

Electronically delivered October 4, 2021

Administrator New Brighton A Villa Center 825 First Avenue Northwest New Brighton, MN 55112

RE: CCN: 245164 Cycle Start Date: August 25, 2021

Dear Administrator:

On September 15, 2021, we notified you a remedy was imposed. On September 30, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 27, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 30, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 15, 2021, in accordance with Federal law, as specified in the Act at **§** 1819(f)(2)(B)(iii)(I)(b) and **§** 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 30, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 27, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Electronically delivered

October 4, 2021

Administrator New Brighton A Villa Center 825 First Avenue Northwest New Brighton, MN 55112

Re: Reinspection Results Event ID: DOBI12

Dear Administrator:

On September 30, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 25, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Electronically delivered September 15, 2021

Administrator New Brighton A Villa Center 825 First Avenue Northwest New Brighton, MN 55112

RE: CCN: 245164 Cycle Start Date: August 25, 2021

Dear Administrator:

On August 25, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 30, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 30, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 30, 2021.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 \$11,160; 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 September 30, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, New Brighton A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 30, 2021. 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" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802-2007 Email: teresa.ament@state.mn.us Office: (218) 302-6151 Mobile: (218) 766-2720

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 February 25, 2022 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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov.</u>

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

Feel free to contact me if you have questions.

Sincerely,

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
		245164	B. WING				C 25/2021
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	survey was conduc was found to be NC requirements of 42	/21, a standard abbreviated ted at your facility. Your facility DT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
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	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.					
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		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/17/2021

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

PRINTED: 09/20/2021

DEPARTMENT OF HEALTI CENTERS FOR MEDICAR				FORM	09/20/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/20/2021 APPROVED 0938-0391
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Facility ID: 00114

If continuation sheet Page 4 of 12

		AND HUMAN SERVICES				FORM	09/20/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245164	B. WING _				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	IGHTON A VILLA CEN	ITER			25 FIRST AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa buttock and left low amputation related plan also indicated repositioning every in chair daily. R1's hospital discha indicated R1 admitt facility and identified pressure ulcers on - Left buttock press at 7 centimeters (cr - Right buttock press 3. Two open areas 0.1 cm and 0.5 cm - Right isheal tuber vs. Stage 3. This ar - Right buttock with (slough or necrotic under this area, will peels away. On 5/20/21, at 12:5 day of R1's admissi pressure ulcers tha or accurately asses - Wound to both bu R1's medical recor documentation of tr isheal tuberosity. On 5/20/21, at 9:28 indicated R1's conc a skin ulcer on R1's breakdown of skin.	age 4 ver leg, and a lower knee to pressure ulcers. R1's care R1 could be resistive to two hours, and was to be up arge summary dated $5/20/21$, ted from the hospital to the d the following existing 5/19/21: sure ulcer Stage 3, measured m) x 5 cm x 0.3 cm asure ulcer Stage 2 vs, Stage measuring 1.2 cm x 0.5 cm x x 0.7 cm x 0.1 cm osity (sitting bones) Stage 2 rea was not measured a large area of devitalized skin tissue). Skin appears intact I monitor as devitalized skin 52 p.m. a progress note the ion, indicated the following it were not measured, staged ased:	F 68	86			
	On 6/9/21, at 4:55 r	p.m. a Wound Assessment					

