CENTERS FOR MEDICARE & MEDICAID SERVICES

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5. EFFECTIVE DATE CHANGE OF OW (L9) 07/01/2015 6. DATE OF SURVEY 07/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW! 18 SNF 18/19 SNF 100 (L37) (L38)	100 (L18) 100 (L17) N 19 SNF (L39)	B. Not in Comp Requirements a ICF (L42)	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP (S CERTIFIED AS: ce With puirements Based On: cceptable POC colliance with Program nd/or Applied Waiv IID (L43)	09 ESRD 10 NF 11 ICF/IID 12 RHC	02	6. Scope of Service 7. Medical Direct	DATE: (L35) ces Limit
17. SURVEYOR SIGNATURE Susanne Reuss,	Unit Supervis	Date :	07/05/2016		18. STATE SURVEY AGENCY AI		Date: 07/15/2016
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28. TERMINATION DATE:	29	INTERMEDIARY/CA	ARRIER NO.		30. REMARKS		
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32. DETERMINATION OF APPROVAL DATE

06/22/2016

(L32)

Posted 07/28/2016 Co.

DETERMINATION APPROVAL

(L33)

31. RO RECEIPT OF CMS-1539



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245164 July 15, 2016

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 June 30, 2016 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.

Health and Rehabilitation of New Brighton July 15, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 15, 2016

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

RE: Project Number S5164025

Dear Ms. Hervin:

On June 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016 that included an investigation of complaint number. 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 5, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 6, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 19, 2016, effective June 30, 2016 and therefore remedies outlined in our letter to you dated June 2, 2016, 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.

Health and Rehabilitation of New Brighton July 15, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

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POST-CERTIFICATION REVISIT REPORT

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CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: U11X

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AGENCY		F	acility ID: 00114
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245164 2.STATE VENDOR OR MEDICAID NO. (L2) 296842800	0.	3. NAME AND ADD (L3) HEALTH AN (L4) 825 FIRST A (L5) NEW BRIGH	ND REHABILITA EVENUE NORTH	ATION OF M	NEW BRIGHTON (L6) 55112	1. 3. 5.	YPE OF ACTION: Initial Termination Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
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6. DATE OF SURVEY 05/19/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCA	AL YEAR ENDING 12/31	DATE: (L35)
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14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 100	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
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Robyn Woolley,			06/13/2016	(L19)	Kate JohnsTo		-	06/17/2016 (L20)
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22. ORIGINAL DATE OF PARTICIPATION 12/09/1968	23. LTC AGREEMI BEGINNING I		24. LTC AGREEME ENDING DATI		26. TERMINATION ACT VOLUNTARY 01-Merger, Closure	00_	INVOLUNT	ARY eet Health/Safety
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DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 2, 2016

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

RE: Projects Numbered S5164025, H5164111, H5164113, H5164114, H5164115

Dear Ms. Hervin:

On May 19, 2016, 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 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 19, 2016 standard survey the Minnesota Department of Health completed an investigation of complaints numbered H5164111, H5164113, H5164114, H5164115 which were found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 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 June 28, 2016, 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

Health and Rehabilitation of New Brighton June 2, 2016 Page 4

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.

Health and Rehabilitation of New Brighton June 2, 2016 Page 5

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 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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

Health and Rehabilitation of New Brighton June 2, 2016 Page 6

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

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure

cc: Licensing and Certification File

PRINTED: 06/13/2016 FORM APPROVED OMB NO. 0938-0391

7111011 27111 01	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COM	E SURVEY IPLETED
		245164	B. WING _		05/	19/2016
	ROVIDER OR SUPPLIER AND REHABILITATIO	N OF NEW BRIGHTON		STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
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	as your allegation o Department's accer enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the stance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.				
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		vey was conducted and tions were also completed at dard survey.				
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1		he results of the assessment and revise the resident's n of care.				
	plan for each reside objectives and time medical, nursing, ar	velop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive				
	to be furnished to a	describe the services that are ttain or maintain the resident's	IATI DE	TITLE		(X6) DATE

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

Electronically Signed

06/09/2016

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

PRINTED: 06/13/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245164	B. WING _		05/	19/2016
	PROVIDER OR SUPPLIER AND REHABILITATION	ON OF NEW BRIGHTON		STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	psychosocial well- §483.25; and any s be required under due to the resident §483.10, including under §483.10(b)(a This REQUIREME by: Based on docume	e physical, mental, and peing as required under services that would otherwise §483.25 but are not provided the right to refuse treatment the right to refuse treatment 4). NT is not met as evidenced ent review and interview, the	F 2'	Preparation, submission and		
	coordinated, and ir regarding hospice reviewed for hospi Findings include: Record review review review an admission record also contain Medicare Hospice began hospice car Terminal Illness, dahospice diagnosis leukemia.	ealed an Admission Record date of 4/23/16 for R31. The ned a Notice of Election for Benefit form showing that R31 e on 4/29/16. A Certificate of ated 4/29/16, listed the primary as chronic lymphocytic		implementation of this plan of do not constitute an admission agreement with the facts and do set forth on the survey report. correction is prepared and exemeans to continuously improve of care and to comply with all a state and federal regulatory received. R31 has had a Compreher Hospice Care Plan review and R31's care plans has been revupdated to ensure a compreher coordinated, and individualized hospice care. Residents at Health and Rehabilitation of New Brighton	of or onclusions Our plan of cuted as a the quality pplicable quirements. asive update. ewed and nsive, plan of	
	contained entries f discharge plan, so Discharge entry re Care Due to Resid Services entry rea Resident and Fam entry read, "Provid	nt plan of care, dated 5/2/16, or hospice care related only to cial services, and mood. The ad, "Resident is on End of Life ent Dx [diagnosis]." The Social d, "Possible Hospice Care per ily." The Mood and Behavior e comfort and prn [as needed] mfort. Resident is on Hospice es [sic]."		signed onto hospice services he potential to be affected by this All residents who are signed or services are at risk and have he of the Hospice Care Plan and comprehensive care plans and assistant care guides have been all staff responsible for implication and integrated plan of care will be on the process of hospice and plan integration by DON/Desig	ave the practice. Into hospice and a review nursing an updated. It is also be educated facility care	

