Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 27, 2023

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

RE: CCN: 245421
Cycle Start Date: August 23, 2023

Dear Administrator:

On October 23, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Electronically delivered

September 1, 2023

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

RE: CCN: 245421
Cycle Start Date: August 23, 2023

Dear Administrator:

On August 23, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 November 23, 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 February 23, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@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 08/23/2023

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 8/22/23 & 8/23/23, 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. H54214669C (MN00095977), H54214670C (MN00095978), H54214671C (MN00095971), & H54214773C (MN00095626) with a deficiency issued at F940 & F689. 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 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		10/16/23

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

Electronically Signed | 09/11/2023

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 689	Continued From page 1 Based on interview and record review the facility failed to ensure a resident's environment remained free from accidents as possible to prevent falls for 4 of 4 residents (R3, R5, R6, and R7) reviewed for falls when there was a lack of evaluation of factors to prevent future falls. Findings include: R3's 5-day MDS dated 8/13/23, noted R3 had intact cognition, required extensive assistance of one for most activities of daily living (ADL's) and had diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, COVID-19, and type II diabetes mellitus. R3's fall risk evaluation dated 8/7/23, noted R3 was a moderate risk for falls. R3's care plan initiated on 8/7/23, noted R3 was at risk for falls due to chronic atrial fibrillation, history of falls, loss of vision. Interventions noted R3 should have his call light within reach and answered timely and to remind him to ask for assistance with transfer and ambulation. A progress note dated 8/14/23, noted R3 had a fall at 11:10 p.m. had no injuries, information to be passed on in report, notification of family, management, and the provider. The electronic medical record (EMR) lacked details of where R3 fell, what he was doing prior to the fall, if the physical environment was a factor, whether fall interventions were in place, if the care plan was followed or any updates to his care plan to prevent further falls. R5's 5-day MDS dated 7/27/23, noted R5 had severely impaired cognition, required limited	F 689	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. F-Tag 689 It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. R3 No longer at facility R5 No longer at facility R6 No longer at facility R7 Current Resident " Review of fall history has been completed and care plan updated to reflect the current interventions. " The care plan has been reviewed to ensure appropriate and all interventions are listed. " Fall Risk Assessment has been completed with updating the care plan as necessary based on fall risk. " A care conference has been scheduled for 9-14-23 with the resident, resident representative, hospice and NBCC. " Non-skid strips placed at bedside. Who else in the facility has the potential to be affected by the deficient practice? " Any resident who experiences a fall has the potential to be affected by the deficient practice. Each resident was reviewed for fall risk and care plans	

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F 689	Continued From page 2 assist of one for most ADL's, and had diagnoses that included epilepsy, hypertensive chronic kidney disease and type II diabetes mellitus. R5's fall risk evaluation dated 7/23/23, noted R5 was a high risk for falls. R5's care plan initiated on 7/22/23, noted R5 was at risk for falls related to neurocognitive disorder, interventions included bed at appropriate height, frequent checks, call light within reach and answer promptly, and remind R5 to ask for assistance with transfers and ambulation. A progress note dated 7/25/23, at 8:35 p.m. noted a nursing assistant (NA) found R5 sitting on the call light on the floor without injuries, R5 stated he wanted to walk to the bathroom. R5's incontinent brief was dry, he refused to be assisted to the toilet, staff educated him on risk of self-transferring, and management, provider and family updated. A progress note dated 8/1/23, noted a NA found R5 on the floor, no injuries, vital signs stable, and he refused assistance to stand. R5 was fixated on leaving to find his wife, report given to oncoming nurse, reassurance and redirection was provided. A progress note dated 8/2/23, noted R5's vital signs were stable, he denied pain and he stated he was looking for his wife when he fell the night before.The EMR lacked the details on whether fall interventions were in place for R5, if the physical environment was a factor, if the care plan was followed or any updates to his care plan to prevent further falls.	F 689	updated to reflect current interventions. " Residents who have not had a recent fall risk will have a new evaluation completed and care plan updated accordingly. What systematic changes were made to prevent further deficiency. " Review of the policy titled Falls and Fall Risk and updated as necessary. " Development of a Fall Scene Investigation Form within PCC for Licensed Staff and IDT to complete and review. " Review and revision of the NBCC Fall Facility Protocol Checklist. " Licensed staff will be re-educated on the completion of Root Casuse Analysis-Fall Investigation and Intervention Form Checklist after a fall to try and determine the root cause of the fall and implement appropriate interventions. " Licensed staff will be educated on the completion of a Fall Risk Evaluation after every fall to compare to the prior to note any changes in scoring. How will be monitored? " Audits of all falls to verify completion of a Root Cause Analysis-Fall Investigation, Fall Risk Evaluation completed, and care plan updated for the next 3 months. " Results of audits will be presented to QA/QAPI monthly with a determination for further monitoring/auditing. QA/QAPI committee will determine further monitoring plan. DON and/or designee responsible for	