If continuation sheet Page 5 of 12

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245164	B. WING	i		C 08/25/2021		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	IGHTON A VILLA CEN	ITER		8	825 FIRST AVENUE NORTHWEST			
					NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	completed by the as (ADON) indicated F ulcer was a healed (redness). No furthe ulcer was complete assessment and m On 6/24/21, at 4:17 R1's coccyx complete the pressure ulcer as further assessment completed. On 7/6/21, a Skin C skin issues as wour abdomen. The Obs assessment. R1's r further assessment On 8/1/21, a Skin C skin issues as wour abdomen. The Obs assessment. R1's r further assessment On 8/1/21, a Skin C skin issues as sheat areas. R1 stated he Observation lacked On 8/9/21, at 3:39 p R1's right outer ank indicated the press measured 3.0 am x depth. R1's medicated monitoring. On 8/11/21, at 4:09 R1's coccyx was co Assessment indicated Stage 3 and measu unknown depth. Th	Also constants director of nursing R1's coccyx (tailbone) pressure Stage 1, with erythema er assessment of the pressure d. R1's medical record lacked onitoring. p.m. a Wound Assessment of eted by the ADON indicated as a healed Stage 1. No of the pressure ulcer was Observation described R1's and healing buttocks and lower pervation lacked any further medical record lacked any or monitoring. Observation described R1's aring to left buttock irregular e was not scratching it. The any further assessment to the completed by the ADON, ure ulcer was unstagable, and a 2.5 cm with an unknown	F	586				

Facility ID: 00114

If continuation sheet Page 6 of 12

PRINTED: 09/20/2021

		AND HUMAN SERVICES				FORM	09/20/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245164	B. WING				C 25/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	IGHTON A VILLA CEN	ITER			25 FIRST AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	gone from a healed Stage 3 pressure ul On 8/13/21 at 4:04 R1 requested to be department (ED) ini ongoing complaints pain medication. Ul paramedics himself ambulance. R1'a Hospital disch R1 had the following - Sacrum pressure unstageable, and m cm - Right ankle was si measured 2.5 cm x 1.5 cm x 1.5 cm x 0 On 8/23/21, 1:19 p. (DON) was interview other assessments except what was in stated R1's largest had healed or was of was the reason why documentation did after the assessment of further measurer R1's buttocks or co assessment on 8/1° time, R1's coccyx w pressure ulcer. The process was to ass week span, and if a	A Stage 1 pressure ulcer, to a lcer. a.m. a progress note indicated sent to the emergency itially at 2:00 a.m. due to of pain after already receiving timately, R1 called the f and left the facility via arge dated 8/16/21, indicated g pressure ulcers: ulcer was staged at neasured 3 cm x 2.5 cm x 0.2 taged at unstabeable and 2.5 cm x 0.5 cm lateral and 0 cm medial m. the director of nursing wed and stated there were no of R1's pressure ulcers the medical record. The DON pressure ulcer on his buttocks closed upon admission, which y weekly pressure ulcer not start. The DON stated ant on 6/9/21, there was a lack ments of the pressure ulcer on ccyx area until the 1/21. The DON stated at that was assessed at a Stage 3 a DON stated the facility's sess pressure ulcer slowed in on weeks, they would change	F 6	86			

Facility ID: 00114

If continuation sheet Page 7 of 12

		AND HUMAN SERVICES				FORM	09/20/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245164	B. WING	i			C 25/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	IGHTON A VILLA CEN	ITER			325 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	On 8/24/21, at 7:12 stated he had left th care. R1 stated he the lack of treatmen going to worsen if h morning of 8/13/21. On 8/24/21, at 4:30 (MD)-A was intervie pressure ulcer asse healed Stage 1 on MD-A stated she di time the end of May the ADON was not accurately. MD-A stated the redness "a little off kilter," an bed was lacking. M staff's lack of know ulcer was not heale excoriation and mo damage, they would a Stage 1. MD-A sta staff to do a very th pressure ulcers. The facility policy S dated 7/7/21, direct process to identify n developing a press readmission, transf changes in conditio Assessment proces the first step in the ulcer/injury can occ	age 7 a.m. R1 was interviewed and be facility due to inadequate felt his overall cares, including ht for his pressure ulcers, were be did not leave the early which was why he called 911. p.m. the medical director wed and stated the ADON's essment on 6/9/21, as a R1's coccyx was incorrect. d some staff education some y or June, when she noticed assessing the pressure ulcers tated she noted issues with llcer documentation. MD-A and the measurements were hd the description of the wound D-A stated this was due to ledge. MD-A stated a pressure ed if there was some isture associated skin d be staged as a Stage 2, not ated she expected nursing orough assessment on kin Protection and Prevention residents with or at risk for ure injury: Upon admission / ier out/in, with significant on routinely through the MDS ss. the policy further directed prevention of pressure uries (PU/PIs) is the resident at risk. A pressure is to the tissue. Some factors	F	586			

