



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 8, 2025

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: October 17, 2024

Dear Administrator:

On December 4, 2024, the Minnesota Department of Health, and on January 6, 2025, the MN Department of Public Safety completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance on December 31, 2024.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 9, 2024

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: October 17, 2024

Dear Administrator:

On October 29, 2024, we informed you that we may impose enforcement remedies.

On December 2, 2024, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected is as follows:

K291, K521

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 17, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 17, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 17, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 2, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, New Brighton Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 2, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office

New Brighton Care Center

December 9, 2024

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Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 April 17, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the

New Brighton Care Center

December 9, 2024

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effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 29, 2024

Administrator
New Brighton Care Center
805 Sixth Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245421
Cycle Start Date: October 17, 2024

Dear Administrator:

On October 17, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor

St. Cloud B District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 January 17, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by April 17, 2025 (six months after the identification of noncompliance), your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

New Brighton Care Center

October 29, 2024

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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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 12/02/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2024
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	E 000			
	On 10/13/24 through 10/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 10/13/24 through 10/17/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed with NO deficiencies cited:				
	H54219450C MN00103916 H54219452C MN00105675 H54219451C MN00103149 H54219453C MN00106837				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/08/2024

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.

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

PRINTED: 12/02/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2024
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1	F 000			
F 582 SS=D	onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582			11/27/24

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2024
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 582	Continued From page 2 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice-Centers for Medicare and Medicaid-10055 (SNFABN-CMS-10055) was provided to 2 of 3 residents (R194 and R195) reviewed for beneficiary notices. Findings include: R194's discharge Minimum Data Set (MDS) dated 9/12/24, indicated R194 was admitted on 8/1/24 and discharged on 9/12/2024. R194's Notice of Medicare non-coverage form-CMS-10123 (NOMNC-CMS-10123), undated, indicated R194's services would end on 8/24/24. However, R194 remained in the facility until 9/12/24.	F 582	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F582 Medicaid/Medicare Coverage/Liability Notice It was found that R194 and R195 were not provided the Medicare and Medicaid Skilled Nursing Facility Advanced Beneficiary Notices (SNF-ABN) during their stay at the facility. Since R194 and R195 are no longer at the facility and under facility's care or have passed away, corrective action cannot be accomplished for these residents at this time. Facility has reviewed and educated staff on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2024
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 582	Continued From page 3 R194's undated SNF Beneficiary Protection Notification Review form, indicated the facility/provider initiated the discharge from Medicare Part A when benefit days were not exhausted. R194's medical record lacked evidence the SNFABN-CMS-10055 was provided to R194 or their representative as required. R195's death in facility tracking record MDS dated 6/8/2024, indicated R195 was admitted on 4/29/24 under the Medicare A benefit which may cover up to 100 days according to cms.gov, and died in the facility on 6/8/2024. R195's NOMNC-CMS-10123, undated, indicated R195's services would end on 5/16/2024. R195's progress note dated 5/25/24, indicated R195 entered hospice care, 9 days after services ended. R195's medical record lacked evidence the SNFABN-CMS-10055 was provided to R195 or their representative as required. On 10/16/24 at 10:28 a.m., the director of social services (SS)-A confirmed R194 and F195 were not provided with a SNFABN-CMS-10055 and SS-A was unaware they needed to be provided. SS-A voiced the importance of providing the SNFABN-CMS-10055 to give the residents adequate time to plan for their discharge and/or appeal if they wish, and it was the residents rights to receive these notifications. On 10/17/24 at 09:47 a.m., The administrator	F 582	Medicare and Medicaid Skilled Nursing Facility guidelines in reference to Advanced Beneficiary Notices and when to appropriately issue them in the future. • Going forward the facility will identify all future residents at the facility that are receiving services through a Medicare Part A plan. This will include current long-term care residents receiving therapy services currently or in the future, new long-term care admissions that may be picked up for therapy services, and all short-term rehab residents who will be staying at the facility rather than discharging back to the community after completing therapy services. These residents will be identified and discussed during daily morning meetings with the treatment team as well as weekly IDT meetings with the treatment team. • A measure that will be put in place to ensure this deficiency will not occur in the future is creating and maintaining a Microsoft Excel Spreadsheet listing all residents in facility that receive services through a Medicare Part A plan. This spreadsheet will be created by 11/27/2024. This spreadsheet will include all current long-term residents and all current and incoming short-term rehab residents. Information that will be collected and included in this spreadsheet will be resident's name, admission date, the fact they have a Medicare Part A plan, what therapy services they are receiving, if the resident is in long-term care or short-term care, last covered days being issued, and whether a NOMNC form, ABN form, or both need to be issued.		

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F 582	Continued From page 4 stated they were aware the SNFABN-CMS-10055 were not being provided appropriately, and they had recently delegated the task of developing a process to an employee, however it was not in place at the time of the survey. The administrator stated their expectation was for the SNFABN-CMS-10055 to be provided when residents go onto and come off Medicare part A services. The Medicare Advance Beneficiary and Medicare Non-Coverage Notices policy last revised September 2022, indicated if the facility believes Medicare will not pay for an otherwise covered skilled services, the resident was notified in writing why the service may not be covered and the resident's potential liability for payment of the non-covered services.	F 582	- To monitor this corrective action to ensure this deficiency practice is being corrected, the facility will review and confirm the insurance providers for all new residents being admitted to the facility. This will occur during daily team meeting that takes place at 10:30am and/or when new admissions are scheduled to admit to the facility. The facility will also engage with IDT daily to discuss any long-term care residents being picked up for therapy services and if they have a Medicare Part A plan. If resident does have a Medicare Part A plan, facility will ensure their name is on this spreadsheet and what therapy services they are receiving. Any last covered days being issued to these residents will also be noted on this spreadsheet. Facility will then follow guidelines to ensure ABN forms are being issued appropriately based on last covered dates and resident's discharge disposition (staying in facility vs. discharging into the community). This spreadsheet will be monitored daily and as needed throughout the day. - This deficiency will be corrected by 11/27/2024.		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623			12/1/24