PRINTED: 06/13/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245164	B. WING			05/	19/2016
	ROVIDER OR SUPPLIER AND REHABILITATIO	N OF NEW BRIGHTON		82	REET ADDRESS, CITY, STATE, ZIP CODE 5 FIRST AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 F 309 SS=D	hospice provider, da generic and did not specific to the resid form that were filled of those developing hospice nurse and a When interviewed or registered nurse (R this unit, stated that the hospice provide on the facility's care refer to the hospice 483.25 PROVIDE OF HIGHEST WELL BISE Each resident must provide the necessary or maintain the high mental, and psychological forms to the resident must provide the necessary maintain the high mental, and psychological forms that were supported to the resident must provide the necessary maintain the high mental, and psychological forms that were filled to the resident must provide the necessary maintain the high mental, and psychological forms that were filled to the resident must provide the necessary that were filled to the resident must provide the necessary that the resident must provide the necessary the resident must provide the necessary that the resident	ed a plan of care from the ated 4/29/16, that was include individualized details ent aside from blanks on the lin with the diagnosis, names the plan, and frequency of aide visits for R31. on 5/19/16, at 1:53 p.m. N)-A, the nurse manager for facility staff generally follow r's care plan and write entries a plan directing facility staff to provider's care plan.	F 2		Resident Hospice Care Plan wireviewed quarterly and PRN at Comprehensive Care Plan Review (CCPR) meetings held weekly to as care plan assessments are appropand current. DON/Designee will auresults from CCPR meetings to enscare plan accuracy x3 charts week one month, then x1 chart weekly for additional two months. Audit results will be reviewed a monthly QAPI meetings x3 months ensure consistent implementation of plan components. Completion date: June 28, 201	ssure riate dit sure ly for r an t to of care	6/28/16
	by: Based on documer facility did not devel individualized, and or related to hospice for reviewed for hospice. Findings include:	ont review and interview, the lop a comprehensive, coordinated plan of care or 1 of 1 resident (R31) e care.			Preparation, submission and implementation of this plan of corredo not constitute an admission of o agreement with the facts and concl set forth on the survey report. Our correction is prepared and execute means to continuously improve the of care and to comply with all applic state and federal regulatory require	r usions plan of d as a quality cable	

PRINTED: 06/13/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(SURVEY PLETED
		245164	B. WING			05/1	19/2016
	PROVIDER OR SUPPLIER AND REHABILITATION	ON OF NEW BRIGHTON		STREET ADDRESS, CITY, STATE 825 FIRST AVENUE NORTHW NEW BRIGHTON, MN 551	VEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD E O THE APPROPRI	3E	(X5) COMPLETION DATE
F 309	record also contain Medicare Hospice began hospice care Terminal Illness, da hospice diagnosis a leukemia. The facility's currer contained entries for discharge plan, soon Discharge entry reach Care Due to Reside Services entry reach Resident and Familientry read, "Provide medications for confor End of Life Care The record contain hospice provider, dispersion and did not specific to the resident that were filled of those developing hospice nurse and When interviewed or registered nurse (Find the hospice provided on the facility's care	date of 4/23/16 for R31. The ed a Notice of Election for Benefit form showing that R31 e on 4/29/16. A Certificate of ated 4/29/16, listed the primary as chronic lymphocytic at plan of care, dated 5/2/16, or hospice care related only to sal services, and mood. The ed, "Resident is on End of Life ent Dx [diagnosis]." The Social I, "Possible Hospice Care per ly." The Mood and Behavior e comfort and prn [as needed] mfort. Resident is on Hospice	F3	R31 has had a Co Hospice Care Plan rev R31's care plans has be updated to ensure a concoordinated, and individually hospice care. Residents at Healt Rehabilitation of New Be signed onto hospice sepotential to be affected All residents who are services are at risk and of the Hospice Care Plans care plansistant care guides be All staff responsible an integrated plan of conthe process of hospilan integration by DO Resident Hospice reviewed quarterly and Comprehensive Care In (CCPR) meetings held care plan assessments and current. DON/Desteresults from CCPR meeting held care plan accuracy x3 one month, then x1 chadditional two months. Audit results will be monthly QAPI meeting ensure consistent implipan components. Completion date: Completion date	view and update been reviewed omprehensive idualized plan th and Brighton who are vices have to by this practisigned onto he dans and nurshave been upole for implementare will be educice and facility N/Designee. Care Plan will depend and plan Review developer will and eletings to ensure the control of the	d and e, of are he ice. ospice review ing dated. enting ucated by care I be sure iate lit ure y for an to f care	

