DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 24, 2023

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

RE: CCN: 245421
Cycle Start Date: July 26, 2023

Dear Administrator:

On August 21, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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Electronically delivered
August 2, 2023

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

RE: CCN: 245421
Cycle Start Date: July 26, 2023

Dear Administrator:

On July 26, 2023, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 October 26, 2023 (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 January 26, 2024 (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

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,

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	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	INITIAL COMMENTS On 7/25-26/2023, a standard abbreviated survey was conducted at your facility. 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. H54219854C (MN00092364), H54214000C (MN00092252), H54214022C, (MN00091890), and H54214023C) MN00091583). The following complaints were reviewed. H54213873C (MN00095415), with a deficiency issued at F726. 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 726		8/11/23

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

Electronically Signed | 08/11/2023

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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F 726	Continued From page 1 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure licensed nursing staff were competent to insert indwelling urinary catheters for 1 of 1 resident (R1) reviewed for nursing services. Findings include: American Nurses Association. Streamlined Evidence-Based RN Tool: Catheter Associated Urinary Tract Infection (CAUTI) Prevention. Key Practice Strategies to Reduce CAUTI: 1) Fewer Catheters Used, 2) Timely Removal and 3) Insertion, Maintenance and Post-Removal Care.	F 726	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. How Corrective action will be accomplished for those residents found to have been affected by deficient practice. 1. Current employed RN/LPN nursing staff of New Brighton Care Center will review policy & procedures on the following: Catheterization, intermittent	

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F 726	Continued From page 2 The guideline follows the CDC (2009) Criteria for Indwelling Urinary Catheter (IUC) Insertion outlining evidence-based steps. Accessed August 1, 2023. https://www.nursingworld.org/~4aede8/globalassets/practiceandpolicy/innovation--evidence/clinical-practice-material/cauti-prevention-tool/anacautipreventiontool-final-19dec2014.pdf R1's physicians orders dated 10/20/2022 indicated to change the Foley catheter, 18 French (Fr) with 10 milliliters (ml) balloon every month for urinary retention. R1's progress note dated 7/19/2023 at 8:27 p.m. written by Licensed Practical Nurse (LPN)-A indicated Foley catheter 18 Fr with 10 ml balloon changed approximately 8:00 p.m. and well tolerated, will continue to monitor. R1's progress note dated 7/20/2023 at 11:33 a.m. written by Registered Nurse (RN)-A indicated night shift reported R1 threw-up around 5:30 a.m. R1 appeared uncomfortable. The Foley catheter was changed yesterday, drainage of the Foley had blood around the penis. Palpation of the abdomen was firm and painful. There was no urine output from the Foley catheter and the Foley was removed with blood draining from the urethra especially with coughing. Informed the Director of Nursing (DON) sending R1 to the emergency room (ER.) Called 911 and R1 was sent to ER at 7:25 this morning. Through the entire assessment R1 was alert and oriented. On 7/20/2023 at 2:42 p.m., Emergency department (ED) of Mercy Hospital, ED admission notes written by MD-B listed the principal problems for R1 upon admission was	F 726	female residents and Catheterization, intermittent male residents within 30 days, completion date 9/10/2023. 2. Current employed RN/LPN nursing staff will participate in a skills lab and demonstrate proficiency in the following: Catheterization, indwelling male residents, Catheterization, indwelling female residents within 45 days, completion date 9/25/2023. How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility identified all residents with an indwelling catheter to have 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? 1. Upon hire and annually all RN / LPN nursing staff will review policy and procedures pertaining to catheterization, intermittent female and catheterization, intermittent male residents. 2. Upon hire and annually all RN/LPN nursing staff will demonstrate proficiency through a skills lab on the following: Catheterization, indwelling male residents, Catheterization, indwelling female residents. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur 1. General orientation and RN/LPN orientation has been updated to include	