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F 623	Continued From page 5 language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F 623			

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F 623	Continued From page 6 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623			

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F 623	Continued From page 7 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of transfer was provided for 1 of 3 residents (R7) upon transfer to the hospital. In addition, the facility failed to notify the Ombudsman for Long Term Care (LTC) of resident transfers to the hospital for 1 of 3 residents (R7), reviewed for hospitalization. This had the potential to affect all residents transferred to hospital. Findings include: R7's quarterly Minimum Data Set (MDS) dated 9/13/24, indicated R7 was cognitively intact. Diagnoses included diabetes, cerebral infarction (stroke), bipolar disorder, and chronic obstructive pulmonary disease (COPD). R7's clinical record indicated R7 was hospitalized from 9/4/24 through 9/6/24. R7's discharge MDS dated 9/4/24, indicated R7 had an unplanned discharge to a short-term general hospital and return was anticipated. R7's record lacked progress notes which indicated the circumstances of the transfer to the hospital on 9/4/24. R7's entry tracking MDS dated 9/6/24, indicated R7 returned from short-term general hospital on 9/6/24. However, R7's record lacked	F 623	• Resident R7 has been educate by the Health Information Management Director about resident and/or facility-initiated transfers and expectations on communicating to the assigned nurse about their resident-initiated transfer to the hospital. • No other residents have been identified by the facility to have resident-initiated transfers. • Health Information Management Director will conduct daily audits Monday thru Friday for three weeks and will review findings with the Nurse Management Team. The weekly audit will take place Monday, Wednesday and Friday for one week and monthly thereafter to determine the transfer status of the residents. The facility data will be reported within the 30 days of the resident transfer to the Ombudsman. • The health information management/medical records team will meet with the nursing team to ensure the process with PCC is being followed. • Both resident and facility-initiated transfers will be reported the Office of the State Long-Term Care Ombudsman		

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F 623	Continued From page 8 evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R7's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital. R7's clinical record indicated R7 was hospitalized from 8/23/24 through 8/24/24. R7's discharge MDS dated 8/23/24, indicated R7 had a planned discharge to a short-term general hospital and return was anticipated. R7's record lacked progress notes which indicated the circumstances of the transfer to the hospital on 8/23/24. R7's entry tracking MDS dated 8/24/24, indicated R7 returned from short-term general hospital on 8/24/24. However, R7's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R7's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital. R7's clinical record indicated R7 was hospitalized from 7/10/24 through 7/12/24. R7's progress note dated 7/10/24 at 1:02 p.m., indicated R7 was sent to the hospital due to chest pain per physician orders. A subsequent progress note dated 7/12/24 at 8:06 p.m., indicated R7 was readmitted to the facility following hospitalization for atrial fibrillation. However, R7's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R7's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital. R7's clinical record indicated R7 was hospitalized from 6/6/24 through 6/7/24. R7's discharge MDS dated 6/6/24, indicated R7 had an unplanned	F 623	monthly at the beginning of each month for the previous month. - The facility Administrator will add resident and facility-initiated transfers to the Agenda for Health Information Management biweekly meeting with the facility Administrator to ensure that the process is being followed. - The Health Information Management Director will submit the data to the Ombudsman monthly during the first week of the month for the previous month. The facility can ensure the deficiency will be corrected December 1st 2024.		

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F 623	Continued From page 9 discharge to a short-term general hospital and return was anticipated. R7's record lacked progress notes which indicated the circumstances of the transfer to the hospital on 6/6/24. R7's progress note dated 6/7/24 at 11:05 p.m., indicated R7 returned to the facility via stretcher accompanied by 3 EMS (emergency medical transport). However, R7's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R7's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital. R7's clinical record indicated R7 was hospitalized from 2/10/24 through 2/16/24. R7's progress note dated 2/10/24 at 5:26 p.m., indicated R7 was sent to the hospital due to uncontrolled pain in left leg per provider order. R7's entry tracking MDS dated 2/16/24, indicated R7 returned from short-term general hospital on 2/16/24. However, R7's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R7's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital. through 1/30/24. R7's discharge MDS dated 1/26/24, indicated R7 had an unplanned discharge to a short-term general hospital and return was anticipated. R7's record lacked progress notes which indicated the circumstances of the transfer to the hospital on 1/26/24. R7's entry tracking MDS dated 1/30/24, indicated R7 returned from short-term general hospital on 1/30/24. However, R7's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R7's record lacked	F 623			

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F 623	Continued From page 10 evidence the Ombudsman for LTC was notified of transfer to the hospital. R7's clinical record indicated R7 was hospitalized from 10/21/23 through 11/7/23. R7's progress note dated 10/31/23 at 2:05 p.m., indicated R7 left for a surgical procedure at 5 a.m., related to right calf ulcer. R7's discharge MDS dated 10/31/24, indicated R7 had a planned discharge to a short-term general hospital and return was anticipated. R7's entry tracking MDS dated 11/7/23, indicated R7 returned from short-term general hospital on 11/7/23. However, R7's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R7's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital. On 10/16/24 at 2:00 p.m., the administrator verified Notice of Transfer forms were not provided to R7 and/or responsible party upon transfers for emergent and therapeutic hospitalizations on 9/4/24, 8/23/24, 7/10/24, 6/6/24, 2/10/24, 1/26/24, and 10/21/23. The administrator stated notice of transfer should have been completed by the floor nurses upon transfer, and it was important for residents to be informed and given the opportunity to decline. Additionally, the administrator acknowledged the facility had not been notifying the ombudsman of resident transfers for hospitalization. On 10/16/24 at 4:01 p.m., the director of social services verified the ombudsman notice of transfer had not been submitted to the ombudsman for R7's hospitalizations, and the ombudsman should have been notified monthly of transfers to an acute care facility. The	F 623			