5164075

PRINTED: 06/16/2016 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 01 - MAIN BUILDING 01 245164 B. WING 05/17/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **825 FIRST AVENUE NORTHWEST** HEALTH AND REHABILITATION OF NEW BRIGHTON **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Health & Rehabilitation of New Brighton was found not 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. 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: Marian.Whitney@state.mn.us and (X6) DATE

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

TITLE

Electronically Signed

06/09/2016

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

Facility ID: 00114

PRINTED: 06/16/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG 01 - Main Building 01		MPLETED
		245164	B. WING	-	05	/17/2016
	PROVIDER OR SUPPLIER	ON OF NEW BRIGHTON		STREET ADDRESS, CITY, STATE, ZIP CODI 825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000		on@state.mn.us ORRECTION FOR EACH ST INCLUDE ALL OF THE	K 0	00		
	 A description of to correct the defi The actual, or p The name and/responsible for co 	what has been, or will be, done				
	determined to be has a partial base sprinklered throug alarm system with corridors and spa monitored for autonotification. Also station smoke def	ng, built in 1963, was of Type II(222) construction. It ment, and is fully fire shout. The facility has a fire a smoke detection in the ces open to the corridors, that is omatic fire department all resident rooms have single sectors. The facility has a eds and had a census of 81 at rvey.				
K 018 SS=D	NOTMETas evide NFPA 101 LIFE S Doors protecting required enclosur hazardous areas as those constructore wood, or cap 20 minutes. Clear and floor covering in fully sprinklered	at 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD corridor openings in other than es of vertical openings, exits, or shall be substantial doors, such sted of 13/4 inch solid-bonded bable of resisting fire for at least rance between bottom of door is not exceeding 1 inch. Doors it smoke compartments are only the passage of smoke. There is	К0	18		6/30/16

Facility ID: 00114

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 06/16/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION 01 - MAIN BUILDING 01	COMPLETED
		245164	B. WING		05/17/2016
	PROVIDER OR SUPPLIE	ION OF NEW BRIGHTON		STREET ADDRESS, CITY, STATE, ZIP CODE 325 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
K 018	open devices that pushed or pulled provided with a m door closed. Duto permitted. Door fi made of steel or owith 8.2.3.2.1. Ro CMS regulations 19.3.6.3 This STANDARD Based on the obfacility had severameet the requirer Section 19.3.6.3, or latch. This def safety of all reside number of staff a were allowed to emaking it untenated where the facility tout 5/17/2016 observed following room down 166 Rm - 166 Rm - 175 Rm - 103 Rm - 82 (Second The deficient practices of pulled in the practices of pulled in the pulled in t	the closing of the doors. Hold the release when the door is are permitted. Doors shall be the doors meeting 19.3.6.3.6 are the doors meeting 19.3.6.3.6 are the rames shall be labeled and other materials in compliance of the rames are prohibited by in all health care facilities. Is not met as evidenced by: servation and staff interview, the factor doors that did not ments of NFPA 101 LSC (00) they did not fit tight in the frame ficient practice could affect the tents and an undetermined and visitors, if smoke from a fire enter the exit access corridors one. In between 0930 and 1330 on rations revealed that the the cors did not positively latch: ary door to Central Supply room) of tice was observed by the	K 018	Preparation, submission and implementation of this plan of correct do not constitute an admission of or agreement with the facts and conclus set forth on the survey report. Our placorrection is prepared and executed a means to continuously improve the quof care and to comply with all applical state and federal regulatory requiremental four affected doors will be replaced. The locksets and hinges will be replaced by June 17th 2016. The doot takes longer to get in due to being a special order. June 30th 2016 is the proposed completion date. I (Tom Lenk) as Maintenance Dirfor the building have taken responsib to make sure these repairs are perforon time to ensure the safety of our residents.	ions an of as a uality ole ents. aired ector
K 025 SS=E	NFPA 101 LIFE S Smoke barriers s least a one half h constructed in ac	commental Services (TL). SAFETY CODE STANDARD Chall be constructed to provide at our fire resistance rating and cordance with 8.3. Smoke permitted to terminate at an	K 025		6/30/16