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F 726	Continued From page 3 septic shock evidenced by persistent hypotension, fever, and high lactate levels indicating acidosis. Most likely source was urinary tract infection associated with indwelling catheter. R1 was admitted to the intensive care unit. LPN-A's personnel record was reviewed and lacked competency for indwelling urinary catheters. LPN-A's Technical Skills/Experience document dated 6/21/23 indicated as a nurse LPN-A answered "yes" to experience and comfort level to the "ability to straight cath/indwelling cath (male/female)". During an interview on 7/25/2023, at 1:36 p.m., DON stated LPN-A told her during orientation to the facility LPN-A had the ability to insert indwelling urinary catheters in both male and female residents. No competency evaluation was done based on LPN-A's assertion. When DON conducted an interview with LPN-A post incident LPN-A and stated she changed the catheter for R1 without incident. When asked specifically, LPN-A admitted there was no urine return from the catheter after insertion. DON stated LPN-A was suspended from further catheter insertion or care until remediation could take place. During an interview on 7/25/2023 at 1:50 p.m., LPN-A stated she had been employed by the facility for about six weeks since relocating and had been an LPN for about two years. LPN-A stated on 7/19/2023, at about 8:00 p.m., the procedure proceeded uneventfully. The urinary catheter was inserted until resistance was met. LPN-A stated she believed this resistance indicated the catheter was in the bladder, so she stopped the insertion and inflated balloon with 10	F 726	review of policy and procedures, and a skills lab to ensure all RN/LPN nursing staff are competent in the placement of indwelling catheters and the ability to manage complications. 2. The Director of Nursing and Staff development will audit employee records during orientation and at annual reviews.	

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F 726	Continued From page 4 ml's sterile saline. LPN-A stated there was no urine in the drainage tubing at that time. LPN-A stated R1 tolerated the procedure well. When asked, LPN-A stated she did not note the length of tube that was inserted into the urethra. LPN-A stated she went back to check on R1 about 30 minutes later and noted a "tiny amount" of urine in the tubing. LPN-A stated she recorded the procedure on R1's medical record reported catheter change to night shift nurse. LPN-A stated the last catheter insertion she performed was over six months ago. LPN-A stated she had no experience on what to do if an obstruction was met while inserting a urinary catheter. LPN-A stated she told the DON she was familiar with the procedure and no skills check or competency evaluation was done. During an interview on 7/26/2023, at 9:30 a.m., DON stated LPN-A claimed she was proficient performing urinary catheter insertion for both on the orientation checklist received. DON stated this checklist was a screening tool. New staff nurses are expected to have another nurse observe the new staff member perform the procedure and indicate successful completion of the observed task. DON states she did not have a checklist for LPN-A. DON stated she presumed LPN-A was in process of completing this list. During an interview on 7/26/2023, at 11:00 a.m., RN-B stated she had been employed by the facility for the past 3 months. Stated for orientation received a list of courses to complete on-line via Relias. RN-B Stated received and completed a skills checklist and that orientation seemed comprehensive, staff and DON were very helpful. Most of the training was done on-line per and there were no competency skills	F 726		

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F 726	Continued From page 5 demonstrations. RN-B stated there has not been any skills demonstrations or skills lab to date. During an interview on 7/26/2023, at 11:22 a.m., LPN-B has been with facility for about 3 months. Orientation was well organized but mostly on-line. LPN-B finished the orientation check list and stated it was OK because everyone was friendly and willing to help. LPN-B had been in practice just over a year. LPN-B stated there was no evaluation of skills for competency, no skills lab and was not aware of any future skills labs. During an interview conducted on 7/26/2023, at 2:10 p.m. with the facility administrator and the DON, the DON stated there is no skills demonstration protocol for this or other procedures at this time. DON further stated LPN-A was remediated using a competency assessment tool she developed for use just after the incident. DON and facility administrator stated this is an issue and work has begun to address orientation and competency assessment for nursing personnel. Facility administrator stated the facility's education coordinator left the facility in June, has yet to be replaced. DON further stated they are seeking to hire a staff education coordinator at this time. The DON stated she is covering this role until a replacement can be found. Materials, processes and polices used for new staff orientation were requested, a skills checklist for new nurses was received. The four-page document titled RN/LPN ORIENTATION TO THE NURSING FLOOR CHECKLIST, consisted or a list of skills with columns to indicate the name of the procedure, trainer initials and date, method of evaluation (demonstrated or explained), and	F 726		

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F 726	Continued From page 6 comments. A second document titled NEW BRIGHTON CARE CENTER GENERAL ORIENTATION AGENDA and consisted of a list of policies to be reviewed by the orientee, Relias delivered required learning topics, and physical plant orientation. The final page consisted of a list of learning objectives. No curriculum or planning documents were received for skills workshops or planning for staff continuing education.	F 726		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 2, 2023

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

Re: Event ID: 2VOD11

Dear Administrator:

The above facility survey was completed on July 26, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted 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 call me with any questions.

Sincerely,

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00507	A. BUILDING: _____ B. WING _____	C 07/26/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/25-26/2023,, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H54213873C (MN00095415), H54219854C	2 000		

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

Electronically Signed | 08/11/23

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2 000	Continued From page 1 (MN00092364), H54214000C (MN00092252), H54214022C, (MN00091890), H54214023C (MN00091583). No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		