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F 623	Continued From page 11 ombudsman should have been notified so they were aware of the resident's transfer so they could contact the resident to determine if they needed any additional services or if any ombudsman follow-up was needed. The facility's Transfer or Discharge policy revised 10/22, indicated a notice of transfer for emergent or therapeutic leave is provided to the resident/representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., monthly).	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625			11/8/24

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F 625	Continued From page 12 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a written notice of a bed hold at the time of transfer for hospitalization for 1 of 3 residents (R7) reviewed for hospitalization. Findings include: R7's quarterly Minimum Data Set (MDS) dated 9/13/24, indicated R7 was cognitively intact. Diagnoses included diabetes, cerebral infarction (stroke), bipolar disorder, and chronic obstructive pulmonary disease (COPD). R7's clinical record indicated R7 was hospitalized from 9/4/24 through 9/6/24. R7's discharge MDS dated 9/4/24, indicated R7 had an unplanned discharge to a short-term general hospital and return was anticipated. R7's record lacked a progress note indicating the reason for the transfer to the hospital on 9/4/24. R7's entry tracking MDS dated 9/6/24, indicated R7 returned from short-term general hospital on 9/6/24. However, R7's record lacked evidence a bed hold notice was provided to the resident and/or responsible party at the time of transfer for hospitalization. R7's clinical record indicated R7 was hospitalized from 8/23/24 Through 8/24/24. R7's discharge MDS dated 8/23/24, indicated R7 had a planned discharge to a short-term general hospital and			F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer - No physical or emotional trauma present for R7 due to omission of bed hold policy noted or reported to DON/Designee by 11/1/24. - DON/Designee reviewed Policy on 11/1/24. - The committee of Director of Nursing, the Assistant Director of Nursing, HIM Director gathered regarding making packets for transfer to hospital on 11/1/24. - The HIM Director will print and provide the bed hold form. The HIM team will place the form inside large envelopes used at transfer. The transfer checklist will be printed and placed on the outside of the envelope to ensure the needed information gets filled out by the Nurse. The Nurse can then check off items as they are putting them in the envelope for transfers. This will be completed by 11/8/24. - The meeting was held for nurses regarding the bed hold policy and form completion on 10/22/24 and 10/23/24. Nurses had a chance to make up for the meeting by the following week. The scheduling department will send nurse's meetings notes to agency in email to keep them updated.		

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F 625	Continued From page 13 return was anticipated. R7's record lacked a progress note indicating the reason for the transfer to the hospital on 8/23/24. R7's entry tracking MDS dated 8/24/24, indicated R7 returned from short-term general hospital on 8/24/24. However, R7's recorded lacked evidence a bed hold notice was provided to the resident and/or responsible party at the time of transfer for hospitalization. R7's clinical record indicated R7 was hospitalized from 7/10/24 through 7/12/24. R7's progress note dated 7/10/24 at 1:02 p.m., indicated R7 was sent to the hospital due to chest pain per physician orders. A subsequent progress note dated 7/12/24 at 8:06 p.m., indicated R7 was readmitted to the facility following hospitalization for atrial fibrillation. However, R7's recorded lacked evidence a bed hold notice was provided to the resident and/or responsible party at the time of transfer for hospitalization. R7's clinical record indicated R7 was hospitalized from 6/6/24 through 6/7/24. R7's discharge MDS dated 6/6/24, indicated R7 had an unplanned discharge to a short-term general hospital and return was anticipated. R7's record lacked a progress note indicating the reason for the transfer to the hospital on 6/6/24. R7's progress note dated 6/7/24 at 11:05 p.m., indicated R7 returned to the facility via stretcher accompanied by 3 EMS (emergency medical transport). However, R7's recorded lacked evidence a bed hold notice was provided to the resident and/or responsible party at the time of transfer for hospitalization. R7's clinical record indicated R7 was hospitalized from 2/10/24 through 2/16/24. R7's progress note	F 625	- There will be an informational meeting regarding Transfer Envelopes which will be held on 11/8/24. The information will also be available on the PCC EMR Bulletin Board that all nurses see before their shift. There will be signage on the North and South Nurse's Stations to direct nurses to this Transfer Envelope for all transfers by 11/8/24. "Bed hold policy reviewed documentation" audit form will be used by DON/Designee 1 x week for 4 weeks, then 1 x month for 3 months, then quarterly x 2 quarters. - Date of Completion: 11/8/2024		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2024
NAME OF PROVIDER OR SUPPLIER NEW BRIGHTON CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
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F 625	Continued From page 14 dated 2/10/24 at 5:26 p.m., indicated R7 was sent to the hospital due to uncontrolled pain in left leg per provider order. R7's entry tracking MDS dated 2/16/24, indicated R7 returned from short-term general hospital on 2/16/24. However, R7's recorded lacked evidence a bed hold notice was provided to the resident and/or responsible party at the time of transfer for hospitalization. R7's clinical record indicated R7 was hospitalized from 1/26/24 through 1/30/24. R7's discharge MDS dated 1/26/24, indicated R7 had an unplanned discharge to a short-term general hospital and return was anticipated. R7's record lacked a progress note indicating the reason for the transfer to the hospital on 1/26/24. R7's entry tracking MDS dated 1/30/24, indicated R7 returned from short-term general hospital on 1/30/24. However, R7's recorded lacked evidence a bed hold notice was provided to the resident and/or responsible party at the time of transfer for hospitalization. R7's clinical record indicated R7 was hospitalized from 10/21/23 through 11/7/23. R7's progress note dated 10/31/23 at 2:05 p.m., indicated R7 left for a surgical procedure at 5 a.m., related to right calf ulcer. R7's discharge MDS dated 10/31/24, indicated R7 had a planned discharge to a short-term general hospital and return was anticipated. R7's entry tracking MDS dated 11/7/23, indicated R7 returned from short-term general hospital on 11/7/23. However, R7's recorded lacked evidence a bed hold notice was provided to the resident and/or responsible party at the time of transfer for hospitalization. On 10/16/24 at 2:00 p.m., the administrator verified bed hold notices were not provided to R7	F 625			

