7/17, at 11:27 p.m. and at 1:07 p.m., R93 was observed lying in bed and yet again had many gray/white facial hairs. When asked if staff helped with shaving, R93 laughed again and indicated, "Shave me, no, I cannot shave myself and I would like to be shaved". In addition, R93 stated was not aware had facial hair because [R93] does not have means to look at self in the mirror. During an interview with LPN-A on 6/7/17, at 1:07	F 279	development of plan of care process, specifically regarding ADL's. Licensed/unlicensed staff received education on documenting resident refusals on care and services. DON/Designee will audit x3 charts weekly for 3 months. Audit results will be reviewed at monthly QAPI meetings x3 months. Date Certain: 7/19/17	

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F 279	Continued From page 12 p.m., LPN-A verified R93 had facial hair and stated, should have been shaved. During an interview with NA-D on 6/7/17, at 1:07 p.m., NA-D confirmed R93's facial hair and stated resident was not shaved today. During an interview with RN-C on 6/7/17, at 1:10 p.m. RN-C substantiated R93's facial hair. During an interview with the director of nursing (DON) on 6/7/17, at 2:16 p.m., DON verified R93's facial hair and mentioned the care plan lacked staff to assist with shaving resident because resident refuses for [R93] face to be touched. Furthermore, indicated there is no documentation regarding resident refusal of shaving but could only go by what the staffing coordinator said. In addition, DON pointed out, "My expectation is care plan to be followed and if there is a change, the nursing assistant should notify nurse manager so that it can be updated." The policy and procedure titled PERSONAL NEEDS dated October 2016, indicated "4. Develop and implement individualized interventions. a. Document on Care Delivery Guide." The policy and procedure titled CARE PLANS dated January 2017, indicated "Develops and implements an interdisplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up".	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		7/19/17

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F 282	Continued From page 13 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for personal hygiene care to 1 of 1 resident (R23) who was reviewed for activities of daily living (ADL's) and who was dependent upon staff assistance to provide care and services for pressure ulcers, failed to follow the care plan to provide services in for 1 of 1 resident (R44) who required assist with shaving, and failed to follow the care plan by offering passive range of motion twice daily for 1 of 1 resident (R62) reviewed for range of motion. Findings include: R23's care plan dated 6/5/17, directed staff R23 required physical assistance of one staff member to provide personal hygiene, grooming, dressing and undressing; and provide set up assistance for oral care.The care plan also indicated R23 required physical assistance of two staff for bed mobility, and should be turned and repositioned with the assist of two every 2 hours and as needed. On 3/16/17, the care plan was updated and directed staff R23 had two stage 2 pressure ulcers; one on left buttocks and one on right lateral ankle. Edema was present. Interventions included to monitor wound weekly and as needed, to see skin grid, provide treatment as	F 282	R23, R44, and R62's Care Plans were reviewed and updated. Services that are care planned for residents have been provided. All residents who are dependent upon staff assist for providing personal hygiene care and services for pressure ulcers have received care plan reviews. Residents who require passive range of motion per care plan received a care plan review. Services that are care planned for residents have been provided. Residents at Health and Rehabilitation of New Brighton have the potential to be affected by this practice. Licensed/unlicensed nursing staff and IDT team were educated on following the resident's plans of care by DON/Designee. DON/Designee will audit residents plan of care at Comprehensive Care Plan Review meetings to ensure the care plan is appropriate x3 charts weekly for one month, then x1 chart weekly for an additional two months. Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components. Date Certain: 7/19/17	

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ordered and to wear boots to bilateral feet with pillows to prop. The care plan indicated R23 would refuse turning and repositioning often however staff was directed to continue to offer.

R23's significant change Minimum Data Set (MDS), dated 4/17/17, indicated a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact) and was alert and oriented. The MDS also identified R23 required extensive assistance of one staff for personal hygiene activities.

During observations on 6/7/17, at 7:15 a.m. continuously until 9:45 a.m., R23 was not offered any personal cares or ADL's. At approximately 8:43 a.m., nursing assistant (NA)-A entered room to bring in breakfast tray and then removed tray at 9:30 a.m. R23 was in bed with hospital gown on and hair uncombed. R23's feet were resting flat on the bedside footboard. Foam boots were not placed on bilateral feet. During this time, no one offered R23 the opportunity to wash face, comb hair, brush teeth or to be repositioned every 2 hours.

On 6/7/17, at 1:15 p.m. NA-A reported usually would go into the room and provide a partial bed bath for R23 because R23 doesn't always get out of bed. NA-A was not assigned to do personal cares. At 6/7/17, at 1:47 p.m. NA-B reported that she had entered the room prior to 7:00 a.m. to reposition resident but R23 had refused. R23 was not re-approached for morning ADL's, or provided any. NA-B did not provide any morning ADL's or personal cares for R23 during the shift.

