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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PRLB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00114

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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, Supervisor 07/012014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/01/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00452
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/12/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5164

July 1, 2014

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

Dear Ms. Hervin:

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

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

Effective "Last Alleged Compliance Date", the above facility is certified 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. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 1, 2014

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

RE: Project Number S5164023

Dear Ms. Hervin:

On May 20, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 8, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 8, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 8, 2014, effective June 17, 2014 and therefore remedies outlined in our letter to you dated May 20, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245164	A. Building B. Wing	6/27/2014

Name of Facility	Street Address, City, State, Zip Code
HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/17/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/17/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/17/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/17/2014**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **06/17/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/17/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	07/01/2014	16022	06/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/8/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PRLB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00114

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245164**
2.STATE VENDOR OR MEDICAID NO.
(L2) **296842800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/08/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 06/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00452
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5164

At the time of the standard survey completed 05/08/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5071

May 20, 2014

Ms. Sandra Larson, Administrator
Health and Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: Project Number S5164023

Dear Ms. Larson:

On May 8, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 June 17, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 17, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 8, 2014 (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 November 8, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	05/08/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAY 29 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION This Plan of Correction is not a submission of guilt on behalf of the provider. This Plan of Correction is being submitted because it is required by law.	6/17/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	F279 Resident #12 has had a care plan developed for dental/denture services All residents care plans have been reviewed for dental/denture services Licensed staff have been re-educated regarding care plans for dental/denture services DON/Designee will audit 5 charts per week for dental/denture care plans, results of audits will be reviewed at QPI Completion date : June 17, 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra Carson | TITLE: Administrator | (X6) DATE: 5/27/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	05/08/2014

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 279	Continued From page 1 by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care for oral hygiene for 1 of 1 resident (R12) in the sample who wore dentures. Findings include: During resident observation and interview, on 5/5/14, at 5:00 p.m., R12 was observed to have a broken upper tooth. When questioned at that time, R12 indicated it did not hurt but if someone wanted to fix it that would be great. R12 did not recall being seen by dental services. R12's medical record was reviewed. The initial MDS (minimum data set), dated 2/20/14, indicated the resident needed extensive assistance from staff for all activities of daily living including personal hygiene including dental. The admission data collection and assessment dated 2/13/1 4 indicated the resident had an upper partial on admission. There was no indication the denture had a broken tooth. The current plan of care, updated 4/27/14 indicated the resident needed physical assist of one or two for oral care daily and as needed. The care plan lacked documentation R12 had dentures and that R12 had a broken tooth in the dentures. On 5/8/14 at 11:11 a.m., nursing assistant (NA-A) indicated the staff clean the resident's dentures, however, R12 will take them out and hand them to you. NA-A reported the denture had been broken since his admission. The registered nurse manager (RN-H) on 5/8/14 at 11:45 a.m. verified the resident was admitted with the broken tooth. RN-H reviewed the care plan and agreed the care plan had not been developed correctly.	F 279		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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 pain control for 1 of 3 residents (R203) in the sample identified as having pain. Findings include: Resident 203 was admitted to the facility with pain and the facility failed to provide adequate pain relief. On 5/5/14 at 5:35 p.m. R203 was observed to be sitting on the bed holding her hands and rubbing them together and then would rub the knees. When resident stood up to get something, R203 said "Ouch, see this is how I have to do it as I try to walk." as resident took small steps while holding on to tray table. R203 added it must be the nerves inside of me or something. When R203 was asked about having discomfort without relief, R203 indicated she did have pain without relief. R203 reported needing pain medication during the previous night, and was told she did not have pain medication available at that time. The pain medication was scheduled to be given	F 309	F309: All residents are being observed for pain daily, residents positive for pain are receiving care and Services for pain. All nursing staff have been re-educated regarding care and services for pain. DON/Designee will audit 5 charts per week for care and services regarding pain, results of auditswill be reviewed at QPI. Completion date: June 17, 2014	

