Electronically delivered

April 23, 2019

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

Re: Reinspection Results - Project Number H5164138

Dear Administrator:

On April 10, 2019 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 8, 2019, with orders received by you on March 25, 2019. At this time these correction orders were found corrected.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted

March 26, 2019

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

This letter will replace the letter dated March 25, 2019. We have corrected the 6 month date in the letter.

RE: Project Numbers H5164130, H5164132, H5164133, H5164135, H5164136 and H5164139C

Dear Administrator:

On January 25, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2019.

On March 4, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on December 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 19, 2019. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our an abbreviated standard survey, completed on December 28, 2018. The deficiency not corrected is as follows:

F689 Free of Accident Hazards/Supervision/Deviced S/S --K

In addition, at the time of this revisit, we identified the following deficiency:

F609 Reporting of Alleged Violations S/S--D

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 1, 2019, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 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), to remain in effect.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify you June 18, 2019, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 18, 2019 (42 CFR 488.417 (b)).

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.

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 $10,483; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 18, 2019. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, New Brighton A Villa Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 18, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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:

Susie Haben, Unit Supervisor
Metro A Survey Team
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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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 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 June 28, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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 Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2019

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

RE: Project Numbers H5164130, H5164132, H5164133, H5164135, H5164136, H5164139C, H5164138C

Dear Administrator:

On January 25, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2019.

We also notified you in our letter of January 25, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2019.

This was based on the deficiencies cited by this Department for an abbreviate standard survey completed on December 28, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 4, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviate standard survey, completed on December 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 19, 2019. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to the abbreviate standard survey, completed on December 28, 2018. As a result of the revisit findings, we notified you of the following:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2019, would remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil Money Penalty. (42 CFR 488.430 through 488.444)

On March 8, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

As a result of the survey findings this Department recommended the enforcement remedies:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2019, would remain in effect.

- Civil Money Penalty. (42 CFR 488.430 through 488.444)

As a result of the survey findings from March 8, 2019, this Department recommended to the CMS Region V Office the following actions:

- Civil Money Penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of January 25, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2019.

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.

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:

Susie Haben, Unit Supervisor
Metro A Survey Team

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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

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 June 28, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON A VILLA CENTER	**825 FIRST 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 3/8/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. New Brighton A Villa Care was found NOT to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5164138C. Deficiency issued at F Tags # 584, 880 and 925 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		4/2/19

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

Electronically Signed | 03/27/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON A VILLA CENTER	**825 FIRST 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 584	Continued From page 1 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a clean environment for 4 of 4 residents (R1, R2, R3, R4) who received nutrition through tube feeding and had dirty feeding tube stands. Findings include:	F 584	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing New Brighton a Villa Center's good faith,	

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	245164	A. BUILDING _____ B. WING _____	C 03/08/2019

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F 584	Continued From page 2 R1's room was observed on 3/8/19, at 9:46 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. R2's room was observed on 3/8/19, at 9:47 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. R3's room was observed on 3/8/19, at 9:49 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. R4's room was observed on 3/8/19, at 9:51 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. An anonymous family member submitted photos of dried tube feeding on the base of the stands and was upset with the lack of cleanliness in the facility. On 3/8/19, at 9:51 a.m. the administrator verified the tube feeding stands were dirty and said they were cleaned on an as needed basis and there was not a set schedule to clean the stands. The administrator stated when a resident who had tube feeding was discharged the stand was cleaned and prepared for the next resident that may need it. The administrator stated the yellow/brown substance was dried tube feeding and may have dripped down the pole and onto the stand when staff changed the tube feeding bag.	F 584	the facility offers the following Plan of Correction and have achieved substantial compliance in each of the areas addressed on April 2, 2019. R#1, #2, #3, #4 are being provided clean tube feeding poles and base of stand. All residents receiving tube feeding have a cleaning schedule implemented to ensure the tube feeding poles and base of stand remain clean. Housekeeping and Nursing staff have been re-educated regarding ensuring tube feeding poles and base of stand are clean. LNHA/Designee will audit 3 rooms weekly x 3weeks then 3 rooms weekly x 3 months to ensure clean tube feeding poles and base of stand. Audited results will be reviewed at facility's QAPI.	