On 6/7/17, at 1:51 p.m., R23 reported no one had come in today to provide any cares or reposition. R23 indicated staff must have been busy.

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F 282	Continued From page 15 On 6/8/17, at 10:20 a.m. the registered nurse (RN-B) indicated it was the expectation the nursing assistants and the nurse would work together to provide ADL's and repositioning to R23 and re-offer cares when refused. RN-B also indicated the foam boots should be worn per the care plan. RN-B verified the care plan had not been followed. On 6/8/17, at 3:46 p.m. the director of nursing (DON) and RN-B reported the nursing assistant (NA-B) indicated offering cares prior to 7:00 a.m. and resident had refused. RN-B also reported the nursing assistant revealed repositioning once during the day, but no time was given. The care plan dated 3/27/17, directed staff R44 had alteration in activities of daily living (ADL's) and directed staff, "Personal Hygiene/Grooming/Dressing/Undressing Assist/encourage/provide per resident preference comb hair, dressing shave undressing... Provide Set up Cue Physical Assist..." Nursing assistant assignment sheet dated 6/5/17, read, "...ADL'S (activities of daily living) A1-A2 (assist of one - assist of two); shave qd (every day)..." Quarterly nursing data collection and assessment sheet dated 3/27/17, indicated, "Personal Hygiene Assist Setup 1A (assist)". On 6/5/17, at 4:45 p.m., R44 was observed to have several gray/white facial hairs to the upper lip and the chin area more than an inch long. R44 unable to explain the reason why when asked by surveyor.	F 282		

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On 6/6/17, at 9:23 a.m., R44 was observed lying in bed and again had numerous gray/white facial hairs to the upper lip and the chin area.

On 6/7/17, at 7:12 p.m. and at 9:25 a.m., was observed sitting up in the wheelchair for breakfast and yet again to have quite a lot of gray/white facial hairs to the upper lip and the chin area.

Review of R44's medical record revealed documentation x 4 of R44 resists care from 4/12/17 - 6/6/17. Otherwise, medical record lacked documentation that resident refuses to be shaved daily as the care plan and nursing assistant indicated to be shaved every day.

During an interview with nursing assistant (NA)-C on 6/7/17, at 9:29 a.m., NA-C verified R44 had several gray/white facial hairs to the upper lip and the chin area and stated resident does not like to be shaved and normally gets aggressive.

During an interview with licensed practical nurse (LPN)-A on 6/7/17, at 9:44 a.m., LPN-A confirmed R44 had several gray/white facial hairs to the upper lip and the chin area and indicated that resident should have been shaved but NA mentioned that resident refuses to be shaved.

During an interview with registered nurse (RN)-C on 6/7/17 at 10:03 a.m., RN-C substantiated resident had several gray/white facial hairs to the upper lip and the chin area and stated the expectation was staff should document refusal when resident refuses cares.

The policy and procedure titled PERSONAL NEEDS dated, October 2016, read, "4. Develop

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and implement individualized interventions. a. Document on Care Delivery Guide."

The policy and procedure titled CARE PLANS dated, January 2017, read, "Develops and implements an interdisplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up".
R62's mobility care plan, last signed and dated on 3/23/17, identified the stroke and weakness as problems for mobility, and directed to "See Restorative Resident Summary Report" for interventions.

Review of R62's admission record, dated 5/16/17, revealed diagnoses including hemiplegia (paralysis on one side of the body), and cerebral infarction (area of necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain).

R62's Restorative Program Summary Report, dated 6/8/17, revealed a passive range of motion program for R62. The restorative program summary report revealed impaired range of motion to R62's left knee as evidenced by contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), and risk for impaired range of motion to R62's right knee related to the stroke and right hemiplegia. The goal of the restorative program was for R62 to "have decreased pain in legs, improved [range of motion] to left knee by staff performing [passive range of motion] exercises twice daily (once upon rising, and once at [hour of sleep] x 90 days."

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The nursing assistant care guide, dated 6/7/17, directed "[Passive Range Of Motion] program to bilateral lower extremities twice daily; once upon rising and once before [hour of sleep]".

During interview on 6/7/217, at 10:01 a.m. occupational therapist (OT)-A confirmed that R62 was admitted to the facility with contracture of the knee. OT-A said R62 had the contracture for years and "has been on a knee extension range of motion program for as long as I remember."

On 6/8/17, at 8:39 a.m. family member (FM)-B was observed to be visiting R62 in the resident's room. R62 was seated in a wheelchair. When asked if facility staff performed any range of motion to the resident's knees that morning, R62 said "No." FM-B, who said they visited R62 almost daily, said "I don't think they always do that, but I think they should."