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F 309	Continued From page 3 at 8:00 a.m. R203 added, "so they gave me my anti anxiety pill" instead of the tramadol (pain medication). R203 was admitted to the facility on 4/30/14 with diagnoses of acute respiratory failure, fibromyalgia and diabetes. On 5 /7/14 at 10:00 a.m. the medical record was reviewed. Admission orders included the following: - Acetaminophen (Tylenol) 325 mg (milligram) 2 tablets every 4 hours if needed for mild pain - Hydrocodone-aceteaminophen 325 mg (Norco) take one tablet every 6 hours if needed for pain. - Tramadol (Ultram) 50 mg take one table four times a day for pain - Gabapentin 300 mg take 3 capsules three times a day for neuropathy pain. - Clonazepam 0.5 mg (Klonopin) take one daily as need for anxiety. - Methocarbamol (Robaxin) 500 mg 2 tablets three times a day for muscle spasms. On 5/2/14 the tramadol was decreased to 50 mg twice a day for pain and the methocarbamol was decreased to 500 mg three times a day for muscle spasms. The admission Pain Data Collection and Assessment was completed on 4/30/14. The assessment indicated R203 had arthritis and fibromyalgia. Tramadol, gabapentin and ibuprofen had been effective medications for the resident in the past. Tylenol had not been effective. The assessment indicated R203 had pain in the past 5 days and was currently having pain. On a scale of 0-10, R203 identified pain for back pain at a two; and joint, soft tissue and other areas were rated at a seven.	F 309		

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F 309	Continued From page 4 The current care plan identified resident as having persistent pain and altered comfort related to pain from fibromyalgia. Interventions directed staff to administer pain medications as ordered, monitor and record effectiveness, assess for verbal and not verbal signs and symptoms of distress or pain unrelieved by ordered treatments and medications and report to signs and symptoms of distress or pain unrelieved by ordered treatments/medications. Alternative comfort measures included cold packs, position change, relaxation techniques, massage, and smooth linens. A progress note from the interdisciplinary team, dated 5/1/14 indicated, R203 was admitted with weakness and fibromyalgia. The entry indicated ibuprofen had helped with pain in the past and R203 was currently taking Norco (hydrocodone-aceteaminophen,narcotic pain medication) as needed, scheduled tramadol, gabapentin and Robaxin (for muscle spasms). A review of the initial physician progress notes, dated 5/6/14, indicated, R203 was taking tramadol for pain/muscle weakness. The physician note read, "Not a good day for her today. Experiencing pain with activity but continues to work with PT/OT/ST." A review of the medication administration record (MAR) for April and May 2014 revealed, the hydrocodone-acetaminophen 5-325 mg had never transcribed onto the medication sheets. R203 did received clonazepam 0.5 mg at 12:15 a.m. on 5/5/14. The "prn analgesic record" indicated the medication, identified as Ativan, was given for anxiety, the pain rating was at a "5".	F 309		

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F 309	Continued From page 5 The record lacked evidence of follow up on effectiveness of the medication. When R203 requested pain medication on 5/513 only Tylenol 325 mg was available even though R203 had indicated it was not effective. On 5/7/14 at 1:41 p.m., the medical record was reviewed with the clinical manager/registered nurse (RN)-H. RN-H reported visiting with R203 that morning. R203 reported her knee was throbbing and the tramadol was not working. RN-H had updated the physician who increased the tramadol 50 mg to four times a day. After reviewing the admission orders and the initial pain assessment, RN-H agreed the hydrocodone-aceteminophen had not been ordered from hospitalization, and the ibuprofen had not been addressed even though R203 indicated it had been effective in the past. RN-H indicated R203's pain management needed to be controlled and provided additional information of talking with R203 and updating physician on what the resident indicated had been effective for pain management in the past.	F 309		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow up with pharmacy recommendations with the attending physician for 1 of 5 residents (R17) in the sample who were reviewed for unnecessary medications. Findings include: R17 was on an antipsychotic medication and the	F 329	F329: Resident #17 refused orthostatic BP monitoring. All residents requiring orthostatic BP monitoring due to psychotropic medications are having Orthostatic BPs monitored monthly. All Licensed staff have been re-educated regarding monitoring of orthostatic BPs. Don/Designee will monitor 5 charts per week for orthostatic BP monitoring; results of audits will be reviewed at QPI. Completion date: June 17, 2014 called re Hale 6/12 - RISKS + BENEFITS were communicated to RP, staff re-approached RP to have BP.	6/17/14

