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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: U11X

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

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

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

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

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

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

6. DATE OF SURVEY **07/05/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 07/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 07/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS
Posted 07/28/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/22/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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.

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

MDH
Minnesota
Department
of Health

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.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245164		7/5/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 06/28/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/28/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 07/15/2016	SIGNATURE OF SURVEYOR 20810	DATE 07/05/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245164 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/6/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 06/30/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 06/30/2016	ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 06/30/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 07/15/2016	SIGNATURE OF SURVEYOR 37010	DATE 07/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: U11X

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

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(L2) **296842800**

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

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

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

6. DATE OF SURVEY **05/19/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

* Code: **A1*** (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 :
Robyn Woolley, HFE NE II — 06/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/17/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS
Posted 06/22/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
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

compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by 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

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

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 _____	05/19/2016

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey. Investigations of complaints H5164111, H5164113, H5164114, and H5164115 were completed and found not to be substantiated.	F 000		
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	F 279		6/28/16

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

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.

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 _____	05/19/2016

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 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 by: Based on document review and interview, the facility did not develop a comprehensive, coordinated, and individualized plan of care regarding hospice for 1 of 1 resident (R31) reviewed for hospice care. Findings include: Record review revealed an Admission Record with an admission date of 4/23/16 for R31. The record also contained a Notice of Election for Medicare Hospice Benefit form showing that R31 began hospice care on 4/29/16. A Certificate of Terminal Illness, dated 4/29/16, listed the primary hospice diagnosis as chronic lymphocytic leukemia. The facility's current plan of care, dated 5/2/16, contained entries for 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]."	F 279	Preparation, submission and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. • R31 has had a Comprehensive Hospice Care Plan review and update. R31's care plans has been reviewed and updated to ensure a comprehensive, coordinated, and individualized plan of hospice care. • Residents at Health and Rehabilitation of New Brighton who are signed onto hospice services have the potential to be affected by this practice. All residents who are signed onto hospice services are at risk and have had a review of the Hospice Care Plan and comprehensive care plans and nursing assistant care guides have been updated. • All staff responsible for implementing an integrated plan of care will be educated on the process of hospice and facility care plan integration by DON/Designee.	

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F 279	Continued From page 2 The record contained a plan of care from the hospice provider, dated 4/29/16, that was generic and did not include individualized details specific to the resident aside from blanks on the form that were filled in with the diagnosis, names of those developing the plan, and frequency of hospice nurse and aide visits for R31. When interviewed on 5/19/16, at 1:53 p.m. registered nurse (RN)-A ,the nurse manager for this unit, stated that facility staff generally follow the hospice provider's care plan and write entries on the facility's care plan directing facility staff to refer to the hospice provider's care plan.	F 279	• Resident Hospice Care Plan will be reviewed quarterly and PRN at Comprehensive Care Plan Review (CCPR) meetings held weekly to assure care plan assessments are appropriate and current. DON/Designee will audit results from CCPR meetings to ensure care plan accuracy x3 charts weekly for one month, then x1 chart weekly for an additional two months. • Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components. • Completion date: June 28, 2016	
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 document review and interview, the facility did not develop a comprehensive, individualized, and coordinated plan of care related to hospice for 1 of 1 resident (R31) reviewed for hospice care. Findings include: Record review revealed an Admission Record	F 309	Preparation, submission and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	6/28/16