In an interview on 6/8/17, at 9:59 a.m. nursing assistant (NA)-F was asked if R62 received range of motion (ROM) that morning. NA-F said R62 did not get ROM today. NA-F said sometimes nursing assistants will do some ROM with R62's hands, but that they don't usually do ROM with the legs because R62 did not like staff to touch his feet. When NA-F was asked to clarify whether staff sometimes performed ROM on the upper body, but not usually on the lower body, NA-F said "Yes."

In an interview on 6/8/17, at 10:45 a.m. registered nurse (RN)-C explained R62 was to have passive ROM (PROM) to the left knee twice daily, and the nursing assistants were to document in the CareTracker system whether the PROM was completed, and the level of participation. RN-C

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F 282	Continued From page 19 said she was able to look up the level of PROM participation in the Restorative Program Summary Report. RN-C ran a Restorative Program Summary Report on 6/8/17, at 10:57 a.m. The report covered the date range of 5/9/17 (starting at 00:00) -6/8/17 (through 10:57 a.m.). At the time the report was run, staff had not yet documented PROM for the morning of 6/8/17. Staff had not documented offering PROM during the morning shift on 5/15/17. PROM was not documented as offered during the evening shifts on 5/11/17, 5/12/17, 5/30/17, 6/2/17, or 6/7/17. The same nursing assistant had commented on each of these shifts that PROM was "Not scheduled this shift," which was contrary to the requirement written on the nursing assistant care guide and restorative program summary report for nursing assistants to perform PROM once upon rising and once before the hour of sleep. In an interview on 6/8/17, at 11:16 a.m. RN-C reviewed the Restorative Program Summary Report that was run on 6/8/17, at 10:57 a.m. RN-C confirmed that PROM should be offered during the evening shift. Review of the Restorative Nursing Program procedure, dated 7/15, required staff to provide restorative interventions as indicated, and document daily participation in CareTracker.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 312		7/19/17

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F 312	Continued From page 20 personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care to 3 of 6 residents (R23, R44 and R93) who were reviewed for activities of daily living (ADL's) and who were dependent upon staff for assistance. Findings include: R23's admission record sheet dated 9/27/16, identified diagnoses that included neoplasm of colon, dysphasia, and duodenal ulcer. R23's significant change Minimum Data Set (MDS), dated 4/17/17, indicated a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact) and is alert and oriented. The MDS also identified R23 required extensive assistance of one staff for personal hygiene activities. R23's care area assessment (CAA) for ADL's printed 4/21/17, indicated R23 needed extensive assistance of staff for all ADL's and was alert. The CAA further indicated a significant change was considered due to a stage 3 pressure ulcer and general decline affecting appetite, ADLs, and mobility. R23 sometimes refused cares. R23's care plan, dated 6/5/17, indicated R23 required physical assistance of one staff member to provide personal hygiene, grooming and dressing and undressing; and provide set up assistance for oral care. The care plan indicated R23 often refused cares, however staff was instructed to re-offer. During observations on 6/7/17, at 7:15 a.m.	F 312	R23, R44, R93's ADL care plan has been updated. Based on assessment the plan of care and NAR care delivery guide has been updated. R23's care plan and NAR care delivery guide will be reviewed and updated as needed due to refusal of cares and effective approaches. All residents have the potential to be effected. ADL assessments are updated and reviewed quarterly and with significant change in status. Resident's with refusal of cares will be identified and care plans will be reviewed and updated as necessary. Licensed/unlicensed nursing staff will receive education that services are to be communicated via the plan of care and NAR care delivery guide to ensure residents receive the necessary services to maintain good nutrition, grooming, and personal hygiene. DON/designee will complete weekly audits of 3 residents for a month focusing on ADL care and services received. NAR care delivery guides will also be audited to ensure compliance with the plan of care. Audits will be continued monthly to ensure compliance with the plan of correction. Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components. Date Certain: 7/19/17	

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continuously until 9:45 a.m. R23 was not offered any personal cares or ADL's. At approximately 8:43 a.m. nursing assistant (NA)-A entered the room to bring in breakfast tray and then removed tray at 9:30 a.m. R23 was in bed with hospital gown on and hair uncombed. R23's feet were resting flat on the bedside footboard. Foam boots were not placed on bilateral feet. During this time, no one offered R23 the opportunity to wash his face, comb his hair or brush his teeth.