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F 329	Continued From page 7 facility failed to conduct monthly orthostatic blood pressures as recommended by pharmacy. Review of the medical record indicated R17 had diagnoses that included vascular dementia and a traumatic brain injury. R17 had a physician order for risperidone 1 mg/ml solution 0.25 milliliter (ml) (0.25 mg) orally at bedtime for paranoid delusions. Review of a pharmacist consulting report dated 6/19/13 requested the facility to consider monitoring postural blood pressures at least monthly assessing for orthostatic hypotension. The medical record lacked evidence of any follow up to this recommendation. On 5/8/14 at 10:15 a.m., the unit registered nurse manager (RN-A) reviewed the medical record including the current and past medication administration records and the vital flow sheet and verified orthostatic blood pressures were not being monitored and the recommendation had been overlooked. The policy/procedure for psychoactive medications, last revised 10/2009, indicated review of psychoactive medication may include the following, but is not limited to: pharmacy recommendations.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371: Food from the steam table is being distributed in a safe and sanitary manner. All food service employees have been re-educated regarding safe and sanitary food distribution. DSM/Designee will audit 5 meals per week; results of audits will be reviewed at QPI. Completion date: June 17, 2014	6/17/14

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F 371	Continued From page 8	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to serve food in a sanitary manner to prevent the spread of food borne illness for 1 of 2 dining rooms, this had the potential to affect approximately 30 of 74 residents that ate in the main dining room.

Findings include:

During observation in the main dining room on 5/5/14 at 5:09 p.m. staff were bringing residents into the dining room for supper. At 5:14 p.m. dietary aid (DA)-A was behind the steam table and had gloves on both hands, ready to temp the food for supper. DA-A proceeded by taking the thermometer, removed the probe cover, then inserted the probe into the grilled cheese sandwiches until temp was read. DA-A then removed the probe from the grilled cheese and leaned the thermometer up against the probe cover which was laying on the steam table counter. DA-A then removed gloves, came around the front of the steam stable, took a napkin from the table to the left of the steam table and placed the napkin on the top counter of the steam table. DA-A then proceeded to wash hands in the sink across the dining room and returned to the steam table and gloved both hands. DA-A grabbed the napkin off the top of the steam table counter and began to wipe the end of the thermometer probe with the napkin. DA-A then laid the napkin down on the counter beside him. DA-A continued this same process when he was

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F 371	Continued From page 9 temping the tomato soup until the dietary manager (DM) told him to use probe wipes kept under the steam table, instead of the napkin to wipe the end of the probe off. At 5:35 p.m. residents were sitting in the main dining room and staff members went around to the tables to ask residents what they would like to eat for supper. DA-A was wearing the same gloves that were used to take food temps and started to serve supper. DA-A grabbed a bowl from a stack of bowls off to the right, on the counter and ladled soup into the bowl. The bowl was put on the counter of the steam table. DA-A proceeds to grab a plate from the plate warmer, picked up a grilled cheese sandwich with gloved hands and placed it on the plate. DA-A then picked up a pickle spear from a round plastic container with gloved hands and placed it on the plate. DA-A then placed the plate over the soup bowl sitting on the steam table counter and placed the bowl and the plate on the top of the steam table. DA-A grabbed the menu slip with the same gloved hands and placed the menu slip next to the bowl and plate on the top of the steam table for staff to deliver to the resident. At 5:49 p.m. DA-A goes went to the warming tray, grabbed a set of warming mitts, opened the warming tray with gloved hands and pulled out a silver metal tray of grilled cheese sandwiches and placed them on the counter of the steam table. DA-A then closed the warming tray with gloved hands and proceeded to grab the warming mitts to switch out the silver metal trays on the steam table. At 5:53 p.m. staff brought 4 more menu slips and placed them on the top counter of the steam table. DA-A grabbed the slips off the top of the counter, with the same gloved hands, and placed the menu slips on the counter of the	F 371		