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F 625	Continued From page 15 and/or responsible party upon transfers for hospitalization on 9/4/24, 8/23/24, 7/10/24, 6/6/24, 2/10/24, 1/26/24, and 10/21/23. The administrator stated bed hold notice at time of transfer for hospitalization was important so residents were made aware they can return to the facility, any cost to them to hold the bed, and provided the opportunity to decline a bed hold. On 10/16/24 at 4:01 p.m., the director of social services stated the floor nurses were responsible for obtaining bed hold notices at the time of transfer for hospitalization, and it was important for residents to know they would not be discharged and could return to the facility and know the cost for holding the bed. The facility's Bed-Holds and Returns policy revised 10/22, indicated residents, regardless of payer source, are provided written notice about these policies at least twice: notice 1 - well in advance of any transfer (e.g., in the admission packet); and notice 2 - at the time of transfer (or, if the transfer was an emergency, within 24 hours). Multiple attempts to provide the resident/representative with notice 2 should be documented in cases where staff were unable to reach and notify the resident/representative timely. The facility's Transfer or Discharge policy revised 10/22, indicated a notice of bed hold for emergent or therapeutic leave is provided to the resident/representative within 24 hours of transfer.	F 625			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684			11/8/24

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F 684	Continued From page 16 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician orders were followed for 1 of 1 residents (R7) reviewed for skin conditions. Findings include: R7's quarterly Minimum Data Set (MDS) dated 9/13/24, indicated R7 was cognitively intact. Diagnoses included diabetes, cerebral infarction (stroke), bipolar disorder, and chronic obstructive pulmonary disease (COPD). R7's progress note dated 10/5/24 at 10:23 p.m., indicated R7 called 911 at 7:50 p.m. R7 wanted to go to the hospital "because the cream (ammonium lactate) that was applied to her legs" made them feel numb. R7's progress note dated 10/6/24 at 2:00 p.m., indicated R7 returned from the hospital at 1:30 p.m., with no change in condition noted, no new orders, and still complained of pain in her legs. During observation on 10/13/24 at 2:52 p.m., R7's lower extremities were swollen and red with multiple blisters covering both legs from under the knees to the ankles.	F 684	F684 Quality of Care-Physician Orders - Regarding R7, DON/Designee checked on resident's legs and at this time there is no new trauma, no open areas, no new blisters as of 11/6/24. - DON/Designee reviewed the policy on transcribing Physician Orders on 11/1/24. - The HUC/HIM team will communicate to the nursing team if there is an order that needs to be clarified. Nursing to follow up immediately and contact provider for clarification. If HUC is not available, the nurse that is transcribing the order will contact the provider for clarification immediately. Nursing and HIM will be educated on the process 11/8/2024. - Audits for transcription of orders will be done on 2 residents 2 x week for 2 weeks, then 1 x week for 4 weeks, then 1 x month for 3 months. Findings will be brought to the QAPI meeting. - Completion Date: 11/8/2024		

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F 684	Continued From page 17 On 10/13/24 at 3:07 p.m., R7 stated approximately a week prior, she had call 911 because she had throbbing, burning pain in both of legs and feet, and had spent the night in the hospital due to the condition and pain. She needed to stay in bed due to pain when her legs were not elevated, and had an appointment with the wound clinic on 10/14/24. On 10/16/24 at 9:35 a.m., R7 stated the wound clinic physician told her that the old cream that had been ordered (ammonium lactate) caused the issue of blisters and pain in her legs. R7's Wound Clinic After Visit Summary dated 10/14/24, indicated the following skin care plan was ordered for R7's bilateral lower extremities: - skin care outside of clinic performed by facility staff - mild compression is recommended - can be removed at night and put back on first thing in the morning - avoid use of ammonium lactate topical due to history of blistering with use - moisturize daily with general lotion (such as Cetaphil or CeraVe) - gently wash legs/feet with wash cloth to displace flaky dry skin which will resolve with consistent care - compression will assist swelling reduction which in turn will minimize risk for wound recurrence R7's progress noted dated 10/14/24 at 12:17 p.m., indicated R7 had been seen by the wound clinic, no open areas were seen and no new dressing was ordered, an order for mild compression and R7 returned with Spandage white netting, and a box was placed in R7's room	F 684			

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F 684	Continued From page 18 for morning cares. Recommendation to moisturize skin daily with CeraVe or Cetaphil after general cleanse, and orders were applied to PCC [PointClickCare clinical charting system]. However, the recommendation to avoid use of Ammonium Lactate was not indicated in the progress note. R7's October 2024 Treatment Administration Record (TAR) indicated Ammonium Lactate External Cream 12% had been applied topically at bedtime to R7's legs and feet on 10/14/24 and 10/15/24. However, the wound clinic provider had indicated the use of Ammonium Lactate should have been discontinued on 10/14/24. On 10/16/24 at 11:44 a.m., the director of nursing (DON) verified R7's TAR indicated Ammonium Lactate cream had been applied to R7's legs/feet on 10/14/24 and 10/15/24. DON stated she would have expected the nurse to discontinue the order for Ammonium Lactate, or if the nurse was unsure, the Ammonium Lactate should have been placed on "hold" while the nurse clarified the order with the provider. The facility's Administering Medications policy, revised 4/2019, indicated medications were administered in accordance with prescriber orders.	F 684			
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732			11/18/24