On 6/7/17, at 1:15 p.m. NA-A reported usually would go into room and provide a partial bed bath for R23 because R23 doesn't always get out of bed. NA-A was not assigned to do personal cares. At 6/7/17, at 1:47 p.m. NA-B reported that she had entered the room prior to 7:00 a.m. to reposition resident but he had refused. R23 was not re-approached for morning ADL's. NA-B had not received any morning activities of daily living/personal cares for R23 during the shift.

On 6/7/17, at 1:51 p.m., R23 reported no one had come in today to wash him up etc. R23 indicated staff must have been busy.

On 6/8/17, at 10:20 a.m. the registered nurse (RN-B) indicated it was her expectation the nursing assistant and the nurse would work together to provide ADL's and repositioning to R23 and re-offer cares when refused. RN-B verified the care plan had not been followed.

R44 was observed to have several facial hairs the evening of 6/5/17, and during subsequent days of the survey on 6/6/17, and 6/7/17.

On 6/5/17, at 4:45 p.m., R44 was observed to

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have several gray/white facial hairs to the upper lip and the chin area more than an inch long. R44 unable to explain the reason why when asked by surveyor.

On 6/6/17, at 9:23 a.m., R44 was observed lying in bed and again had numerous gray/white facial hairs to the upper lip and the chin area.

On 6/7/17, at 7:12 p.m. and at 9:25 a.m., R44 was observed sitting up in the wheelchair for breakfast and yet again to have quite a lot of gray/white facial hairs to the upper lip and the chin area.

R44's admission and clinical records noted R44 admitted to facility on 11/22/11, and had diagnoses which included agitation plus combative psychosis, hidradenitis, major depressive disorder, glaucoma and tremor.

Quarterly nursing data collection and assessment sheet dated 3/27/17, indicated, "Personal Hygiene Assist Setup 1A (assist)".

R44's quarterly Minimum Data Set (MDS) dated 3/26/17, identified R44 required extensive assist of one staff with personal hygiene needs - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers).

Review of R44's medical record, revealed medical record had documentation x 4 of R44 resists care from 4/12/17 - 6/6/17. Otherwise, medical record lacked documentation that resident refuses to be shaved daily as the care plan and nursing assistant indicated to be shaved

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every day.

The care plan dated 3/27/17, identified R44 had alteration in ADL's and directed staff, "Personal Hygiene/Grooming/Dressing/Undressing Assist/encourage/provide per resident preference comb hair, dressing shave undressing... Provide Set up Cue Physical Assist..."

Nursing assistant assignment sheet dated 6/5/17, read, "...ADL'S (activities of daily livings) A1-A2 (assist of one - assist of two); shave qd (every day)..."

During an interview with nursing assistant (NA)-C on 6/7/17, at 9:29 a.m., NA-C verified R44 had several gray/white facial hairs to the upper lip and the chin area and stated resident does not like to be shaved and normally gets aggressive.

During an interview with licensed practical nurse (LPN)-A on 6/7/17, at 9:44 a.m., LPN-A confirmed R44 had several gray/white facial hairs to the upper lip and the chin area and indicated that resident should have been shaved but NA mentioned that resident refuses to be shaved.

During an interview with registered nurse (RN)-C on 6/7/17 at 10:03 a.m., RN-C substantiated resident had several gray/white facial hairs to the upper lip and the chin area and stated the expectation was staff should document refusal when resident refuses cares.

R93 was observed to have several facial hairs the evening of 6/5/17, and during subsequent days of the survey on 6/6/17, and 6/7/17.

On 6/5/17, at 6:19 p.m., R93 was observed to

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have several gray/white facial hairs to the chin area approximately 1 inch long. When asked if staff assist with shaving, R93 laughed and stated, "Shave me, no".

On 6/6/17, at 9:23 a.m., R93 was observed lying in bed and again had numerous gray/white facial hairs.

On 6/7/17, at 11:27 p.m. and at 1:07 p.m., R93 was observed lying in bed and yet again had many gray/white facial hairs. When asked if staff helped with shaving, R93 laughed again and indicated, "Shave me, no, I cannot shave myself and I would like to be shave". In addition, R93 stated, was not aware had facial hair because [R93] does not means to look at self in the mirror.

R93's admission and clinical records noted R93 was admitted to facility on 4/22/16, and had diagnoses, which included weakness, moderate advanced dementia, major depressive disorder and hypertension.

Quarterly nursing data collection and assessment sheet dated 5/2/17, indicated, "Personal Hygiene Assist 1A (assist)".

R93's annual Minimum Data Set (MDS) dated 5/2/17, identified R93 required extensive assist of one staff with personal hygiene needs - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers).