PRINTED: 06/16/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245164	B. WING.		05/	17/2016
	PROVIDER OR SUPPLIER	ON OF NEW BRIGHTON		STREET ADDRESS, CITY, STATE 825 FIRST AVENUE NORTHV NEW BRIGHTON, MN 551	E, ZIP CODE VEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
K 025	fire-rated glazing o steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD Based on observa facility failed to ma accordance with th 2000 NFPA 101, S The deficient pract patients and an un and visitors. Findings include: On the facility tour 5/17/2016 observa barriers had peneti locations:	ws shall be protected by r by wired glass panels and 7.5 is not met as evidenced by: tion and staff interview, the intain smoke barrier walls in the following requirements of ection 19.3.7.3, and 8.3.4.1. ice could affect 70 of the 100 determined amount of staff between 0930 and 1330 on tions revealed that smoke rations at the following	K 0	 All affected areas fire safety and a whole completed of all smok The sealant and completed by June 17 	te barrier walls. audit will be Ith 2016 Ith aintenance Director aken responsibility epairs are performed	
K 027 SS=D	Over the Houseker Services Area smo penetrations above approved method in area around the real The penetrations who both sides of the same The deficient pract Director of Environ NFPA 101 LIFE SAME	eping and Environmental ske doors there a large the bundle of wires and and need to be used to seal the paired cut-out area. will all need to be sealed on	ΚO	27		6/30/16
	20-minute fire prot 10-inch thick solid protective plates the	ection rating or are at least a bonded wood core. Non-rated nat do not exceed 48 inches the door are permitted.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00114

PRINTED: 06/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
		245164	B. WING			05/1	7/2016
	PROVIDER OR SUPPLIER AND REHABILITATION	N OF NEW BRIGHTON		82	REET ADDRESS, CITY, STATE, ZIP CODE 15 FIRST AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 027	Doors are self-clos accordance with 19 not required to swir latching is not required. 19.3.7.7 This STANDARD is Based on observathas failed to mainta accordance with LS practice could affect Findings include: On facility tour betwo 5/17/2016, observation of the smoke barrier dining room overlaproperly.	oors comply with 7.2.1.14. ing or automatic closing in 0.2.2.2.6. Swinging doors are no with egress and positive ired. 19.3.7.5, 19.3.7.6, is not met as evidenced by: tions and interview, the facility ain smoke/fire barrier doors in SC 19.3.7.5. This deficient all patients. I ween 0930 and 1330 on vation revealed: I doors leading to the main opped and did not close		027	Replacement hinges are on order properly square up the affected doctors frame The door repairs will be done to 30th 2016 If (Tom Lenk) as Maintenance If for the building have taken respons to make sure these repairs are per on time to ensure the safety of our residents.	or by June Director sibility formed	

Facility ID: 00114



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered June 2, 2016

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

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number S5164026

Dear Ms. Hervin:

The above facility was surveyed on May 16, 2016 through May 19, 2016 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. 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.

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 Supervised Living Facilities.

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 is 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 first page of the order form should be signed and returned to this

office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. 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 Susanne Reuss, Unit Supervisor at (651) 201-3793. A written plan for correction of licensing orders is not required.

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

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

Feel free to contact me with any questions related to this letter.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

PRINTED: 06/13/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00114 05/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST **HEALTH AND REHABILITATION OF NEW BRIG NEW BRIGHTON, MN 55112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments

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

INITIAL COMMENTS:

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

06/09/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00114	B. WING		05/19/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HEALTH	AND REHABILITATION	IN OF NEW BRIG	T AVENUE N GHTON, MN	IORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure procompletion date, th corrected prior to e Minnesota Department"s staff the following correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigations of correction that you and identify the dat Investigation of the cassessment as def comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. The 05/19/16, surveyors of this visited the above provider and ction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed. Implaints H5164111, 14, and H5164115 were and not to be substantiated.	2 555			6/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
		00114	B. WING		05/1	9/2016
	PROVIDER OR SUPPLIER	N OF NEW BRIG 825 FIRS		STATE, ZIP CODE NORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 555	This MN Requirements: Based on document facility did not deve coordinated, and in regarding hospice for reviewed for hospice freviewed for hospice. Record review revewith an admission of record also contain. Medicare Hospice for began hospice care Terminal Illness, dathospice diagnosis a leukemia. The facility's current contained entries for discharge plan, soot Discharge entry read Services entry read Services entry read Resident and Familientry read, "Provide medications for confor End of Life Care. The record contained hospice provider, digeneric and did not specific to the reside form that were filled of those developing hospice nurse and did not specific nurse and did not specific to the resident form that were filled of those developing hospice nurse and did not specific nurse and did not nurse nurse nurse nurse nurse nurse nurse nurse n	ent is not met as evidenced at review and interview, the lop a comprehensive, dividualized plan of care or 1 of 1 resident (R31) are care. Faled an Admission Record date of 4/23/16 for R31. The ed a Notice of Election for Benefit form showing that R31 are on 4/29/16. A Certificate of ated 4/29/16, listed the primary as chronic lymphocytic at plan of care, dated 5/2/16, or hospice care related only total services, and mood. The ad, "Resident is on End of Life ent Dx [diagnosis]." The Social, "Possible Hospice Care per ly." The Mood and Behavior e comfort and prn [as needed] infort. Resident is on Hospice es [sic]." Bed a plan of care from the ated 4/29/16, that was include individualized details lent aside from blanks on the d in with the diagnosis, names the plan, and frequency of	2 555	corrected		