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F 732	Continued From page 19 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on document review and interviews the facility failed to ensure the required staffing information was posted daily. This had the potential to affect all 41 residents residing in the facility and their visitors who may wish to review the information.	F 732			
			F732 Posted Nurse Staffing Information		
			- Residents did not consistently or daily have access to the nursing hours in the building. - To ensure the facility will not be impacted by the nursing staffing, the		

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F 732	Continued From page 20 Findings include: During review of the staff posting documentation from April, May, June, and August 14th through October 14th the facility failed to provide evidence of the staff postings for the following dates: April: 6th, 7th, 13th, 14th, 20th, 21st, 27th, and 28th of 2024. May: 4th, 5th, 11th, 12th, 18th, 19th, 25th, and 26th of 2024. June: 1st, 2nd, 8th, 9th, 14th, 15th, 16th, 22nd, 23rd, 29th, 30th of 2024. August: 17th, 18th, 24th, 25th, and 31st of 2024. September: 1st, 7th, 8th, 14th, 15th, 21st, 27th, 28th, 29th of 2024. October: 5th, 6th, and 12th of 2024. On 10/16/24 at 4:11 p.m., the staffing coordinator (O)-C confirmed they had not been completing the staff posting on the weekends and was unaware it was required to be posted daily. On 10/17/24 at 9:47 a.m., the administrator expected the staff posting to be displayed every day. During the week the staffing coordinator was responsible for completing it and on the weekends the north nurse was to be completing and posting the staff posting. The administrator stated they were unaware the posting had not been completed on the weekends and it was important to post the staffing information to know they had enough nursing staff on site and to	F 732	staffing/scheduling coordinator has notified and educated all staff by proper sign postings within the facility, implemented daily assigned hours to ensure the accuracy of nursing schedule. • The Scheduling department, Lead CNA, and charge nurse are responsible for posting the daily nursing hours and verifying they are accurate for schedule/staffing changes per shift. • PCC access has been permitted to nursing staff and lead CNA to retrieve the most accurate facility census data to add to the daily nursing hour posting. • All responsible parties have received the education and process for filling out the nursing hours form. • HIM director will audit the posting hours 3x week for 3 weeks verifying weekend postings were completed, then 2 x week for 3 weeks. • Completion Date: 11/18/2024		

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F 732	Continued From page 21 ensure the information was available for family and visitor to review if they wish to do so. The Daily Posting of Nursing Hours Policy dated 12/12/2022, indicated it was the policy of New Brighton Care Center to post the staffing numbers of licensed and non-licensed nursing personnel for each shift per Centers for Medicare and Medicaid guidelines.	F 732			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761			11/8/24

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F 761	Continued From page 22 by: Based on observation and interview, the facility failed to ensure insulin flexpens and eye drops were appropriately labeled with an opened on date to prevent expired medications from being administered in 3 of 3 medication carts. In addition, the facility failed to ensure controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 3 medication carts, and 1 of 1 medication refrigerators. This had the potential to effect all residents. Findings include: On 10/15/24 at 7:36 a.m., the medication cart located on the West wing was reviewed. Licensed practical nurse (LPN)-A stated the top drawer contained an opened multidose bottle of Dorzolamide-timolol 2-0.5% eye drops. However, it had not been labeled with the date the bottle had been opened. On 10/16/24 at 4:26 p.m., the medication cart located on the East wing was reviewed. LPN-C stated the cart contained an opened Ozempic 4 mg/3 mL (insulin) flexpen. The flexpen and/or box had not been labeled with the date the insulin had been opened. On 10/16/24 at 4:42 p.m., the medication cart located on the North wing was reviewed. Registered nurse (RN)-A stated the second drawer on the left contained an emergency kit (e-kit) which contained controlled substances. However, the e-kit was not secured in a separately locked, permanently affixed compartment as required. Additionally, an opened bottle of Latanoprost 0.0005% eye drops had not	F 761	New Brighton Care Center attempts to label and store drugs and biologicals correctly No residents had reported issues from the findings reported. No individuals were reported or noted to be harmed due to the medications that were improperly labeled. All unlabeled or incorrectly labeled medications were disposed of and new medications were ordered for those individuals that originally had unlabeled medications. DON/Designee reviewed the policy and procedure on 11/1/24. Nurse meetings were held on 10/22/24 and 10/23/24 regarding many issues, including medication labeling, narcotic diversion, locked refrigerator, and expirations of drugs. There was a chance for nurses to ask questions and get answers. Agency nurses will be sent emails from HIM department to update the nurses to the medication labeling expectation, narcotic diversion, expiration dates, and locked refrigerator. Nurses that didn't make it to the meeting were given the paperwork and signed that they received it. HIM Director made laminated signs for the medication carts with all the expirations for the medications for the meeting held on 10/22/24 and 10/23/24. The E-kit was not stored in a manner that reduced risk or diversion originally. Omnicare Pharmacy was called and was unable to provide an Ekit small enough to lock in the narc box in the medication cart. Therefore, the E-kit is now double		

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F 761	Continued From page 23 been labeled with the date the eye drops had been opened. RN-A confirmed the e-kit was not stored in a secured, separately locked compartment as required, and the eye drops had not been labeled with the date they had been opened. On 10/16/24 at 3:28 p.m., the director of nursing (DON) stated licensed staff were expected to write the date a multi-dose vial had been opened or accessed on the product label. Additionally, licensed staff were expected to review the opened date prior to administration of a multi-dose vial so they could be properly discarded within 28 days unless the manufacturer specifies differently. At 4:56 p.m., a review of the locked medication room located on the North wing was completed with the DON. The DON opened the unlocked medication refrigerator and found four bottles of unopened liquid Ativan (controlled substance) inside a separate, permanently affixed compartment. DON stated it was unlocked and all controlled substances should be locked in a separate, permanently affixed compartment to prevent diversion. Manufacturer's directions included disposal of opened Ozempic after 56 days. Drugs.com included direction for dispose of Dorzolamide-timolol after expiration date, and Latanoprost 6 weeks after opening. The facility's Medication Labeling and Storage policy, revised 2/2023, indicted multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter of longer date for the open vial.	F 761	locked-locked in a cupboard in the locked medication room. The refrigerator now has a lock on it to keep refrigerated narcotics double locked in the locked medication room. Nursing Leadership or Designee will audit the medication carts and medication rooms 1 x week for 4 weeks, then 1 x month for 3 months, then quarterly. Results will be brought to the QAPI meeting for review.		