The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 5/10/17, reads, "...Res (resident)

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

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F 312	Continued From page 25 requires ext. (extensive) assist of 1-2 with all ADL (activities of daily living)/mobility needs except eating..." Reviewed of R93's medical record, revealed medical record lacked documentation of R93 refusal to be shaved daily as part of daily grooming. The care plan dated 4/17/17, identified R93 had alteration in ADL's and directed staff, "potential or Actual ADL/Mobility deficit, poor oral hygiene, oral infection r/t Arthritis (osteo)..." the care plan lacked resident requires assistant with shaving." During an interview with LPN-A on 6/7/17, at 1:07 p.m., verified R93 had facial hair and stated, should have been shaved. During an interview with NA-D on 6/7/17, at 1:07 p.m., confirmed R93's facial hair and stated resident was not shaved today. During an interview with RN-C on 6/7/17, at 1:10 p.m. substantiated R93 facial hair. During an interview with the director of nursing (DON) on 6/7/17, at 2:16 p.m., verified R93's facial hair and mentioned, the care plan lacked staff to assist with shaving resident because resident refuses for [R93] face to be touched. Furthermore, indicated there is no documentation regarding resident refusal of shaving but could only go by what the staffing coordinator said. In addition, DON pointed out, "My expectation is care plan to be followed and if there is a change, the nursing assistant should notify nurse manager so that it can be updated."	F 312		

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F 312	Continued From page 26 The policy and procedure titled PERSONAL NEEDS dated October 2016, indicated "Personal care and ADL support will be provided according to the resident's Care Plan... Grooming/dressing Shave... Document in the Progress Notes, if an exception to the established care plan occurs. 4. Develop and implement individualized interventions. a. Document on Care Delivery Guide."	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services for pressure ulcers for 1 of 2 residents (R23) who had pressure ulcers. Findings include:	F 314	R23 is no longer a resident at Health and Rehabilitation of New Brighton. R23 has had a Skin Integrity Assessment Prevention and Treatment Care Plan review and update. R23's plan of care has been followed to ensure timely repositioning per resident's plan of care.	7/19/17

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F 314	Continued From page 27 R23's admission record sheet dated 9/27/16, identified diagnoses that included neoplasm of colon, dysphasia, and duodenal ulcer. R23's significant change Minimum Data Set (MDS), dated 4/17/17, indicated a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact), was alert and oriented and would reject evaluation or cares. The MDS also identified R23 required extensive assistance of two persons for bed mobility, had a colostomy, an indwelling catheter and was at risk for developing pressure ulcers. The MDS indicated R23 did have two stage 2 pressure ulcers. R23's care area assessment (CAA) for activities of daily living (ADL's) printed 4/21/17, indicated R23 needed extensive assistance of staff for all ADL's and was alert. The CAA further indicated a significant change was considered due to a stage 3 pressure ulcer and general decline affecting appetite, ADLs, and mobility. The CAA analysis indicated resident Braden score of 15 reflects at risk for pressure related skin breakdown. Has stage III PU (pressure ulcer) on right ankle. The medical record review indicated R23 was hospitalized from 5/23-5/31/17 for sepsis and peritonitis. On 6/1/17, R23 was admitted to hospice care. R23's care plan, dated 6/5/17, indicated R23 required physical assistance of two staff for bed mobility, and should be turned and repositioned with the assist of two every 2 hours and as needed. On 3/16/17, the care plan was updated and indicated R23 had two stage 2 pressure ulcers; one on left buttocks and one on right	F 314	Residents at Health and Rehabilitation of New Brighton who are at risk for pressure ulcers have the potential to be affected by this practice. Residents who are at risk for pressure ulcers have had a review of the Skin Integrity Assessment Prevention and Treatment Care Plan and nursing assistant care guides have been updated. Licensed/unlicensed nursing staff and IDT team were educated on following resident's plans of care by DON/Designee. Resident Skin Integrity Assessment Prevention and Treatment Care Plan will be reviewed quarterly and PRN at Comprehensive Care Plan Review (CCPR) meetings held weekly to assure care plan assessments are appropriate and current. DON/Designee will audit results from CCPR meetings to ensure care plan accuracy x3 charts weekly for one month, then x1 chart weekly for an additional two months. Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components. Date Certain: 7/19/17	

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lateral ankle. Edema was present. Interventions included to monitor wound weekly and as needed, to see skin grid, provide treatment as ordered and to wear boots to bilateral feet with pillows to prop. The care plan identified R23 would refuse turning and repositioning often, however staff were directed to continue to offer.