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

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F 309	Continued From page 3 with an admission date of 4/23/16 for R31. The record also contained a Notice of Election for Medicare Hospice Benefit form showing that R31 began hospice care on 4/29/16. A Certificate of Terminal Illness, dated 4/29/16, listed the primary hospice diagnosis as chronic lymphocytic leukemia. The facility's current plan of care, dated 5/2/16, contained entries for 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]." The record contained a plan of care from the hospice provider, dated 4/29/16, that was generic and did not include individualized details specific to the resident aside from blanks on the form that were filled in with the diagnosis, names of those developing the plan, and frequency of hospice nurse and aide visits for R31. When interviewed on 5/19/16, at 1:53 p.m. registered nurse (RN)-A ,the nurse manager for this unit, stated that facility staff generally follow the hospice provider's care plan and write entries on the facility's care plan directing facility staff to refer to the hospice provider's care plan.	F 309	• R31 has had a Comprehensive Hospice Care Plan review and update. R31's care plans has been reviewed and updated to ensure a comprehensive, coordinated, and individualized plan of hospice care. • Residents at Health and Rehabilitation of New Brighton who are signed onto hospice services have the potential to be affected by this practice. All residents who are signed onto hospice services are at risk and have had a review of the Hospice Care Plan and comprehensive care plans and nursing assistant care guides have been updated. • All staff responsible for implementing an integrated plan of care will be educated on the process of hospice and facility care plan integration by DON/Designee. • Resident Hospice Care Plan will be reviewed quarterly and PRN at Comprehensive Care Plan Review (CCPR) meetings held weekly to assure care plan assessments are appropriate and current. DON/Designee will audit results from CCPR meetings to ensure care plan accuracy x3 charts weekly for one month, then x1 chart weekly for an additional two months. • Audit results will be reviewed at monthly QAPI meetings x3 months to ensure consistent implementation of care plan components. • Completion date: June 28, 2016	

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	245164	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/17/2016**

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**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, 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	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 1 story building, built in 1963, was determined to be of Type II(222) construction. It has a partial basement, and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. that is monitored for automatic fire department notification. Also all resident rooms have single station smoke detectors. The facility has a capacity of 100 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOTMETas evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is	K 018		6/30/16

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K 018	Continued From page 2 no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of all residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0930 and 1330 on 5/17/2016 observations revealed that the following room doors did not positively latch: Rm -166 Rm - 175 Rm - 103 Rm - 82 (Secondary door to Central Supply room) The deficient practice was observed by the Director of Environmental Services (TL).	K 018	Preparation, submission and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. • All four affected doors will be repaired or replaced. • The locksets and hinges will be replaced by June 17th 2016. The door takes longer to get in due to being a special order. June 30th 2016 is the proposed completion date. • I (Tom Lenk) as Maintenance Director for the building have taken responsibility to make sure these repairs are performed on time to ensure the safety of our residents.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an	K 025		6/30/16

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K 025	Continued From page 3 atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 70 of the 100 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0930 and 1330 on 5/17/2016 observations revealed that smoke barriers had penetrations at the following locations: Oxygen room to the storage room there is a 2 in hole drilled out of the dry wall. Over the Housekeeping and Environmental Services Area smoke doors there a large penetrations above the bundle of wires and and approved method need to be used to seal the area around the repaired cut-out area. The penetrations will all need to be sealed on both sides of the smoke barrier. The deficient practice was observed by the Director of Environmental Services (TL).	K 025	• All affected areas will be re sealed for fire safety and a whole house audit will be completed of all smoke barrier walls. • The sealant and audit will be completed by June 17th 2016 • I (Tom Lenk) as Maintenance Director for the building have taken responsibility to make sure these repairs are performed on time to ensure the safety of our residents.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.	K 027		6/30/16

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K 027	Continued From page 4 Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect all patients. Findings include: On facility tour between 0930 and 1330 on 05/17/2016, observation revealed: The smoke barrier doors leading to the main dining room overlapped and did not close properly. This deficient practice was verified by the Director of Environmental Services (TL).	K 027	• Replacement hinges are on order to properly square up the affected door frame • The door repairs will be done by June 30th 2016 • I (Tom Lenk) as Maintenance Director for the building have taken responsibility to make sure these repairs are performed on time to ensure the safety of our residents.	