If continuation sheet Page 8 of 12

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245164	B. WING		C 08/25/2021	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	IGHTON A VILLA CEN	ITER		825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	ge 8	F 68	6		
	are modifiable while Nutrition/Hydration CFR(s): 483.25(g)(Status Maintenance	F 69	2		9/27/21
	(Includes naso-gast both percutaneous percutaneous endo enteral fluids). Bas	essment, the facility must				
	of nutritional status, desirable body weig balance, unless the	tains acceptable parameters such as usual body weight or ght range and electrolyte resident's clinical condition his is not possible or resident e otherwise;				
	§483.25(g)(2) Is off maintain proper hyd	ered sufficient fluid intake to Iration and health;				
	there is a nutritional provider orders a th This REQUIREMEN by:	NT is not met as evidenced				
	facility failed to time recommendations f registered dietician residents (R1) revie	or a speech evaluation and a recommendations for 1 of 1		 R1 is no longer a resident at the facility All residents with the potential for swallowing difficulties and nutritional problems were assessed. 	or	
	was admitted from the diagnoses included	inted 8/24/21, indicated R1 the hospital on 5/20/21. R1's infection of left amputation g chronic osteomyelitis		3. Nursing staff has been educated identifying and reporting swallowing difficulties, pain during eating/swallo and identifying potential for weight lo	owing	

Facility ID: 00114

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PRINTED: 09/20/2021

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES	r		C	<u>MB NO.</u>	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	Сом	E SURVEY PLETED
		245164	B. WING	/ING		08/	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	IGHTON A VILLA CE	NTER			25 FIRST AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 692	Continued From pa	age 9	F 6	92			
	neuropathy, severe gastro-esophageal R1's admission Mii 5/27/21, indicated had complaints of further indicated R ulcer and was at ri- MDS lacked identiti ulcers.	nimum Data Set (MDS) dated R1 was cognitively intact, and difficulty in swallowing. MDS 1 had one Stage 1 pressure sk for pressure ulcers. The fication of any other pressure			4. The Director of Nursing/Designee will audit weight loss, reported swallow and pain with swallowing issues 3 times per week for 4 weeks. The Director of Nursing will report results to QAPI for further guidance.		
	a swallowing probl while seated uprigl having a history of	lated 5/21/21, indicated R1 had em related to difficulty and pain ht for oral intake, as well as choking. R1's care plan noted refer to speech therapy for tion.					
	nutritional problem problem related to amputation (BKA) Intervention include ordered 120 millilit	lated 5/21/21, indicated R1 had s or potential nutritional a history of left below knee with wound to stump. ed to provide supplements as ers (mL) Strawberry Mighty supplement) twice daily.					
	indicated R1 was a to secondary to dy edentulous (lack of high blood pressur The CAA further in	tional Status dated 5/27/21, at increased nutritional risk due sphagia (swallowing difficulty), f teeth), left BKA, diabetes, re,and infection of the tonsils. dicated a referral was needed (ST) for dysphagia.					
	5/21/21, indicated swallowing. The as	ve Nutrition Assessment dated R1 had problems chewing and ssessment also indicated R1 and a ST evaluation was					