During observations on 6/7/17, at 7:15 a.m. continuously until 9:45 a.m. R23 was not repositioned off of buttocks. At 7:15 a.m. R23 was laying in bed, feet resting near footrest of bed, covered with linen. The room door remained closed and no staff entered the room. At approximately 8:43 a.m., nursing assistant (NA)-A entered room to bring in breakfast tray. R23 was resting on his back with feet resting flat on the bedside footboard. The head of bed was at approximately 45 degree angle. R23 was wearing a hospital gown and covered with bed linen. Foam boots were not placed on bilateral feet. Licensed practical nurse (LPN)-C entered room to bring in morning medications and while NA-A and LPN-C were in the room, no one offered to reposition R23. At 9:15 a.m., NA-A entered room and removed breakfast tray from bedside table. The door was left closed. The bedroom door was observed from 9:15 a.m.-9:45 a.m. and no staff entered the room. At 1:51 p.m. R23 appeared to be in the same position; on his back, positioned to the outside of the bed with legs stretched out and feet resting on foot board. R23 continued to wear a hospital gown, and was covered with linen. The head of bed was at approximately 45 degree angle.

Review of the skin grid forms, (form to write measurements of wound) dated 5/1/17, indicated R23 had a stage II pressure ulcer on the left

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buttocks that measured in centimeters 7.0 x 2.0, depth 0.2 with serosanguinous drainage, color red and yellow and with no odor. On 5/8/17, measurements on the left buttocks wound were: 6.4 x 2.0, depth 0.2 with serosanguinous drainage, color red and yellow. On 5/15/17, measurements on stage II buttocks wound were 6.4 x 2.2, depth 0.3, with serosanguinous drainage, red and yellow in color with no odor. No measurements were taken on 5/22/17. R23 was hospitalized from 5/21/17-5/31/17. No further measurements were available in the medical record.

The Nursing Comprehensive Admission Data Collection and Assessment and Skin Assessment, dated 5/31/17, indicated resident had pressure sore on right ankle and buttocks. No measurements or notes were entered on form. The most current progress note after hospital return was on 6/2/17, and indicated resident returned with order for hospice, was readmitted with Braden of 9, skin assessment showed dry skin to toes and part of right chest, colostomy to upper quadrant, Foley catheter and pressure ulcers to buttocks and right ankle.

On 6/7/17, at 1:51 p.m., R23 indicated no one had come in to wash him up or to reposition him yet. R23 reported staff must be kind of busy. When asked about the foam boots for feet, R23 indicated not sure they were supposed to be worn. R23 offered no complaint about feet. R23 was in the same position as during morning observation.

On 6/7/17 at 1:15 p.m. nursing assistant (NA)-A verified not providing repositioning for R23 this shift. NA-A indicated another staff person was

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assigned to R23.

On 6/7/17 at 1:47 p.m. NA-B indicated was in R23's room before noon to reposition R23. NA-B was unable to give the specific time of being in the resident's room.

On 6/8/17, at 2:00 p.m. RN-B verified no further wound measurements were documented. and was unable to explain why no additional measurements were documented when R23 returned from the hospital.

On 6/8/17, at 2:20 p.m. RN-B and surveyor entered R23's room and verified resident was not wearing foam protective boots. The boots were placed in nearby chair. RN-B was unsure why R23 was not wearing the foam boots.

On 6/8/17, at 3:46 p.m. the director of nursing (DON) first indicated the facility would not necessarily take wound measurements when returned from the hospital, however, the DON clarified the facility would assess wounds and document measurements according to the facility's policy. During this time, RN-B added the nursing assistant assigned to R23 on 6/7/17, indicated R23 was repositioned prior to lunch however, there were no times documented.

On 6/9/17, at 2:00 p.m., new wound measurements were provided: The right ankle stage II pressure ulcer measured in centimeters 1.6 x 0.8 with depth less than 0.1. The wound had improved. The measurements for the buttocks were 8 cm x 2.9 cm with depth 0.8 cm with drainage as purulent and color was identified as pink and red. Notes indicated slough was present and a fax was sent to the medical doctor for new

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F 314	Continued From page 31 orders. According to the measurements, the left buttocks pressure ulcer had increased in size. When interviewed, RN-B was unaware of what could have contributed to the change in size of the wound on R23's left buttocks. The facility's policy for Pressure Ulcer Prevention/Treatment, effective July 2015 indicated all residents will be assessed on admission and weekly for four weeks, quarterly, and with a significant change of condition using the Braden Risk Assessment and Skin Integrity Assessment: Prevention and Treatment Care Plan.	F 314		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) 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) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		7/19/17

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F 431	Continued From page 32 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to ensure medications were removed when expired for 1 of 1 resident (R132) whose eye ointment had not been removed from the medication cart and the facility did not ensure expired stock medications (Aplisol, tuberculin solution) were removed from medication storage on the north unit. This had the potential to affect	F 431	R132's eye ointment was removed from the medication cart. Expired stock medications (Aplisol, tuberculin solution) were removed from the medication refrigerator on north unit. Resident and stock medications were audited to ensure medications are labeled and dated with expiration dates.	