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE			SURVEY LETED	
			A. BUILDING:			
		00114	B. WING		05/1	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HEALTH	AND REHABILITATION	IN OF NEW BRIG	T AVENUE N GHTON, MN	IORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 3	2 555			
	this unit, stated that the hospice provide on the facility's care	t facility staff generally follower's care plan and write entries plan directing facility staff to provider's care plan.				
	The director of nurs procedures related care for hospice ca these polices, and a	THOD OF CORRECTION: sing could develop policies and to development of plan of re, educate staff regarding audit resident records for e policies and procedures.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			6/28/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on document facility did not deve individualized, and	ent is not met as evidenced at review and interview, the lop a comprehensive, coordinated plan of care or 1 of 1 resident (R31)		corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00114	B. WING		05/	19/2016
	PROVIDER OR SUPPLIER AND REHABILITATIO	N OF NEW BRIG 825 FIRS		STATE, ZIP CODE NORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 830	reviewed for hospice Findings include: Record review revewith an admission of record also contains Medicare Hospice Ebegan hospice care Terminal Illness, da hospice diagnosis a leukemia. The facility's currencontained entries for discharge plan, soon Discharge entry read Services entry read Resident and Familientry read, "Provide medications for confor End of Life Care The record contained hospice provider, dispension of the resident and did not specific to the resident form that were filled of those developing hospice nurse and When interviewed or registered nurse (Rethis unit, stated that	realed an Admission Record date of 4/23/16 for R31. The ed a Notice of Election for Benefit form showing that R31 e on 4/29/16. A Certificate of ted 4/29/16, listed the primary as chronic lymphocytic It plan of care, dated 5/2/16, or hospice care related only to sial services, and mood. The ad, "Resident is on End of Life ent Dx [diagnosis]." The Social I, "Possible Hospice Care per ly." The Mood and Behavior e comfort and prn [as needed] infort. Resident is on Hospice es [sic]." The da plan of care from the lated 4/29/16, that was include individualized details lent aside from blanks on the d in with the diagnosis, names of the plan, and frequency of	2 830			
	refer to the hospice	e plan directing facility staff to provider's care plan. THOD OF CORRECTION:				

Minnesota Department of Health

STATE FORM 6899 U11X11 If continuation sheet 5 of 10

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00114	B. WING		05/1	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HEALTH	AND REHABILITATIO	N OF NEW BRIG	T AVENUE N GHTON, MN	IORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
	procedures related care for hospice ca these polices, and a compliance to these	sing could develop policies and to development of plan of re, educate staff regarding audit resident records for e policies and procedures. R CORRECTION: Twenty-one				
21426	MN St. Statute 144A Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			6/28/16
	maintain a comprehinfection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volume Health shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.				
	by: Based on staff inter	ent is not met as evidenced rview and document review, ensure 5 of 5 residents (R43,		corrected		

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3			(X3) DATE SURVEY COMPLETED	
		00114	B. WING		05/1	9/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
HEALTH	AND REHABILITATION	IN OF NEW BRIG	T AVENUE N GHTON, MN	ORTHWEST 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	Continued From pa	ge 6	21426				
	(E-1, E-3, E-4, E-5, skin testing (TST) v and interpretation re ensure the facility's contained current re	d R198) and 5 of 6 employees and E-6) received tuberculin which included both induration eading results, and failed to tuberculosis screening policy egulatory procedures. This effect all 80 residents in the sitors.					
	Findings include:						
	R43 was admitted to the facility on 4/5/16. R43 received a first step TST on 4/6/16 and a second step TST on 4/16/16. Both TST results lacked an interpretation of the results (positive or negative).						
	received a first step	o the facility on 3/24/16. R49 o TST on 3/24/16 and a n 4/3/16. Both TST results n of the results.					
	R77 was admitted to the facility on 2/26/16. R77 received a first step TST on 2/27/16. The TST results lacked the date of the reading. R77 received a second step TST on 3/8/16. The TST results lacked induration and interpretation of the results.						
	R99 was admitted to the facility on 1/21/16. R99 received a second step TST on 2/6/16. The TST results lacked interpretation of results.						
	received a first step results lacked inter received a second	to the facility on 5/4/16. R198 o TST on 5/5/16. The TST pretation of the results. R198 step TST on 5/12/16. The millimeters of induration.					
	On 5/17/16, informa	ation on staff tuberculosis					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00114		B. WING		05/	19/2016
	PROVIDER OR SUPPLIER AND REHABILITATIO	N OF NEW BRIG	825 FIRS		STATE, ZIP CODE IORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21426	E-1 was hired at the facility was unable to TST, or symptom s E-2 was hired at the facility was unable to fa TST or symptom s E-3 was hired at the facility provided a distatus form. The for tuberculosis screen. Indicated "Please pany test results to the facility provided and the facility provided and the facility was unable to fa TST or symptom of a TST or sympt	rested, and the facility on information on 5/- e facility on 4/20/16. To provide documentation on hire. re facility on 4/11/16. To provide any document screen on hire. re facility on 3/30/16. To provide any document titled "Evaluation had a "X" next to be ening, and a "X" neat to be ening and a "X" neat to be en	The ation of a The nentation The pation of the line at to line rm form and exiscuss exister for ith provide The nentation The grool for o provide the facility ST, but 15/19/16, llows their	21426			