MDH
Minnesota
Department
of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00114	A. BUILDING: _____ B. WING _____	05/19/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00114	A. BUILDING: _____ B. WING _____	05/19/2016

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 05/16/16 through 05/19/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Investigations of complaints H5164111, H5164113, H5164114, and H5164115 were completed and found not to be substantiated.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.	2 555		6/28/16

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2 555	Continued From page 2 This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive, coordinated, and individualized plan of care regarding hospice for 1 of 1 resident (R31) reviewed for hospice care. Findings include: Record review revealed an Admission Record with an admission date of 4/23/16 for R31. The record also contained a Notice of Election for Medicare Hospice Benefit form showing that R31 began hospice care on 4/29/16. A Certificate of Terminal Illness, dated 4/29/16, listed the primary hospice diagnosis as chronic lymphocytic leukemia. The facility's current plan of care, dated 5/2/16, contained entries for 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]." The record contained a plan of care from the hospice provider, dated 4/29/16, that was generic and did not include individualized details specific to the resident aside from blanks on the form that were filled in with the diagnosis, names of those developing the plan, and frequency of hospice nurse and aide visits for R31. When interviewed on 5/19/16, at 1:53 p.m. registered nurse (RN)-A ,the nurse manager for	2 555	corrected	

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2 555	Continued From page 3 this unit, stated that facility staff generally follow the hospice provider's care plan and write entries on the facility's care plan directing facility staff to refer to the hospice provider's care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and procedures related to development of plan of care for hospice care, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive, individualized, and coordinated plan of care related to hospice for 1 of 1 resident (R31)	2 830	corrected	6/28/16

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2 830	Continued From page 4 reviewed for hospice care. Findings include: Record review revealed an Admission Record with an admission date of 4/23/16 for R31. The record also contained a Notice of Election for Medicare Hospice Benefit form showing that R31 began hospice care on 4/29/16. A Certificate of Terminal Illness, dated 4/29/16, listed the primary hospice diagnosis as chronic lymphocytic leukemia. The facility's current plan of care, dated 5/2/16, contained entries for 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]." The record contained a plan of care from the hospice provider, dated 4/29/16, that was generic and did not include individualized details specific to the resident aside from blanks on the form that were filled in with the diagnosis, names of those developing the plan, and frequency of hospice nurse and aide visits for R31. When interviewed on 5/19/16, at 1:53 p.m. registered nurse (RN)-A ,the nurse manager for this unit, stated that facility staff generally follow the hospice provider's care plan and write entries on the facility's care plan directing facility staff to refer to the hospice provider's care plan. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 5 The director of nursing could develop policies and procedures related to development of plan of care for hospice care, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
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. This MN Requirement is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure 5 of 5 residents (R43,	21426	corrected	6/28/16

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21426	Continued From page 6	21426		

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 4/16/16. 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 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.

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 the results. R198 received a second step TST on 5/12/16 . The TST results lacked millimeters of induration.

On 5/17/16, information on staff tuberculosis

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21426	Continued From page 7 screening was requested, and the facility provided the following information on 5/18/16: E-1 was hired at the facility on 4/20/16. The facility was unable to provide documentation of a TST, or symptom screen on hire. E-2 was hired at the facility on 4/11/16. The facility was unable to provide any documentation of a TST or symptom screen on hire. E-3 was hired at the facility on 3/30/16. The facility provided a document titled "Evaluation status form". The form had a "X" next to the line for tuberculosis screening, and a "X" next to line "Negative screen." The bottom of the form indicated "Please provide a copy of this form and any test results to the individual. Please discuss any necessary accommodations with the individual. The employer is responsible for maintaining all records in accordance with regulations." The facility was unable to provide any other documentation. E-4 was hired at the facility on 3/14/16. The facility was unable to provide any documentation of a TST or symptom screen on hire. E-5 was hired at the facility on 2/29/16. The facility provided a "baseline TB screening Tool for Health Care Workers", but was unable to provide any documentation of a TST on hire. E-6 was hired at the facility on 2/2/16. The facility provided documentation of a first step TST, but not a second step TST. Interview with the Director of Nursing on 5/19/16, at 2:00 p.m., she indicated the facility follows their policy, and if the policy is incorrect the corporate	21426		