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F 431	Continued From page 33 residents admitted to the north unit. Findings include: On 6/7/17, at 2:07 p.m. during medication storage review of cart 2 on the transitional care unit, cart 2 contained an antibiotic ointment for R132. The physician order, dated 4/25/17, read: "Start polytrim 1 gtt {drop} each eye qid {four times a day} times 7 days." The medication was not removed from the medication cart. On 6/8/17, at 12:45 p.m. during review of the medication storage refrigerator on the north unit, 3 of 4 bottles of tuberculin (Aplisol) solution were found to be opened and not dated. One Aplisol (tuberculin, PPD) vial was opened and dated 3/27/17, and remained in the refrigerator available for use of residents. Two other vials of Aplisol remained in the medication refrigerator available for use, were opened, however not dated. Both vials had been dispensed 2/20/17. On 6/7/17, at 2:08 p.m. licensed practical nurse (LPN)-C verified the antibiotic eye drops were no longer being used and should have been removed from the medication cart. On 6/8/17, at 12:46 p.m. LPN-B indicated the vials should be removed and destroyed. LPN-B placed the expired Aplisol vials in the container for medications to be destroyed. On 6/9/17, at approximately 10:00 a.m. the director of nursing (DON) verified the the eye antibiotic medication should be removed from cart after stop date and the tuberculin solution vials should be removed 30 days after opening.	F 431	Licensed nurses and TMA's received education regarding: 1) Dating a new medication when the medication is opened. 2) Timely disposal of expired medications. 3) Timely removal and disposal of medications when resident discharges from the facility or the medication is no longer in use. DON/Designee will audit medication carts x2 weekly and 1 medication room weekly for 3 months to ensure compliance. Audit results will be reviewed at monthly QAPI meeting x3 months to ensure compliance. Date Certain: 7/19/17	

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F 431	Continued From page 34 The facility's policy for Storage and Expiration Dating of Medications, Biologicals, Syringes and needles, effective 12/1/07 indicated under Procedure 4. "Facility should ensure that medications and biologicals that (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines, or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier." and 5. "Once any medication or biological package is open, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the mediction container when the medication has a shortened expiration date once opened. 5.1 Facility staff may record the calculated expiration date based on date opened on the medication container. 5.2 Medications with a manufacturer's expiration date expressed in month and year (e.g. May, 2019) will expire on the last day of the month."	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 441		7/19/17

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F 441	Continued From page 35 conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 441		

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F 441	Continued From page 36 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were maintained for 2 of 2 residents (R17 and R111) observed for activities of daily living and the facility failed to ensure the mechanical stand lift was sanitized between uses. Findings include: During observation of wound and incontinence care for R17, staff were not observed to wash hands or use hand sanitizers after removing gloves and the EZ stand (mechanical stand lift) was not wiped down between resident use. On 6/8/17, at 10:11 a.m. - 10:51 a.m., during continuous observation of incontinent cares the following was observed: At 10:11 a.m. nursing assistant (NA)-C went into R17's room. R17 was sitting up in the wheel chair and asked to be laid down for a rest and to have the incontinent pad checked. NA-C replied being able to do that and would need to get R17 up in 30 minutes because R17 was expecting a visitor.	F 441	Employees assigned to provide care for R17 and R111 received education. Licensed/unlicensed nursing staff received re-education regarding: 1) Hand washing and hand sanitizer use during wound and incontinence care. 2) Sanitation requirements for mechanical lifts between resident use. 3) Hand washing and hand sanitizer requirements after removal of gloves. DON/Designee will audit 3 licensed/unlicensed nursing staff per week for 1 month and 1 licensed/unlicensed nursing staff per week for 2 months. Audit results will be reviewed at monthly QAPI meeting x3 months to ensure compliance. Date Certain: 7/19/17	