Minnesota Department of Health

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00114	B. WING		05/	19/2016
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	STATE, ZIP CODE		
HEALTH	AND REHABILITATIO	N OF NEW BRIG	FIRST AVENUE N BRIGHTON, MN	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21426	Tuberculosis Scree dated revised Octobe following: The center will: - Administer a treatment of the comment o	the changes. by's policy: Procedure ning - Healthcare Worker over 2015 directed the wo-step Tuberculin Skin Team (Wealthcare Workers) as that do not have of a negative TST which ed millimeters (mm) of form a two-step TST on all al volunteers unless otherwork complete and read the fint contact. Can Administer second step and no more than three egative result from the first on the second step and the first of the second step and the second ste	rise rst no t for e is ed ld ear), on ning, s			

Minnesota Department of Health

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		00114	B. WING		05/1	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
HEALTH	AND REHABILITATION	IN OF NEW BRIG	T AVENUE N GHTON, MN	IORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	90 days before hire Page 23, Screening principles, "Screening principles, "Screening 72 hours of admiss admissionTST do should include the of the number of millir induration, docume (i.e., positive or neg SUGGESTED MET The director of nurs policies and proceed The director of nurs staff to their policies employee and resid and tuberculosis so ongoing tuberculos nursing could monit	g Residents, General ng should be initiated within ion or 90 days prior to ocumentation for residents date (i.e., month, date, year), meters of induration (if no nt "0" mm), and interpretation	21426			

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00114	B. WING		05/19/2016
					03/13/2010
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	,	
HEALTH A	AND REHABILITATION O	F NEW BRIGHTON	RST AVENUE NOF RIGHTON, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of finithe Minnesota Depart Determination of whe corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Live-inspection with any result in the assessments of the runumber and MN Rule when a rule contains comply with any of the lack of compliance.	ther a violation has been			
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic cure orders consistent with cment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00114	B. WING		05/19/2016
	ROVIDER OR SUPPLIER	825 FIRS	DRESS, CITY, STA T AVENUE NOR GHTON, MN 55	THWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	you electronically. Ali is necessary for State enter the word "correct text. You must then in State licensure process completion date, the corrected prior to elect Minnesota Department On 05/16/16 through Department's staff vist the following correction Please indicate in you correction that you had and identify the date vinvestigations of com H5164113, H5164114	orders being submitted to though no plan of correction statutes/Rules, please of ted" in the box available for dicate in the electronic as, under the heading date your orders will be stronically submitting to the not of Health. 05/19/16, surveyors of this ited the above provider and on orders are issued. In electronic plan of over reviewed these orders, when they will be completed.	2 000		
2 555	Subpart 1. Develor must develop a compeach resident within scompletion of the comprehensive plant by an interdisciplinary attending physician, a responsibility for the rappropriate staff in distinct the resident's needs,	pment. A nursing home rehensive plan of care for seven days after the aprehensive resident and in part 4658.0400. The of care must be developed team that includes the a registered nurse with esident, and other sciplines as determined by and, to the extent participation of the resident,	2 555		