If continuation sheet Page 10 of 12

		AND HUMAN SERVICES				FORM	09/20/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245164	B. WING				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	IGHTON A VILLA CEN	ITER			25 FIRST AVENUE NORTHWEST IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	indicated. R1 had c difficulty and of hav hospital. R1 was als meals related to pa directed staff to pro Mighty Shake twice R1's order summar orders: - Effective 7/29/21: week for four week Order date 7/30/21 - Interventional radii (swallow study) per (SLP) recommenda dysphagia, and gas (GERD). On 7/28/21, at 1:05 indicated the Assoc (ACP) notes from 7 mentioned he has b swallowing. Reques to rehab manager a manager (TCU NM On 8/24/21, at 12:0 nursing (ADON) wa stated he submitted evaluation to be con coordinator (HUC) a swallow evaluation, R1's care plan on 5 On 8/24/21, at 12:5 (RD)-A was intervie able to meet with R	 omplained of swallowing ing a choking episode while in so unable to sit fully upright at in. The assessment further vide 120 mL Strawberry a day. y indicated the following ST clarification: three times a s for swallowing treatment. ology referral for sonogram speech-language pathologist ations due to ongoing stroesophageal reflux disease p.m. a progress note clated Clinic of Psychology /27/21, were reviewed. R1 been having difficulty st for a referral to SLP emailed and transitional care unit nurse). 2 p.m. the assistant director of as interviewed. The ADON d the referral for a swallow mpleted to the health unit and was unable to confirm or I not had a been scheduled for even though it was noted in 	F	592			

If continuation sheet Page 11 of 12

		AND HUMAN SERVICES				FORM	09/20/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245164	B. WING	i			C 25/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
NEW BR	RIGHTON A VILLA CEN	ITER		-	325 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Mighty Shakes for i would benefit R1 in wounds. RD-A state receiving Mighty Sh trial it first to see if I down due to his nat Mighty Shakes had admission on 5/20/2 On 8/24/21, at 1:17 and stated R1 had 5/21/21, there was and she only starter SP-A stated when s agreeable to going swallow evaluation. supposed to be sch documentation lack attempts. The facility policy tit Management dated to maintain adequa extent possible, to e to maintain the high well-being. The ear with, or at risk for, in status may allow th develop and implen or improve nutrition arise. Body weight a often be stabilized o not be correctable i alone, is not the on nutritional status. R co-morbidities may	increased protein intake, which the healing process of his ed prior to her visit, R1 was not nakes as she had wanted to R1 would be able to keep it usea. RD-A also confirmed the been ordered since R1's	F	692			

If continuation sheet Page 12 of 12



Electronically delivered September 15, 2021

Administrator New Brighton A Villa Center 825 First Avenue Northwest New Brighton, MN 55112

Re: State Nursing Home Licensing Orders Event ID: DOBI11

Dear Administrator:

The above facility was surveyed on August 23, 2021 through August 25, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Rapid Response Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802-2007 Email: teresa.ament@state.mn.us Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

M. Ping

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00114	B. WING		08/2) 5/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW BR	IGHTON A VILLA CEN	ITER	T AVENUE N GHTON, MN	IORTHWEST 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Pla plan of correction y and identify the date	FS: /21, a complaint survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 09/17/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 14

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED		
		00114	B. WING		08/25/2021			
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE				
IEW BR	IGHTON A VILLA CEI	NTER	ST AVENUE NO					
(X4) ID								
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 000	Continued From pa	age 1	2 000					
	The following complaints were found to be SUBSTANTIATED: H5164194C (MN75832 / MN75830) with licensing orders issued at 0900 and 0940.							
	documenting the S Orders using Fede have been assigne statutes/rules for N tag number appear "ID Prefix Tag." Th compliance is listed of Deficiencies" col Comply" portion of column also include violation of the stat "This Rule is not m the surveyor's findi of Correction and T You have agreed to receipt of State lice the Minnesota Dep Informational Bulle <https: www.healtti<br="">on/infobulletins/ib1-</https:>	partment of Health is tate Licensing Correction ral software. Tag numbers d to Minnesota state lursing Homes. The assigned rs in the far-left column entitled he state statute/rule out of d in the "Summary Statement lumn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidence by." Following ngs are the Suggested Method Time Period for Correction. b participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at h.state.mn.us/facilities/regulati 4_1.html> The State licensing ed on the attached Minnesota of the orders being submitted to						