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F 371	Continued From page 10 steam table next to him. DA-A continued to serve the supper meal until 6:09 p.m. in this fashion, wearing the same gloved hands during the entire meal. During interview on 5/5/15 at 6:15 p.m. DA-A confirmed he wore the same pair of gloves during the entire meal service, and verified he handled each residents menu slip between preparing each meal. DA-A also stated "for sandwiches we always use our hands." and confirmed this was not a sanitary manner to serve ready to eat food. During interview on 5/7/14 at 11:23 a.m. DM confirmed DA-A should not be using a napkin in-between temping food, should be using probe wipes instead and verified this is not good infection control measures. DM also confirmed that DA-A should not be touching the menu slips with his gloved hands and should be using tongs while he is serving. DM stated "this is not sanitary and good infection control measures to handle food. " Review of the facility policy titled, Serving, revised 7/2011,directed staff to serve food safely in order to prevent contamination and foodborne illness, never to touch cooked or ready to eat (i.e., raw fruits/vegetable, breads) and use sanitized thermometer.	F 371	Call to Aspen 6/11/14 R12 was short term stay. Discharged 5/23/14. Dentures were going to be repaired after discharge.	6/11/14
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this	F 411	F411: Resident #12 declined dental services for repair of his denture. All residents are being offered dental services. Nursing and Social Service staff have been re-educated regarding provision of dental services. DSS/Designee will audit 5 charts per week for offering of dental services audit results will be reviewed at QPI. Completion date: June 17, 2014	

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F 411	Continued From page 11 part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 1 resident (R12) reviewed for dental services. Findings include: During resident observation, on 5/5/14, at 5:00 p.m., R12 was observed to have a broken upper tooth. When questioned at that time, R12 indicated it did not hurt but if someone wanted to fix it that would be great. R12 did not recall being seen by dental services. R12's medical record was reviewed. R12 was admitted to the facility on 2/13/14 with diagnosis of aspiration pneumonitis and dementia without behaviors. The initial MDS (minimum data set), dated 2/20/14, indicated the resident needed extensive assistance from staff for all activities of daily living including personal hygiene including dental. The admission data collection and assessment, dated 2/13/1 4, indicated the resident had a upper partial on admission. There was no indication the denture had a broken tooth. The plan of care, updated 4/27/14, indicated the resident needed physical assist of one or two staff persons for oral care daily and as needed. The check off for loose or broken teeth was not	F 411		

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F 411	Continued From page 12 marked off, and having dentures was not included in the care plan. On 5/8/14 nursing assistant (NA-A) indicated the staff clean the resident's dentures, however, he will take them out and hand them to you. NA-A reported the denture had been broken since his admission. The registered nurse manager (RN-H) on 5/8/14 at 11:45 a.m. verified the resident was admitted with the broken tooth. RN-H reviewed the care plan and agreed it had not been developed correctly. RN-H indicated the facility did have dental services visit on a scheduled basis; however, the resident had not been scheduled for any appointment. The unit social worker (SW-A) reported on 5/8/14 at 11:55 a.m., dental services had not been offered to the resident since admission and indicated the resident would be transferring from the transitional care unit to the long term care unit and services would be offered. The Dental Services Policy/ Procedure, effective 4/2000, indicated, the facility will assist residents in obtaining routine and 24 hour emergency dental care. The procedure identified those with damaged dentures would need a prompt referral.	F 411	F441: An infection control program has been implemented; procedures are in place for insulin. Administration, storage of ice packs, screening and documenting mantoux for employees and residents. All staff have been re-educated regarding infection control programs and procedures. DON/Designee will audit infection control program weekly, 5 insulin administrations, all food refrigerators weekly, 5 resident mantoux weekly and new employees. Audit results will be reviewed at QPI. Completion date: June 17, 2014	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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F 441	Continued From page 13 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to establish an infection control program that included comprehensive surveillance of employee symptoms, analysis of that surveillance, and investigation of patterns identified through the analysis. This had the potential to affect 74 of 74 residents who resided in the facility. Also, the facility did not ensure proper infection control procedures were followed	F 441		