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RED.				DATE SURVEY COMPLETED	
		00114		B. WING		05	5/19/2016
	ROVIDER OR SUPPLIER	F NEW BRIGHTON	STREET ADDRE 825 FIRST A NEW BRIGHT	VENUE NOR	THWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 555	This MN Requiremer by: Based on document facility did not develo coordinated, and indi regarding hospice for reviewed for hospice Findings include: Record review revea with an admission da record also contained Medicare Hospice Bebegan hospice care of Terminal Illness, date hospice diagnosis as leukemia. The facility's current contained entries for discharge plan, social Discharge entry read Care Due to Resident Services entry read, Resident and Family entry read, "Provide of medications for comfor End of Life Cares The record contained hospice provider, dat generic and did not in specific to the reside form that were filled i of those developing thospice nurse and ail. When interviewed on	review and interview, the pa comprehensive, ividualized plan of care of 1 of 1 resident (R31) care. Idea an Admission Record the of 4/23/16 for R31. The standard day 1/29/16. A Certificate of 4/29/16, listed the princh of care, dated 5/2/16, hospice care related or all services, and mood. If the mood and services, and mood. If the mood and Behave comfort and prn [as need the mo	rd The or t R31 te of imary 16, hly to The f Life Social e per vior eded] spice etails the ames of	2 555			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00114		B. WING		05/19/2016		
	ROVIDER OR SUPPLIER	825 FIRST	RESS, CITY, STA AVENUE NOR HTON, MN 55	THWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 555	the hospice provider's on the facility's care prefer to the hospice possible. SUGGESTED METH The director of nursin procedures related to care for hospice care these polices, and au compliance to these polices. TIME PERIOD FOR (21) days.	acility staff generally follow scare plan and write entries plan directing facility staff to rovider's care plan. OD OF CORRECTION: g could develop policies and development of plan of educate staff regarding dit resident records for policies and procedures. CORRECTION: Twenty-one	2 555			
2 830	2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.		2 830			
	by: Based on document r facility did not develop	ordinated plan of care				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00114	B. WING		05/19/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HEALTH A	AND REHABILITATION O	F NEW BRIGHTON	FAVENUE NOR SHTON, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 830	Continued From page 4		2 830			
	reviewed for hospice	care.				
	Findings include:					
	with an admission darecord also contained Medicare Hospice Bebegan hospice care of Terminal Illness, date hospice diagnosis as leukemia. The facility's current prontained entries for	plan of care, dated 5/2/16, hospice care related only to				
	discharge plan, social services, and mood. The Discharge entry read, "Resident is on End of Life Care Due to Resident Dx [diagnosis]." The Social Services entry read, "Possible Hospice Care per Resident and Family." The Mood and Behavior entry read, "Provide comfort and prn [as needed] medications for comfort. Resident is on Hospice for End of Life Cares [sic]."					
	hospice provider, date generic and did not in specific to the resider form that were filled in	nclude individualized details nt aside from blanks on the n with the diagnosis, names he plan, and frequency of				
	this unit, stated that fa the hospice provider's on the facility's care p refer to the hospice p)-A ,the nurse manager for acility staff generally follow s care plan and write entries plan directing facility staff to				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00114		B. WING		05/19/2016		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	PRESS, CITY, STA	,	1 00/10/2	0.10
HEALTH A	AND REHABILITATION O	F NEW BRIGHTON	AVENUE NOR HTON, MN 55			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) COMPLETE DATE
2 830	procedures related to care for hospice care these polices, and au compliance to these p	g could develop policies and development of plan of educate staff regarding dit resident records for policies and procedures.	2 830			
21426	21426 MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.		21426			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST NEW BRIGHTON NS STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST NEW BRIGHTON NS STATE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFINITION CRAPT REGULATORY OR LSC IDENTIFYING INFORMATION) 21426 Continued From page 6 R49, R77, R99, and R198) and 5 of 6 employees (E-1, E-3, E-4, E-5, and E-6) received tuberoulin skin testing (TST) which included both induration and interpretation reading results, and falled to ensure the facility buberoulois screening policy contained current regulatory procedures. This had the potential to effect all 80 residents in the facility, staff and visitors. Findings include: R43 was admitted to the facility on 4/5/16. R43 received a first step TST on 4/6/16. Both TST results lacked an interpretation of the results (positive or negative). R49 was admitted to the facility on 3/24/16. R49 received a first step TST on 3/24/15 and a second step TST on 4/3/16. The TST results lacked interpretation of the results. R77 was admitted to the facility on 2/26/16. R77 received a first step TST on 3/8/16. The TST results lacked induration and interpretation of the results. R99 was admitted to the facility on 1/21/16, R99 received a second step TST on 3/6/16. The TST results lacked interpretation of the results. R198 was admitted to the facility on 5/4/16. R198 received a first step TST on 5/6/16. The TST results lacked interpretation of results. R198 was admitted to the facility on 5/4/16. The TST results lacked interpretation of results. R198 was admitted to the facility on 5/4/16. The TST results lacked interpretation of results. R198 was admitted to the facility on 5/4/16. The TST results lacked interpretation of results.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		`	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
S25 FIRST AVENUE NORTHWEST	00114			В	B. WING		05	6/19/2016
PREFIX TAG (EACH DEFICIENTY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 21426 Continued From page 6 R49, R77, R99, and R198) and 5 of 6 employees (E-1, E-3, E-4, E-5, and E-6) received tuberculin skin testing (TST) which included both induration and interpretation reading results, and falled to ensure the facility's tuberculosis screening policy contained current regulatory procedures. This had the potential to effect all 80 residents in the facility, staff and visitors. Findings include: R43 was admitted to the facility on 4/5/16. R43 received a first step TST on 4/6/16 and a second step TST on 4/16/16. Both TST results lacked an interpretation of the results. R77 was admitted to the facility on 3/24/16. R49 received a first step TST on 3/24/16. Both TST results lacked interpretation of the reading. R77 received a second step TST on 2/27/16. The TST results lacked induration and interpretation of the reading. R77 received a second step TST on 3/8/16. The TST results lacked induration and interpretation of the results. R99 was admitted to the facility on 1/21/16. R99 received a first step TST on 2/6/16. The TST results lacked interpretation of results. R198 was admitted to the facility on 5/4/16. R198 received a first step TST on 5/5/16. The TST results lacked interpretation of results.			F NEW BRIGHTON	5 FIRST AV	ENUE NOR	THWEST		