Minnesota Department of Health STATE FORM

6899

DOBI11

If continuation sheet 2 of 14

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
				·	С
		00114		I	08/25/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE NORTHWEST	
NEW BR	IGHTON A VILLA CE	NTFR	GHTON, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE E DATE
2 000	Continued From pa	age 2	2 000		
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.			
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		9/27/21
	comprehensive res	sores. Based on the sident assessment, the director must coordinate the nursing care plan which			
	without pressure s pressure sores unl condition demonst	no enters the nursing home cores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and			
	receives necessar	who has pressure sores by treatment and services to revent infection, and prevent veloping.			
	by: Based on interview facility failed to pro pressure ulcers for for pressure ulcers the hospital with ex pressure ulcers we This resulted in ha	ent is not met as evidenced y, and document review, the perly assess and monitor 1 of 3 residents (R1) reviewed R1 had been admitted from kisting pressure ulcers, and the ere not monitored or assessed. If the results and he sustained a worsened and he sustained a		corrected	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or contraction	IDENTIFICATION NOMBER.	A. BUILDING:			
		00114	B. WING		C 08/25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NEW BR	IGHTON A VILLA CE	NTER	ST AVENUE NO			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET
2 900	Continued From pa	age 3	2 900			
		Pressure Ulcer definitions by the National Pressure Injury Advisory Panel:				
	erythema of intact a Intact skin with a lo erythema (redness may appear with pe hues. The presenc changes in sensati may precede visua	njury: Non-blanchable skin: ocalized area of non-blanchable). In darker skin tones, the PI ersistent red, blue, or purple e of blanchable erythema or on, temperature, or firmness I changes. Color changes of o indicate a deep tissue PI	9			
	loss with exposed of Partial-thickness lo dermis, presenting wound bed is viable also present as an Adipose (fat) is not	Jlcer: Partial-thickness skin dermis: oss of skin with exposed as a shallow open ulcer. The e, pink or red, moist, and may intact or open/ruptured blister. visible and deeper tissues are ation tissue, slough and eschar	•			
	Full-thickness loss fat may be visible in tissue and epibole present. Slough an does not obscure t depth of tissue dan location; areas of s develop deep wour tunneling may occu	Jlcer: Full-thickness skin loss: of skin, in which subcutaneous n the ulcer and granulation (rolled wound edges) are ofter id/or eschar may be visible but he depth of tissue loss. The nage varies by anatomical significant adiposity can nds. Undermining and ur. Fascia, muscle, tendon, and/or bone are not exposed.	5			
	tissue loss:	Jlcer: Full-thickness skin and and tissue loss with exposed				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00114	B. WING	B. WING		C 08/25/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
NEW BR	IGHTON A VILLA CE	NTFR	ST AVENUE NO				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	or directly palpable ligament, cartilage and/or eschar may the wound bed. Ep undermining and/o varies by anatomic Unstageable Press full-thickness skin extent of tissue dan be confirmed beca obscured by slough dry, adherent, intac fluctuance) should clinical consideration resident's physician physician assistant allowable under sta or eschar is remov pressure ulcer will depth of the tissue determined, then the assigned. The press completely debride eschar for reclassif Findings include: R1's Face Sheet po was admitted from diagnoses included stump, chronic osta bone) of the left low	fascia, muscle, tendon, or bone in the ulcer. Slough be visible on some parts of ibole (rolled edges), r tunneling often occur. Depth al location. sure Ulcer: Obscured and tissue loss: and tissue loss in which the mage within the ulcer cannot use the wound bed is n or eschar. Stable eschar (i.e et without erythema or only be removed after careful on and consultation with the n, or nurse practitioner, c, or clinical nurse specialist if ate licensure laws. If the slough ed, a Stage 3 or Stage 4 be revealed. If the anatomical damage involved can be ne reclassified stage should be sure ulcer does not have to be d or free of all slough or fication of stage to occur.					
anagata D	R1's admission Mir 5/27/21, indicated I	nimum Data Set (MDS) dated R1 was cognitively intact, and assistance from two staff for					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00114	B. WING	B. WING		C 08/25/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE. ZIP CODE			
	IGHTON A VILLA CE	NTER 825 FIR	ST AVENUE NO	ORTHWEST			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE	
2 900	Continued From pa	age 5	2 900				
2 900	incorrectly indicate pressure ulcer and ulcers. The MDS la Stage 3, or Stage 4 R1's Care Area Ass Ulcer and Injury da at increased risk or further indicated R to buttocks which w creme (a sterile co wound or peri-wou CAA indicated R1 m with bed mobility a two for bed mobility incontinent of blad of bowel, he requir	ansfers. The MDS further d R1 had one Stage 1 was at risk for pressure acked further record of Stage 2 4 pressure ulcers. sessment (CAA) for Pressure ted 5/27/21, indicated R1 was f skin breakdown. The CAA 1 had a Stage 1 pressure ulcer was being treated by Triad ating applied directly onto the nd as a moisture barrier). The required assistance of two staf nd was an extensive assist of y, and since he was always der and frequently incontinent ed extensive assistance with indicated R1 was at risk for	r				
	had actual impairm buttock and left lov amputation related plan also indicated	updated 8/9/21, indicated R1 nent to skin integrity on his ver leg, and a lower knee to pressure ulcers. R1's care R1 could be resistive to y two hours, and was to be up					
	indicated R1 admit facility and identifie pressure ulcers on - Left buttock press at 7 centimeters (c - Right buttock pre 3. Two open areas 0.1 cm and 0.5 cm	sure ulcer Stage 3, measured m) x 5 cm x 0.3 cm ssure ulcer Stage 2 vs, Stage measuring 1.2 cm x 0.5 cm x					