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F 689	Continued From page 3 R6's 5-day MDS dated 7/31/23, noted R6 had intact cognition, required limited assistance of one for most ADL's, and had diagnoses the included cellulitis of buttock, cutaneous abscess of buttock, iron deficiency anemia and atrial fibrillation. R6's fall risk evaluation dated 7/25/23, noted he was a low risk for falls. R6's care plan initiated on 7/25/23, lacked fall risk information including interventions but noted weakness and required assistance with transfers and ambulation. A progress note dated 7/28/23, noted a NA called out for a nurse due to R6 found on the floor in his room, he was lying on his side and there was blood dripping from his left eyebrow. R6 denied pain, declined assessment at the hospital, and was then assisted to the bathroom as he requested. R6 stated he needed to use the bathroom in a hurry and tried to stand on his own when he lost his balance and fell. The note identified family, management and provider were notified. A progress note dated 7/29/23, noted to help maintain continence and avoid infection or falls, staff should respond to R6's call light promptly and assist with transfers to the bathroom. A progress note dated 7/30/23, noted a NA called the nurse to R6's room, as the NA was lowering the bed to transfer R6 he became dizzy and fell to the floor. R6 did not have any injuries, vital signs were checked, provider and family notified. The EMR lacked any information on whether R6's physical environment was a factor, if his call light	F 689	compliance. Date of Compliance: October 16th, 2023	

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F 689	Continued From page 4 was on or in reach, if his falls risk assessment needed to be reevaluated or updated information regarding falls was added to his care plan. R7's significant change MDS dated 6/9/23, noted R7's cognition was not assessed, she required extensive assistance of one for most ADL's and had diagnoses that included urinary tract infection, sepsis, atrial fibrillation, and acute kidney failure. R7's fall risk evaluation dated 5/16/23, noted R7 was at high risk for falls. R7's care plan initiated on 5/16/23, noted she was at risk for falls related to atrial fibrillation, osteoarthritis and the interventions in place were to have her call light within reach and answer promptly and to remind her to ask for assistance with transfers and ambulation. A progress note dated 5/25/23, noted R7 was found lying on the floor, near the bed, calling for help, no injury, reported pain to her right knee, provider and family were notified. A progress note later that day noted R7 denied pain, vital signs were stable and R7 was reminded to use her call light to prevent falls. A progress note dated 6/18/23, noted R7 was found siting on the floor by her bed, R7 stated she was going to get her walker so that she could go home when she fell, denied hitting her head and denied pain. The note stated R7 was confused and had been yelling throughout the shift that she wanted to go home and contained suggestions such as a fall mat on the floor, a bigger bed and leaving her bedroom door open so that R7 could be seen from the hall.	F 689		

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F 689	Continued From page 5 A progress note dated 6/25/23, noted R7 lost her balance and was lowered to the floor by staff when being transferred, no injuries were noted. A progress note dated 7/29/23, noted R7 was found lying on the floor next to her bed, her call light was attached to the blanket on the floor next to her. R7 complained of pain to her right arm when she was lifted from the floor, was given pain medications, no injuries noted, provider and family notified of fall. A progress note dated 7/30/23, noted R7 was anxious all shift and fell out of bed, R7 stated she needed to go home. A progress note dated 8/10/23, noted R7 was found sitting on the floor, denied injuries, and stated she was getting in bed and lost her balance, provider, management, and family notified. A facility incident report printed on 8/22/23, noted R7 had seven falls in the last three months. R7's falls were noted on the following dates: 5/24/23, 6/18/23, two falls on 7/30/23, 8/2/23, and 8/10/23. R7's EMR lacked information regarding a fall on 8/2/23, if her care plan was followed at the times of her falls, whether her physical environment was a factor to her falls, or updates to her care to prevent further falls. During an interview on 8/23/23, at 3:04 p.m. the director of nursing (DON) stated she expected to see updated fall interventions in resident care plans.	F 689		

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F 689	Continued From page 6 A facility policy titled Falls and Fall Risk, Managing last revised in March 2018, noted staff will implement a resident-centered fall prevention plan to reduce the risk factors of falls for each resident at risk or with a history of falls and if falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.	F 689		
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an agency nurse was oriented to the facility medication administration system for 5 of 5 resident (R1, R2, R3, R4, and R5) reviewed for medications when a nurse did not perform blood glucose testing or administer insulin. Findings include: R1's 5-day Minimum Data Set (MDS) dated 8/6/23, noted she was cognitively intact, required limited assistance of one person for most activities of daily living (ADL's). Her diagnoses	F 940	F-Tag 940 It is the policy of this facility to maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. R1 No longer in the facility R2 No longer in the facility R3 No longer in the facility R4 No longer in the facility R5 No longer in the facility	10/16/23