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F 761	Continued From page 24	F 761			
F 851 SS=F	The facility's Controlled Substances policy, revised 11/2022, indicated controlled substances are separately locked in permanently affixed compartments. All keys to controlled substance containers are on a single key ring that is different from any other keys. Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether	F 851			11/14/24

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F 851	Continued From page 25 the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to submit any data for staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarter reviewed (quarter 3), to the centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS.	F 851			
			o The responsible party will contact a representative from SimplePBJ (platform used to submit PBJ) prior to due date, and schedule an educational session to go over steps of upload, to ensure correct submission. o The responsible party will contact a representative from SimplePBJ prior to		

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F 851	Continued From page 26 Findings Include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705D for quarter 3 2024 (April 1st through June 30th), identified no data had been submitted. As a result, the metric for excessively low weekend staffing, Registered Nurse (RN) hours and licensed nursing coverage was suppressed for the quarter. On 10/17/24 at 09:43 a.m., the human resources specialist (O)-B stated they were responsible for gathering and submitting the data for each quarter to CMS. O-B confirmed they had forgotten the last step and did not submit it to CMS for quarter 3. O-B stated the importance of completing and submitting this information because it could interfere with the facility's overall star rating, admissions related to the rating, and accurate staffing information being presented to the public and CMS. On 10/17/24 at 09:47 a.m., the administrator confirmed the PBJ information had not been submitted for quarter 3 of 2024, and their expectation was for it to be completed by the deadline. The Staffing, Sufficient and Competent Nursing policy last revised August 2022, lacked specific information regarding submission requirements.	F 851	due date, to ensure that employee has correct credentials to be able to submit to send to CMS. o The responsible party will contact a representative from SimplePBJ, to verify correct submission through CMS after submission of PBJ through SimplePBJ. o Resident(s) have not specifically been affected. Facility understands why it is important to have accurate information reported to CMS of direct care staff per resident per day. o The responsible party will schedule recurring reminders on calendar and add the facility administrator, set up for one week prior to due dates, to ensure timely and correct submission. The facility Administrator will add the PBJ reporting to the Agenda for biweekly meetings between the facility administrator and the responsible party to ensure completion. The 11/14/2024 submission was completed and accepted. o 11/14/2024 ☐ due date of next PBJ submission.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880			11/8/24

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F 880	Continued From page 27 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880			

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F 880	Continued From page 28 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain infection control measures when performing wound care for 1 of 1 residents (R25) reviewed for wound care. Findings include: R25's annual minimum data set (MDS) dated 10/1/24, identified R25's cognition as intact and included diagnoses of diabetes mellitus (a blood disorder characterized by impaired ability of the body to maintain proper levels of sugar in the blood), heart failure and hypertension. Further, R25 had a stage 4 full thickness pressure ulcer	F 880	F880 Infection Prevention: Wound Care • R25 has no signs or symptoms of infection to wound as of 11/6/24. • DON/Designee reviewed and updated policy and procedure for wound care 11/6/24. • Audits performed on all residents that receive wound care on 11/4/24. Half of wound care dressings were dated and initialed. Nursing Leadership to add wound care orders to initial/date the wound dressings, effective 11/8/24. • Nurse meetings at change of shift on 11/8/24 will go over to make sure to initial and date wound care dressings. This		

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F 880	Continued From page 29 (an injury to the skin and tissue due to pressure on the skin for a long time) with exposed bone, tendon, or muscle. R25's current care plan identified R25 had skin alteration related to stage 4 sacral ulcer. Nursing staff were to keep skin clean and dry, provide wound care per orders, observe for changes and update provider as needed. Furthermore, R25 was to receive a skin assessment per protocol and nursing staff to observe skin with personal cares. R25's nurse practitioner (NP) orders dated 10/7/24, indicated R25 needed daily dressing changes to his stage 4 pressure ulcer, required an air mattress, and was followed weekly by the wound team. A wound progress note dated 10/14/24, indicated R25 required daily foam dressing changes, instructed nursing staff to keep skin clean and dry, and R25 would continue to be followed weekly by wound care team. During observation on 10/15/24 at 8:28 a.m., licensed practical nurse (LPN-A) and LPN-B completed R25's dressing change. R25 was positioned lying in bed on his left side, exposing his buttocks towards LPN-A. A yellow disposable chux pad (a disposable absorbent sheet designed to protect surfaces) was observed tucked under R25's left hip/buttocks. A brown and grayish tan substance was noted on the chux pad. LPN-A and LPN-B performed hand hygiene and applied clean gloves. LPN-B opened dressing packages and handed LPN-A a clean chux pad; LPN-A unfolded the clean chux pad and placed it over the outer edge of the dirty yellow chux pad	F 880	information will also be put in staff updates on the bulletin board in PCC EMR. - Nursing Leadership to audit nurses doing two resident's wound care twice a week for 2 weeks, then 1 x week for 4 weeks, then 1 x every other week for one month, then monthly x 3 months. - Completion Date: 11/8/2024		