	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMI	E SURVEY PLETED
		00114	B. WING		08/25/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
NEW BR	IGHTON A VILLA CE	NTER	RST AVENUE NO RIGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 6	2 900			
	- Right buttock with large area of devitalized skin (slough or necrotic tissue). Skin appears intact under this area, will monitor as devitalized skin peels away.		n			
	day of R1's admiss pressure ulcers that or accurately asses - Wound to both bu R1's medical reco					
	indicated R1's cond a skin ulcer on R1's breakdown of skin.	³ p.m. a progress note dition upon admission include s sacrum (tailbone) limited to The progress note lacked pressure area on R1's	d			
	completed by the a (ADON) indicated I ulcer was a healed (redness). No furth	p.m. a Wound Assessment issistant director of nursing R1's coccyx (tailbone) pressu Stage 1, with erythema er assessment of the pressured. R1's medical record lacke ionitoring.	e			
	R1's coccyx compl the pressure ulcer	7 p.m. a Wound Assessment of eted by the ADON indicated as a healed Stage 1. No t of the pressure ulcer was	of			
	skin issues as wou abdomen. The Obs	Dbservation described R1's nd healing buttocks and lowe servation lacked any further medical record lacked any t or monitoring.	r			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00114	B. WING	B. WING		C 08/25/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, ST	TATE, ZIP CODE			
NEW BR	IGHTON A VILLA CE	NTFR	RST AVENUE NO RIGHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 7	2 900				
2 900	skin issues as she areas. R1 stated h Observation lacked On 8/9/21, at 3:39 R1's right outer an indicated the press measured 3.0 am depth. R1's medic documentation of v	Observation described R1's aring to left buttock irregular e was not scratching it. The d any further assessment. p.m. a Wound Assessment to kle completed by the ADON, sure ulcer was unstagable, and x 2.5 cm with an unknown cal record lacked when this pressure ulcer cked assessment and					
	R1's coccyx was c Assessment indica Stage 3 and meas unknown depth. Th R1's coccyx press	9 p.m. a Wound Assessment to ompleted by the ADON. The ated the pressure ulcer was a ured 5.0 cm x 4.0 cm with an his documentation indicated ure ulcer had worsened, havin d Stage 1 pressure ulcer, to a ulcer.					
	R1 requested to be department (ED) ir ongoing complaint pain medication. U	a.m. a progress note indicate e sent to the emergency nitially at 2:00 a.m. due to s of pain after already receivin ltimately, R1 called the If and left the facility via					
	R1 had the followir - Sacrum pressure	narge dated 8/16/21, indicated ng pressure ulcers: ulcer was staged at neasured 3 cm x 2.5 cm x 0.2					
		staged at unstabeable and x 2.5 cm x 0.5 cm lateral and 0 cm medial					