R49, R77, R99, and R198) and 5 of 6 employees (E-1, E-3, E-4, E-5, and E-6) received tuberculin skin testing (TST) which included both induration and interpretation reading results, and failed to ensure the facility's tuberculosis screening policy contained current regulatory procedures. This had the potential to effect all 80 residents in the facility, staff and visitors. Findings include: R43 was admitted to the facility on 4/5/16. R43 received a first step TST on 4/6/16 and a second step TST on 4/6/16. Both TST results lacked an interpretation of the results (positive or negative). R49 was admitted to the facility on 3/24/16. R49 received a first step TST on 3/24/16 and a second step TST on 4/3/16. Both TST results lacked interpretation of the results. R77 was admitted to the facility on 2/26/16. R77 received a first step TST on 3/8/16. The TST results lacked interpretation of the reading. R77 received a second step TST on 3/8/16. The TST results lacked the date of the reading. R77 received a second step TST on 3/6/16. The TST results lacked induration and interpretation of the results. R99 was admitted to the facility on 1/21/16. R99 received a first step TST on 2/6/16. The TST results lacked interpretation of results. R198 was admitted to the facility on 5/4/16. R198 received a first step TST on 5/5/16. The TST results lacked interpretation of results.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
received a second step TST on 5/12/16 . The TST results lacked millimeters of induration. On 5/17/16 information on staff tuberculosis	21426	R49, R77, R99, and F (E-1, E-3, E-4, E-5, al skin testing (TST) wh and interpretation real ensure the facility's to contained current reghad the potential to elfacility, staff and visitor. Findings include: R43 was admitted to received a first step T step TST on 4/16/16. an interpretation of the negative). R49 was admitted to received a first step T second step TST on 4/16/16. an interpretation of the negative of the second step TST on 4/16/16. In the second step TST on 4/16/16. In the second step TST on 4/16/16/16/16/16/16/16/16/16/16/16/16/16/	R198) and 5 of 6 employees and E-6) received tuberculing ich included both induration ding results, and failed to aberculosis screening policy ulatory procedures. This feet all 80 residents in the bors. The facility on 4/5/16. R43 and a second Both TST results lacked e results (positive or the facility on 3/24/16. R49 and 3/24/16. Both TST results of the results. The facility on 2/26/16. R77 and TST on 2/27/16. The TST e of the reading. R77 ap TST on 3/8/16. The TST ion and interpretation of the the facility on 1/21/16. R99 ap TST on 2/6/16. The TST etation of results. The facility on 5/4/16. R19 ap TST on 5/5/16. The TST etation of the results. R198 ap TST on 5/12/16. The illimeters of induration.	s n n n / / dd	21426			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00114			B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
HEALTH A	AND REHABILITATION O	F NEW BRIGHTON	RST AVENUE NORT RIGHTON, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21426	screening was request provided the following. E-1 was hired at the facility was unable to TST, or symptom screen. E-2 was hired at the facility was unable to of a TST or symptom. E-3 was hired at the facility provided a documentation of the status form. The formal for tuberculosis screen. The formal for tuberculosis screen. The facility provided a documentation of the status form. The formal formal formal facility experience in the status form tuberculosis screen. The facility results to the any necessary accomming the stress of the status form the facility and the facility was unable to of a TST or symptom. E-5 was hired at the facility provided a "bathealth Care Workers any documentation of the status formal facility provided at the facility provided documentation of the status formal facility provided documentation of the status formal facility provided at the facility provided documentation of the status formal facility provided documentation of the status formal facility provided documentation of the status formal facility provided documentation of the status facility provided facility provided facility provided facility provided facility f	sted, and the facility information on 5/18/16: facility on 4/20/16. The provide documentation of a seen on hire. facility on 4/11/16. The provide any documentation screen on hire. facility on 3/30/16. The sument titled "Evaluation m had a "X" next to the line ning, and a "X" next to line see bottom of the form vide a copy of this form and individual. Please discuss a modations with the over is responsible for s in accordance with lity was unable to provide tion. facility on 3/14/16. The provide any documentation screen on hire. facility on 2/29/16. The seline TB screening Tool for ", but was unable to provide fa TST on hire. facility on 2/2/16. The facility ion of a first step TST, but	21426			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00114	B. WING		0:	5/19/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	•	
HEALTH A	AND REHABILITATION O		RST AVENUE NORT	HWEST		
- ILALIII A	NETIABLE TATION O	NEW B	RIGHTON, MN 5511	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From page	e 8	21426			
	office has to make the	e changes.				
	dated revised October following: The center will: Administer a two (TST) to all new HCW individual volunteers documented proof of includes documented induration. Procedure: 1. Performew HCW/individual vindicated. a. step prior to resident b. less than one week a	ong - Healthcare Worker one 2015 directed the one-step Tuberculin Skin Test of (Healthcare Workers) and of that do not have a negative TST which of millimeters (mm) of orm a two-step TST on all ordunteers unless otherwise complete and read the first contact. Administer second step no ond no more than three gative result from the first				
	Tuberculosis Control Settings, A guide for	nt of Health, Regulations for in Minnesota Health Care implementing tuberculosis lation in your facility, dated				
	include the date of the the number of millime induration, document (i.e., positive or negal "An employee may be after a negative TB st	Health Care Workers, FST documentation should the test (i.e. month, day, year), theres of induration (if no "0" mm) and interpretation tive). Baseline TB screening, tegin working with patients tymptom screen and a T (i.e., first step) dated within				

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PRINTED: 06/02/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED				
00114			B. WING		05/19/2016			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112							
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE			
21426	90 days before hire. Page 23, Screening F principles, "Screening 72 hours of admission admissionTST document for the day of the number of millime induration, document for the director of nursin policies and procedur. The director of nursin staff to their policies are employee and resider and tuberculosis screening could monitor.	Residents, General g should be initiated within nor 90 days prior to umentation for residents te (i.e., month, date, year), sters of induration (if no "0" mm), and interpretation tive). OD OF CORRECTION: g could review tuberculosis es to ensure compliance. g could educate nursing and procedures for not tuberculosis skin tests ens and provide all staff training. The director of	21426					