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21426	Continued From page 8 office has to make the changes. Review of the facility's policy : Procedure Tuberculosis Screening - Healthcare Worker dated revised October 2015 directed the following: The center will: - Administer a two-step Tuberculin Skin Test (TST) to all new HCW (Healthcare Workers) and individual volunteers that do not have documented proof of a negative TST which includes documented millimeters (mm) of induration. Procedure: 1. Perform a two-step TST on all new HCW/individual volunteers unless otherwise indicated. a. complete and read the first step prior to resident contact. b. Administer second step no less than one week and no more than three weeks after a negative result from the first step or according to State/Federal Regulation. Minnesota Department of Health, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis infection control regulation in your facility, dated July 2013. Page 10, Screening Health Care Workers, General principles, "TST documentation should include the date of the test (i.e. month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). Baseline TB screening, "An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (i.e., first step) dated within	21426		

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21426	Continued From page 9 90 days before hire. Page 23, Screening Residents, General principles, "Screening should be initiated within 72 hours of admission or 90 days prior to admission...TST documentation for residents should include the date (i.e., month, date, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative). SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate nursing staff to their policies and procedures for employee and resident tuberculosis skin tests and tuberculosis screens and provide all staff ongoing tuberculosis training. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 830	Continued From page 5 The director of nursing could develop policies and procedures related to development of plan of care for hospice care, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
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. This MN Requirement is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure 5 of 5 residents (R43,	21426		

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	00114	A. BUILDING: _____ B. WING _____	05/19/2016

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21426	Continued From page 6	21426		

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 4/16/16. 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 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.

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 the results. R198 received a second step TST on 5/12/16 . The TST results lacked millimeters of induration.

On 5/17/16, information on staff tuberculosis

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screening was requested, and the facility provided the following information on 5/18/16:

E-1 was hired at the facility on 4/20/16. The facility was unable to provide documentation of a TST, or symptom screen on hire.

E-2 was hired at the facility on 4/11/16. The facility was unable to provide any documentation of a TST or symptom screen on hire.

E-3 was hired at the facility on 3/30/16. The facility provided a document titled "Evaluation status form". The form had a "X" next to the line for tuberculosis screening, and a "X" next to line "Negative screen." The bottom of the form indicated "Please provide a copy of this form and any test results to the individual. Please discuss any necessary accommodations with the individual. The employer is responsible for maintaining all records in accordance with regulations." The facility was unable to provide any other documentation.

E-4 was hired at the facility on 3/14/16. The facility was unable to provide any documentation of a TST or symptom screen on hire.

E-5 was hired at the facility on 2/29/16. The facility provided a "baseline TB screening Tool for Health Care Workers", but was unable to provide any documentation of a TST on hire.

E-6 was hired at the facility on 2/2/16. The facility provided documentation of a first step TST, but not a second step TST.

Interview with the Director of Nursing on 5/19/16, at 2:00 p.m., she indicated the facility follows their policy, and if the policy is incorrect the corporate

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21426	Continued From page 8 office has to make the changes. Review of the facility's policy : Procedure Tuberculosis Screening - Healthcare Worker dated revised October 2015 directed the following: The center will: - Administer a two-step Tuberculin Skin Test (TST) to all new HCW (Healthcare Workers) and individual volunteers that do not have documented proof of a negative TST which includes documented millimeters (mm) of induration. Procedure: 1. Perform a two-step TST on all new HCW/individual volunteers unless otherwise indicated. a. complete and read the first step prior to resident contact. b. Administer second step no less than one week and no more than three weeks after a negative result from the first step or according to State/Federal Regulation. Minnesota Department of Health, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis infection control regulation in your facility, dated July 2013. Page 10, Screening Health Care Workers, General principles, "TST documentation should include the date of the test (i.e. month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). Baseline TB screening, "An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (i.e., first step) dated within	21426		

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21426	Continued From page 9 90 days before hire. Page 23, Screening Residents, General principles, "Screening should be initiated within 72 hours of admission or 90 days prior to admission...TST documentation for residents should include the date (i.e., month, date, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative). SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate nursing staff to their policies and procedures for employee and resident tuberculosis skin tests and tuberculosis screens and provide all staff ongoing tuberculosis training. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		