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUF COMPLET	
		00114	B. WING		C 08/25/2021	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
NEW BR	IGHTON A VILLA CEN	NTER	ST AVENUE NO IGHTON, MN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
2 900	Continued From pa	age 8	2 900			
	On 8/23/21, 1:19 p.m. the director of nursing (DON) was interviewed and stated there were no other assessments of R1's pressure ulcers except what was in the medical record. The DON stated R1's largest pressure ulcer on his buttocks had healed or was closed upon admission, which was the reason why weekly pressure ulcer documentation did not start. The DON stated after the assessment on 6/9/21, there was a lack of further measurements of the pressure ulcer on R1's buttocks or coccyx area until the assessment on 8/11/21. The DON stated at that time, R1's coccyx was assessed at a Stage 3 pressure ulcer. The DON stated the facility's process was to assess pressure ulcers over a week span, and if a pressure ulcer slowed in healing for over two weeks, they would change the treatment plan.					
	stated he had left th care. R1 stated he the lack of treatmen going to worsen if h	e a.m. R1 was interviewed and the facility due to inadequate felt his overall cares, including nt for his pressure ulcers, were the did not leave the early , which was why he called 911.				
	(MD)-A was intervie pressure ulcer asso healed Stage 1 on MD-A stated she di time the end of May) p.m. the medical director ewed and stated the ADON's essment on 6/9/21, as a R1's coccyx was incorrect. Id some staff education some y or June, when she noticed				
	accurately. MD-A s the R1's pressure u stated the redness	assessing the pressure ulcers tated she noted issues with ulcer documentation. MD-A and the measurements were				
	bed was lacking. M	nd the description of the wound ID-A stated this was due to Iedge. MD-A stated a pressure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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		00114	B. WING	B. WING		25/2021
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
IEW BR	IGHTON A VILLA CE	NTER	RST AVENUE NO RIGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 9	2 900			
	ulcer was not healed if there was some excoriation and moisture associated skin damage, they would be staged as a Stage 2, no a Stage 1. MD-A stated she expected nursing staff to do a very thorough assessment on pressure ulcers.					
	dated 7/7/21, direc process to identify developing a press readmission, trans changes in conditio Assessment proce the first step in the ulcers/pressure injuidentification of the ulcer/injury can occ	Skin Protection and Prevention ted our facility applies a residents with or at risk for sure injury: Upon admission / fer out/in, with significant on routinely through the MDS ss. the policy further directed prevention of pressure uries (PU/PIs) is the e resident at risk. A pressure cur wherever pressure has n to the tissue. Some factors es others are not.				
	The director of nur- educate staff regar pressure ulcer pre- turning/repositionin devices. The direct could develop a sc assessments and n assessments in the	THOD OF CORRECTION: sing, or designee, could rding the importance of vention measures including and pressure-relieving tor of nursing or designee hedule for weekly skin require documentation of e electronic record. The or designee, could conduct nsure compliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	•			
2 940	MN Rule 4658.052	5 Subp. 9 Rehab - Hydration	2 940			9/27/21
	Subp. 9. Hydratior					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED		
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NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE				
NEW BR	IGHTON A VILLA CE	NTFR	RST AVENUE RIGHTON, MN					
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOLD)			ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 940	Continued From pa	age 10	2 940					
		ate water and other fluids to dration and health, unless I.						
	by: Based on interview facility failed to time recommendations registered dietician residents (R1) revie maintenance to pro	for a speech evaluation and a recommendations for 1 of 1		Corrected				
	diagnoses included stump, left lower le (infection of the bo	the hospital on 5/20/21. R1's d infection of left amputation eg chronic osteomyelitis ne), diabetes with diabetic e morbid obesity and reflux disease.						
	5/27/21, indicated I had complaints of a further indicated R ulcer and was at ris	nimum Data Set (MDS) dated R1 was cognitively intact, and difficulty in swallowing. MDS 1 had one Stage 1 pressure sk for pressure ulcers. The fication of any other pressure						
	a swallowing proble while seated uprigh having a history of	ated 5/21/21, indicated R1 ha em related to difficulty and pa nt for oral intake, as well as choking. R1's care plan noted efer to speech therapy for ion.	in					
	nutritional problem	ated 5/21/21, indicated R1 ha s or potential nutritional a history of left below knee	d					