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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 441	Continued From page 14 for 2 of 2 residents (R 64 and R117) observed to receive insulin injections. In addition, the facility failed to ensure proper infection control techniques were followed to minimize the spread of infection for 1 of 1 resident (R7) whose ice cream sundae cones were observed with reusable ice packs stored in 1 of 4 refrigerators, and potentially affecting residents who stored food in resident use refrigerators. Findings include: During review of the facility's Infection Control Log(s) from December 2013, through May 2014. The facility's infection control logs were being completed by the infection control coordinator (ICC); however, the ICC did not analyze the data to track and trend patterns of infections within the facility. Furthermore, the ICC lacked surveillance logs for employee infections/diseases for comparison to the resident logs during analysis and investigation. On 5/7/14, at 2:19 p.m. the director of nursing (DON) confirmed that she did not have any documentation to support analysis of the infection control logs for employees and just got caught up on the infection control logs for the residents. She was unable to produce any other documentation to support infection control surveillance within the facility to track/trend staff and resident infection/disease. Review of the facility policy titled Infection Prevention and Control Program, revised on 11/2009, indicated the infection control program goal was to identify and reduce the risks of acquiring and transmitting infections among residents and employees. Further more indicated to record infections on the monthly line listing reports/monthly healthcare associated infection incidence rate, identifying and track all healthcare associated infections.	F 441		

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 _____	05/08/2014

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 441	Continued From page 15 During observation of medication administration on 5/5/14 at 5:08 p.m., Licensed Practical Nurse (LPN-A) administered R117's Humalog insulin per physician order. LPN-A did not cleanse the administration site with alcohol before administering the insulin. LPN-A on 5/5/14 at 5:10 p.m. administered R64's Novolog insulin, and did not cleanse the site before administering the insulin. On 5/5/14 at 5:30 p.m., LPN-A verified that she did not cleanse the site before administering the insulin. Interview with the Director of Nursing on 5/5/14 at 5:35 p.m., she verified the facility policy regarding the cleansing of the insulin administration site. Review of the facility's insulin Injection procedure dated April 2006 directed the following: 17. Cleanse selected site with alcohol wipe using a circular motion from center of site and working out. Allow to dry. The refrigerator in the north nursing station back room was observed on 5/6/14, at 9:56 a.m. accompanied by the nurse manager. The freezer held seven re-useable ice packs, and was stored next to two vanilla with carmel core sundae cones labeled with R7's name. Several containers of ice cream were also stored in the freezer; including six vanilla flavored reduced fat ice cream coated with orange sherbets in unlabeled bucket. During an interview with registered nurse (RN)-A on 5/6/14, at 11:14 a.m. RN-A stated, the ice packs should have been stored separately in the	F 441		

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 _____	05/08/2014

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 441	Continued From page 16 medication room and not with food. RN-A verified findings and removed the ice packs from the freezer. In addition, RN-A stated, "They are not supposed to put the ice packs in this freezer." A voice message from the administrator on 5/9/14, at 10:20 a.m. the administrator stated, the facility did not have a policy and procedure related to the storage of ice packs.	F 441		

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

F516 4023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH AND REHABILITATION OF NEW BRIG	**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
K 000	INITIAL COMMENTS FIRE SAFETY 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 to be in substantial compliance with the requirements for participation in (Medicare(/)Medicaid) at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5071

May 20, 2014

Ms. Sandra Larson, Administrator
Health and Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, Minneosta 55112

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5164023

Dear Ms. Larson:

The above facility was surveyed on May 5, 2014 through May 8, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions about this letter.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Original - Facility
Licensing and Certification File