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F 880	Continued From page 30 leaving the brown and grayish tan substance uncovered. LPN-A removed the dressing from R25's buttocks exposing the stage 4 pressure ulcer to the open air. Behind and slightly to the right of LPN-A was a free-standing oscillating fan that was turned on and blowing directly at R25's exposed wound. LPN-A sprayed wound cleaner on clean 4x4 gauze and wiped R25's wound beginning at the inner most area of wound working her way towards outer edges. LPN-A repeated this process three times and then dabbed the wound with clean, dry 4x4 gauze. LPN-B then applied an absorbent foam dressing to cover the wound. LPN-B did not initial or date the dressing. LPN-A and LPN-B removed gloves and performed hand hygiene. During interview on 10/15/24 at 8:28 a.m., LPN-B stated R25 wouldn't allow staff to remove the soiled chux pad and replace it with a clean one during dressing changes. LPN-B stated R25 did not allow staff to touch his things or turn off the fan. LPN-B stated if she could shut off the fan, she would. However, she did not ask R25 for permission and therefore left the fan on. Further, LPN-B stated R25's wound was routinely followed by the wound nurse. LPN-A stated the nursing staff would cleanse the outer aspect of the wound and complete the outer foam dressing changes daily. LPN-A stated R25 would not let her shut off the fan, however, then confirmed she had not asked to shut the fan off during dressing changes. LPN-A stated if left on, the fan could blow germs and bacteria all over the place. During interview on 10/15/24 at 2:30 p.m., director of nursing (DON) stated her expectation was to remove all soiled chux pads prior to a clean dressing change. She went on to state	F 880			

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F 880	Continued From page 31 nursing staff should be dating and initialing all dressings so all staff would know who performed and when the last dressing change was completed. Furthermore, DON stated she expected staff to shut off any fans during dressing changes so air was not blowing directly into an open wound. DON stated this was important because a fan could blow bacteria or debris into the wound and potentially cause an infection.	F 880			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the acting infection	F 882			11/30/24
			F882 – No certified IP Employed: • How corrective action will be		

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F 882	Continued From page 32 preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 41 residents residing in the facility. Findings include: On 10/17/24 at 9:59 a.m., the interim director of nursing (DON) stated the DON and assistant director of nursing (ADON) shared IP duties. The DON stated she had not completed specialized training in infection prevention and control. On 10/17/24 at 10:29 a.m., the administrator stated the DON and the ADON had not completed specialized training in infection prevention and control. A policy related to infection preventionist specialized training was requested, but not provided.	F 882	accomplished for those residents found to have been affected by the deficient practice. - o Job posted on Indeed October 14, 2024. - o Reviewing applications every 24-48 hours. - o Contacting qualified applicants for phone screenings within 24-48 hours of review. - o Timely responses to applicants who contact. - o Sourcing candidates outside of applications via Indeed. - o Working with marketing team to identify job fair opportunities or other recruitment opportunities. - o Once job posting becomes one month old, and there have been no candidates selected, it will be reposted as to ensure it is at the top of job positing lists on job positing platform. • How the facility will identify other residents having the potential to be affected by the same deficient practice. - o The Assistant Director of Nursing is currently taking IP online certification, projected end date of 12/15/2024, through the CDC. - o The daily morning meeting discusses potential infection patterns, and adjusting cares accordingly, and monitor the antibiotics. - o The Assistant Director of Nursing manages all infectious notes. - o The Assistant Director of Nursing will be taking over IP duties in the absence of an IP and will access any residents that		

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F 882	Continued From page 33	F 882	show evidence of an infection. - o Each month, the team will review trends at QAPI and discuss treatments (if not already determined) moving forward. • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? - o Assistant Director of Nursing is currently taking IP online certification through CDC. With a projected completion date of 12/15/2024 and will be able to take over IP duties in the absence of an IP. - o Leave detailed instructions, and manual from Pathways to ensure proper resources upon absence of IP. - o Once job posting becomes one month old, and there have been no candidates selected, it will be reposted as to ensure it is at the top of job positing lists on job positing platform. • How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. - o Monitor Assistant Director of Nursing certification to ensure no lapse in absence of IP. - o Once job posting becomes one month old, and there have been no candidates selected, it will be reposted as to ensure it is at the top of job positing lists on job positing platform. - o The facility will see to employ a temporary Infection Preventionist in the vacancy of employment in the future.		

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F 882	Continued From page 34	F 882			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's	F 883	- The date of each deficiency will be corrected. - o Job was posted on October 14, 2024.		11/15/24

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F 883	Continued From page 35 representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R2, R3) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old, or an adult 19-64 years old with specified immunocompromising conditions, had received	F 883	F883 Influenza/Pneumococcal Immunization - Regarding R2 and R3, both residents signed consents and were given the PCV20-valent pneumococcal immunizations on 10/17/24 without issue. - The policies and procedures regarding Immunizations of Influenza and Pneumococcal were reviewed by DON/Designee on 11/1/24. - Nurse education will be provided on the importance of immunization for Pneumonia when the residents become eligible. Meetings at change of shift on 11/8/24 regarding this information will be held and if nurses miss this meeting, there will be handouts available with a		

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F 883	Continued From page 36 the complete series (i.e., PPSV23 and PCV13) then the patient and provider (shared clinical decision-making) may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20). R2's quarterly Minimum Data Set (MDS) dated 8/16/24, indicated R2 was 68 years old and diagnoses included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure. R2's immunization report, dated 10/17/24, indicated R2 received PPSV23 on 9/7/2017 and PCV13 on 12/18/2010. The record lacked evidence of shared clinical decision-making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R2 was offered or received PCV20. R3's quarterly MDS dated 7/18/24, indicated R3 was 62 years old and diagnoses included the following specified immunocompromising conditions: chronic respiratory failure and heart failure. R3's immunization report, dated 10/17/24, indicated R3 received PPSV23 on 5/21/09 and PCV13 on 8/24/18. The record lacked evidence of shared clinical decision-making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R3 was offered or received PCV20. On 10/17/24 at 9:59 a.m., director of nursing/infection preventionist (DON/IP) verified R2 and R3 had not been offered or provided education on PCV20, and there had been no shared clinical decision-making with the resident	F 883	chance to ask questions afterward through 11/15/24. - Pneumonia immunizations are offered upon admission and when residents become eligible. - DON/Designee will audit the resident list against the Minnesota Immunization Information Connection. Those that are eligible will be offered Pneumonia Immunization and Influenza Immunization. Appropriate education and documentation will be provided and uploaded into the PCC Electronic Medical Record by 11/8/24 and ongoing. MIIC will be updated by DON. - Audits to be performed upon admission by DON/Designee for vaccination status. Orders will be placed in PCC orders for when the resident becomes eligible for the Pneumococcal vaccine. - Audits to be performed 1 x week for 4 weeks, then 1 x month for 3 months. Audits will be brought to QAPI for review. - Completion Date: 11/15/2024		