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00114	B. WING		08/2	25/2021
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
IEW BR	IGHTON A VILLA CEN	NTER	ST AVENUE NO IGHTON, MN			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 940	Continued From pa	ige 11	2 940			
	amputation (BKA) with wound to stump. Intervention included to provide supplements as ordered 120 milliliters (mL) Strawberry Mighty Shake (nutritional supplement) twice daily.					
	R1's CAA for Nutritional Status dated 5/27/21, indicated R1 was at increased nutritional risk due to secondary to dysphagia (swallowing difficulty), edentulous (lack of teeth), left BKA, diabetes, high blood pressure, and infection of the tonsils. The CAA further indicated a referral was needed to speech therapy (ST) for dysphagia.					
	5/21/21, indicated F swallowing. The as had poor dentation indicated. R1 had c difficulty and of hav hospital. R1 was al meals related to pa	ve Nutrition Assessment dated R1 had problems chewing and sessment also indicated R1 and a ST evaluation was complained of swallowing ring a choking episode while in so unable to sit fully upright at in. The assessment further ovide 120 mL Strawberry a day.				
	orders: - Effective 7/29/21: week for four week Order date 7/30/21 - Interventional radi (swallow study) per (SLP) recommenda	ry indicated the following ST clarification: three times a s for swallowing treatment. iology referral for sonogram speech-language pathologist ations due to ongoing stroesophageal reflux disease				
	indicated the Assoc (ACP) notes from 7 mentioned he has I	p.m. a progress note ciated Clinic of Psychology 7/27/21, were reviewed. R1 been having difficulty st for a referral to SLP emailed				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00114		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			C 08/25/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NEW BR	IGHTON A VILLA CEI	NTER	ST AVENUE NO IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 940	Continued From page 12		2 940			
	to rehab manager and transitional care unit nurse manager (TCU NM) .					
	nursing (ADON) was stated he submitted evaluation to be co coordinator (HUC) explain why R1 had	2 p.m. the assistant director of as interviewed. The ADON d the referral for a swallow mpleted to the health unit and was unable to confirm or d not had a been scheduled for , even though it was noted in 5/21/21.				
	(RD)-A was intervie able to meet with R ulcers, and she had Mighty Shakes for would benefit R1 in wounds. RD-A state receiving Mighty Sh trial it first to see if down due to his na	6 p.m. the registered dietitian ewed. RD-A stated she was at once related to his pressure d made the recommendation o increased protein intake, which the healing process of his ed prior to her visit, R1 was no nakes as she had wanted to R1 would be able to keep it usea. RD-A also confirmed the I been ordered since R1's 21.	f t			
	and stated R1 had 5/21/21, there was and she only starte SP-A stated when s agreeable to going swallow evaluation supposed to be sch	7 p.m. SP-A was interviewed been referred to ST, but on not a "concrete" referral, and d working with R1 on 7/30/21. she saw R1 on 8/11/21, he was into the hospital to conduct the . ST-A stated this was neduled, however, facility ked evidence of scheduling				
	Management dated to maintain adequa	tled Nutritional Status d 4/2/18, directed it is importan ite nutritional status, to the ensure each resident is sable	t			

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Minnesc	ta Department of He	alth								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
	00114		B. WING		C 08/25/2021					
NAME OF PROVIDER OR SUPPLIER STREET ADE			DRESS, CITY, S	STATE, ZIP CODE						
NEW BR	IGHTON A VILLA CEN	NTER	T AVENUE N GHTON, MN	IORTHWEST 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 SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	IVE ACTION SHOULD BE ED TO THE APPROPRIATE					
2 940	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		2 940							
Minnesota Department of Health										