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F 940	Continued From page 7 included fracture of the left humerus, obesity, lymphedema, and type II diabetes mellitus with chronic kidney disease. R1's physician order dated 7/31/23, to check blood sugar levels before meals and at bedtime. R1's electronic medical record (EMR) contained a diabetic (DIAB) administration report for August of 2023, noted blank spaces for scheduled blood sugar checks on 8/10/23, for 7:00 a.m. and 11:00 a.m. R1's blood glucose logs for August of 2023, noted her blood glucose was checked at 4:43 p.m. and was 152 and checked again at 8:25 p.m. and was 169. All other August dates noted blood sugars checked four times a day. R2's 5-day MDS dated 7/28/23, noted R2 had intact cognition, required the extensive assistance of two staff for bed mobility, toileting and transfers, extensive assistance of one with dressing and walking in her room. R2's diagnoses included encephalopathy (brain dysfunction caused by toxic exposure), sepsis, bipolar disorder, and type II diabetes mellitus. R2's EMR contained a DIAB administration report for August of 2023, noted blank spaces for scheduled blood sugar checks on 8/10/23 for morning and Midday on 8/10/23 for blood glucose checks as well as ordered Insulin Glargine 40 units in the morning, HumaLOG KwikPen 10 units morning and Midday, and Insulin Aspart injection sliding scale. R2's blood glucose logs for August, noted her blood glucose levels were not checked on	F 940	Who else in the facility has the potential to be affected by the deficient practice? " Diabetics within the facility have the potential to be affected. What measures have been put in place to prevent the deficient practice from happening again. " The policy titled Administering Medications has been reviewed and revised as necessary. " A review of the orientation checklist for facility employees has been reviewed to include medication administration system along with the DIAB tab in PCC. " The Orientation Checklist for Visiting Agency Staff has been updated to include the DIAB tab in the eMAR (to note diabetics and their orders). " Facility licensed staff will be educated on the need to assist any new agency personnel with receiving the orientation for the medication administration system used by the facility and have signed off on the orientation form. " The development of a process for communication to the appropriate staff of a new agency nurse coming to the facility and will require orientation. " Stickers have been placed on all the computers used for passing medication that state In PCC check DIAB tab. This is an additional reminder to licensed staff to review the diabetics and their orders. How will be monitored? " Audits will be completed weekly, based on new agency nurses coming to	

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F 940	Continued From page 8 8/10/23. R3's 5-day MDS dated 8/13/23, noted R3 had intact cognition, required extensive assistance of one for most ADL's and had diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, COVID-19, and type II diabetes mellitus. R3's physician order dated 8/7/23, noted Accuchecks (blood glucose testing) before meals and at bedtime. R3's August medication administration record (MAR) noted blank spaces on 8/10/23, for Insulin NPH 35 units for the morning, Insulin Aspart sliding scale for 7:00 a.m. and 11:00 a.m., and for Accuchecks before meals at 7:00 a.m. and 11:00 a.m. R4's MDS dated 7/31/23, noted R4 had intact cognition, required limited assistance of one person for most ADL's and had diagnoses that included aftercare following a surgical procedure on the circulatory system, chronic osteomyelitis and type II diabetes mellitus. R4's physician order dated 7/25/23, noted Accuchecks before meals and at bedtime. R4's EMR contained a DIAB administration report for August of 2023, noted blank spaces for scheduled blood sugar checks on 8/10/23, for 7:00 a.m. and 11:00 a.m. R5's 5-day MDS dated 7/27/23, noted R5 had severely impaired cognition, required limited assist of one for most ADL's, and had diagnoses that included epilepsy, hypertensive chronic	F 940	NBCC for the next 3 months. " Results of audits will be presented to QA/QAPI monthly with a determination for further monitoring/auditing. QA/QAPI committee will determine further monitoring plan. DON and/or designee responsible for compliance. Date of Compliance: October 16th, 2023	

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 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 940	Continued From page 9 kidney disease and type II diabetes mellitus. R5's EMR contained a DIAB administration report for August of 2023, noted blank spaces on 8/10/23 for NovoLOG insulin sliding scale, Accuchecks for 7:00 a.m. and 11:00 a.m. During an interview on 8/22/23, at 2:14 p.m. the director of nursing (DON) stated she received a message from the nurse manager that the agency nurse that worked the day shift on 8/10/23, did not check blood glucose levels or give insulin on the north unit of the facility. The DON stated she had another message from the nurse manager later that evening that a family member was upset because R3's blood glucose level was in the 500's. The DON stated it is assumed that agency staff know how to use the EMR system. During an interview on 8/23/23, at 11:50 a.m. the administrator stated the nurse was a last-minute addition to the schedule on 8/10/23, the overnight nurse gave verbal report and instructed the nurse to reach out to other nursing staff if she had questions. A facility policy titled Administering Medications last revised in April 2019, noted new personnel authorized to administer medications are not permitted to prepare or administer medication until they have been oriented to the medication administration system used by the facility.	F 940		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 1, 2023

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

Re: Event ID: KE9I11

Dear Administrator:

The above facility survey was completed on August 23, 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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@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 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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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 8/22/23 & 8/23/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during	2 000		

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 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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2 000	Continued From page 1 the survey. H54214669C (MN00095977), H54214670C (MN00095978), H54214671C (MN00095971), & H54214773C (MN00095626). 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		