



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

August 21, 2025

Administrator
Brighton Hospice
4500 PARK GLEN ROAD STE 475
SAINT LOUIS PARK, MN 55416

RE: Event ID: 1D3904-H1

Dear Administrator:

On August 13, 2025, a survey was completed at your facility for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, your agency was found to be in compliance with Federal certification regulations.

Electronically attached is your copy of the Federal Form CMS-2567 indicating your facility's compliance with the Federal regulations.

Thank you for your cooperation.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 241594		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2025	
NAME OF PROVIDER OR SUPPLIER Brighton Hospice				STREET ADDRESS, CITY, STATE, ZIP CODE 4500 PARK GLEN ROAD STE 475 , SAINT LOUIS PARK, Minnesota, 55416			
(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
L0000	INITIAL COMMENTS On 8/11/25 through 8/13/25, an abbreviated survey was conducted. This resulted in a standard survey at Brighton Hospice. The agency was found to have met the requirements at 42 CFR. Part §418 for Hospice Agencies. The following complaints were reviewed: H15949408C (117027), H15941940C (112601), H15941941C (112081).			L0000			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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August 21, 2025

Administrator

Brighton Hospice
4500 PARK GLEN ROAD STE 475
SAINT LOUIS PARK, MN 55416

Re: Event ID: 1D3904-H1

Dear Administrator:

On August 13, 2025, a survey was completed at your agency for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under MN Rule 4664.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to contact me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2025	
NAME OF PROVIDER OR SUPPLIER Brighton Hospice				STREET ADDRESS, CITY, STATE, ZIP CODE 4500 PARK GLEN ROAD STE 475 , SAINT LOUIS PARK, Minnesota, 55416			
(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
40000	Initial Comments On 8/11/25 through 8/13/25 an abbreviated complaint survey was conducted. The agency was found to be in compliance with MN State Licensing Chapter Rules 4664, Hospice Services.			40000			

Office of Primary Care and Health Systems Management

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