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F 441	Continued From page 37 At 10:21 a.m., NA-C and NA-E introduced self to resident, explained what was going to happen, washed hands and donned gloves to initiate cares. NA-E emptied R17's catheter bag. EZ stand (mechanical lift) brought in resident's room, setup and realized that the battery was low and had to change it. NA-E removed gloves, took the battery out and went to get another battery without washing hands or use of hand sanitizer when gloves were removed. At 10:23 a.m., NA-E donned gloves again without washing hands or use of hand sanitizer proceeded to assist R17 with the transfer via EZ stand and with assist from NA-C. NA-E assisted R17 with cares while NA-C assisted with positioning R17 on the side. R17's incontinent pad was wet with small to medium bowel movement. Incontinent pad was removed and a slit on the coccyx (in between the buttocks) and excoriation on the right buttock area was observed. At 10:24 a.m. licensed practical nurse (LPN)-B knocked on the door, entered and donned gloves without washing hands or use of hand sanitizer. At 10:25 a.m., LPN-B removed gloves, grabbed another pair of gloves and donned gloves without washing hands or use of hand sanitizer in between. At 10:27 a.m., LPN-B assessed resident's buttocks, touched excoriation, and slit area. LPN-B indicated that R17 had an order for Alleyn. At 10:29 a.m., LPN-B removed gloves, stepped out of R17's room and returned to R17's room at 10:31 a.m., donned gloves without washing hands or use hand sanitizer but proceeded in applying the Alleyn dressing on R17's buttock area. At 10:31 a.m., NA-C removed gloves, grabbed the EZ stand and left R17's room without washing hands or use of hand sanitizer and did not wipe down or disinfect the EZ stand. At 10:51 a.m., NA-C was observed taking the EZ	F 441		

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	245164	A. BUILDING _____ B. WING _____	C 06/09/2017

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F 441	Continued From page 38	F 441		

stand to R111's room to lay R111 down via EZ stand without disinfecting the EZ stand prior to using it for R111.

On 6/8/17, at 10:45 a.m., LPN-B verified not washing hands or use of hand sanitizer when gloves were removed when assisting R17 in the room and prior to leaving the room. LPN-B stated, "I forget to wash my hands or use hand sanitizer in between glove changes. I know that anytime you remove gloves, hands are supposed to be washed or use hand sanitizer".

On 6/8/17, at 10:59 a.m., NA-E confirmed not washing hands or use of hand sanitizer when gloves were removed when assisting R17 in the room and indicated, "I forget to do that, I will remember from now on to wash my hands or use hand sanitizer in between glove change".

On 6/8/17, at 11:02 a.m., NA-C acknowledged not washing hands or use of hand sanitizer when gloves were removed after assisting R17 in the room, prior to leaving the room and did not wipe down the EZ stand (mechanical lift) by disinfecting it when finished using it. NA-C mentioned, "I forget to wipe down the EZ stand between residents (R17 and R111) use and to wash my hands or use hand sanitizer before leaving the room. I will remember to wash my hands or use hand sanitizer from now on".

On 6/8/17, at 12:26 p.m., registered nurse (RN)-B stated, staff recently did training on hand washing and hand sanitizing and glove changes. We did the whole infection control training, which is a computer based training. RN-B added, the expectation is that all mechanical lifts are to be wiped down in between resident use. Staff should

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F 441	Continued From page 39 wash hands or use hand sanitizer in between glove changes and before leaving resident room after removing gloves. Policy and procedure titled HAND HYGIENE - ALCOHOL BASED HAND RUB dated, January 2017, directed staff, "the center requires personnel to use hand hygiene to remove dirt, organic material, and transient microorganisms. Example of when an alcohol based hand rub may be used: After removing gloves." Policy and procedure titled HAND HYGIENE - PLAIN SOAP AND WATER dated January 2017, read, "Hand hygiene is the most important procedure for preventing Healthcare Associated Infections... Plain soap is an effective agent. The center requires personnel to use hand hygiene to remove dirt, organic material and transient microorganisms. After removing gloves".	F 441		

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	245164	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2017**

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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 COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Health & Rehabilitation of New Brighton was found not to be in compliance with the requirements for participation in (Medicare(/)Medicaid) at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/07/2017

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 1 story building, built in 1963, was determined to be of Type II(222) construction. It has a partial basement, and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. that is monitored for automatic fire department notification. Also all resident rooms have single station smoke detectors. The facility has a capacity of 100 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT METas evidenced by:	K 000		
K 521 SS=D	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		7/19/17

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K 521	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 100 residents. Findings include: On a facility tour between the hours of 0800 and 1200 on Jun 08, 2017, observation revealed that the facility was using their egress corridors as an exhaust plenum. This deficiency need not be corrected with the approval of an annual waiver. This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 521	Corrected. Waiver submitted and accepted in 2014 per Fire Marshal	
K 754 SS=D	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96	K 754		7/19/17

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K 754	Continued From page 3 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On the facility tour between 0800 and 1200 on 06/08/2017 it was found that the facility was storing multiple bins exceeding 32 gallons for soiled linen containers per 64 square feet (in area). This deficient practices was confirmed by the Facility Manager.	K 754	Storage bins were removed from the area and replaced with new bins that do not exceed 32 gallons. ED/Designee to perform audits of facility storage areas. Audit results will be reviewed at monthly QAPI meeting. Date Certain: 7/19/17	