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F 883	Continued From page 37 providers regarding pneumococcal immunizations. The DON/IP stated the PCV20 vaccine should have been offered when the resident became eligible and pneumococcal immunizations were important to maintain resident health. The facility's Pneumococcal Vaccine policy revised 3/22, indicated all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections in accordance with current CDC recommendations.	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on October 15, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, New Brighton Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION			K 000			

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

Electronically Signed

TITLE

(X6) DATE

11/08/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. New Brighton Care Center is a 2-story building with no basement. The building at 2 different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the north and was determined to be of Type II (111) construction. Because the original building and the 1 addition are of the same type of	K 000			

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K 000	Continued From page 2 construction, the building was surveyed as 1 building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 57 beds and had a census of 52 at the time of the survey.	K 000			
K 291 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 11:00 AM and 1:00 PM, it was revealed by observation and staff interview, that all of the emergency lights had been removed from this facility. There was a finding in 2023 for not testing the lights and the facility decided to remove all of the bulbs as a remediation, Emergency Lighting is required under NFPA 101,	K 291	K291 Emergency Lighting 1. Verified all lighting boxes work, need to order new lights 12 emergency lighting boxes. 2. Testing of lighting on weekly basis, put into TELS software system checklist. 3. TELS software will trigger the maintenance department to check lighting weekly. 4. Maintenance Manager 5. November 22nd, 2024	11/22/24	

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FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y00Y21 Facility ID: 00507 If continuation sheet Page 4 of 11

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K 321	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors to hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, 7.2.1.15, and 7.2.1.15.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 11:00 AM and 1:00 PM, it was revealed by observation that room across from the laundry room was being used for storage and had no self closing device on it. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 321	K321 Hazardous Areas – Enclosure 1-5. The door closure was ordered and placed onto door, is now self-closing. This is complete.		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as	K 351		11/15/24	

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K 351	Continued From page 5 required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. Thia deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 11:00 AM and 1:00 PM, it was revealed by observation that there were wires in contact with the sprinkler pipe above the ceiling near room 103.. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 351	K351 Sprinkler System – Installation 1. Observed wires were reinstalled with Fire Marshall in building. 2. Maintenance audited all other areas for the same concern, completed. 3. Add quarterly audits to ensure wire connected. 4. Maintenance Department 5. 11/15/2024		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		11/29/24	

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K 521	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 11:00 AM and 1:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the dampers in the facility had been inspected within four years. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 521	K521 HVAC 1. Facility is in communication with Egan Company about scheduling smoke damper inspection with Fire Inspection scheduled for November 2024. 2. Enter a 4-year smoke damper inspection to the TELS system. 3. TELS software will trigger for inspection in 4 years. 4. Maintenance Department 5. 11/29/2024		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712		11/8/24	

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K 712	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 11:00 AM and 1:00 PM, it was revealed by a review of available documentation at the time of the survey, the facility had no documentation to show that fire drills had been conducted at the following times: a. 2nd and 3rd shift of 2023 b. 1st and 3rd shift of 2024 c. 3rd shift of 2024 d. 2nd and 3rd shift of 2024 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	K712 Fire Drills 1. Fire Drills have been scheduled per regulation for the next 12 months on the outlook calendar. 2. Administrator is added to the calendar invite to ensure completion in absence of maintenance. 3. The Maintenance Manager will ensure that the fire drills are scheduled at the end of each year for the following year. 4. Maintenance Manager 5. 11/8/2024		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		11/8/24	

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K 918	Continued From page 8 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.4.1, 8.4.2, and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 11:00 AM and 1:00 PM, it was revealed by a review of available documentation that at the time of the survey the	K 918	K918 Electrical Systems – Essential Electric System Maintenance and Testing 1. Collect Reports from Cat Zeigler after service. 2. Cat Zeigler now has the correct email address to send reports to the maintenance manager. 3. The Maintenance Manager will ensure reports are received after service by following up with Cat Zeigler. 4. Maintenance Manager 5. Completion Date: 11/8/2024		

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K 918	Continued From page 9 facility could not provide documentation showing that generator had been tested in January, August and September of 2024 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918			
K 927 SS=F	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to implement Gas Equipment - Transfilling Cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.2. This deficient finding have a patterned impact on the residents within the facility. Findings include: On 10/15/2024, between 11:00 AM and 1:00 PM, it was revealed by observation that 2 liquid oxygen cylinder tank were being stored in the corridor by room 113.	K 927	K927 Gas Equipment – Transfilling Cylinders 1. Residents will be moving to a single room to ensure space for oxygen tanks to be stored by regulation behind a fire door. 2. Admissions and Nursing Management Team educated on oxygen orders changed to 4-6 L need consideration of single room for oxygen storage. Staff educated that oxygen tanks cannot be stored in hallways. 3. Maintenance will audit hallways weekly on rounding days to ensure oxygen is not stored in hallways.	11/29/24	

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K 927	Continued From page 10 An interview with the Director of Maintenance verified this finding of deficiency at the time of discovery.			K 927	4. Maintenance Manager 5. 11/29/2024		