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F 584	Continued From page 3 The policies entitled 5 Step Daily Patient Room Cleaning and Complete Room Cleaning (dated 1/1/2000) were reviewed and did not identify when to clean a tube feeding stand.	F 584		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		4/2/19

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F 880	Continued From page 4 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper handwashing and glove usage was implemented for 3 of 3 residents (R1, R3, R2) reviewed for trach cares and tube feeding.	F 880	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it	

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F 880	Continued From page 5 Findings include: Hand hygiene and glove use: On 3/8/19, at 7:38 a.m. R1 was observed seated in the wheelchair next to his bed. R1 was observed with a tracheostomy and the long tube was connected to a heater with water that provided humidity. Also R1 was observed with tube feeding infusing. When approached R1 was not able to respond. -At 8:05 a.m. registered nurse (RN)-A stated she was going to administer R1's medications. RN-A applied a gown and gloves then approached R1 and stated she was going to give him his medications. RN-A then went over to the sink and added 30 milliliter (ml) of water into the cup with all medications. RN-A stated R1 had an order to cocktail (mix all medications together) all the medications. Before RN-A administered the medications, she checked the placement of the Gastrostomy feeding tube (G-tube) then flushed the tube with 30 ml of water then gave the medications. After the medications, RN-A connected the feeding tube at 8:21 a.m. RN-A then pulled the canister connected to the suctioning machine which was three quarter (3/4) filled with secretions and dumped the thick yellow secretions in the sink, rinsed the canister both inside and outside then set it back on the holder of the suction machine. With the same gloves, RN-A proceeded to adjust the tubing connected to the trach and set the nebulizer machine, ran it, then turned it off still wearing the same gloves. -At 8:25 a.m. RN-A touched multiple things in the room including the trach and re-connected R1 to the humidifier tube as R1 sounded congested at this time. At 8:27 a.m. RN-A removed the gown, gloves and washed her hands with hand sanitizer	F 880	is required by law. However, evidencing New Brighton a Villa Center's good faith, the facility offers the following Plan of Correction and have achieved substantial compliance in each of the areas addressed on April 2, 2019. R#1, #2, and #3 are receiving care using proper hand hygiene and glove usage during trach care and tube feeding. All residents are receiving care utilizing proper hand hygiene and glove usage. Licensed Nurses, Nursing Assistants, and Respiratory Therapist have been re-educated regarding providing care using proper hand hygiene and glove usage. DON/Designee will perform patient care audits related to; G-tube, trach care, peri-care, and hand hygiene in relation to infection prevention technique on the Residents weekly x 3 weeks then monthly x 3 months. Audit results will be reviewed at facility's QAPI.	

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F 880	Continued From page 6 before leaving the room. On 3/8/19, at 9:12 a.m. RN-A acknowledged after she had poured the secretions in the sink and rinsed the canister inside and outside she had not changed her gloves and completed hand hygiene. RN-A stated "we are supposed to change gloves and wash hands." R1's care plan dated 1/19/19, identified R1 had the potential for infection related to history of cystic Pseudomonas of sputum, trach status and G-tube status. The care plan directed staff to maintain standard precautions when providing resident care. Gloving: On 3/8/19, at 7:54 a.m. the respiratory therapist (RT) was observed to suction R3 using one hand sterile technique. At 7:55 a.m. the RT removed the gloves, and cleansed his hands with hand sanitizer then re-applied another pair of gloves. -At 7:56 a.m. R3 asked the RT to remove the inner cannula of the trach to check if it was clean. The RT twisted and pulled it out slowly and showed it to R3. The RT then re-inserted it back in, removed the gloves again and cleansed hands with hand sanitizer. -At 7:58 a.m. R3 dropped her reading glasses on the floor and this surveyor picked them off the floor for her. Surveyor observed a Kleenex lying on the floor right next to the bedside table. -At 7:59 a.m. the RT was observed to pick the Kleenex from the floor with his right hand and tossed it to the garbage. Then the RT, still wearing the same gloves, approached R3 reached for the stethoscope from around his neck and listened to R3's lungs. The RT, with the same gloves, adjusted the blue trach humidifier	F 880		

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F 880	Continued From page 7	F 880		

tubing and the tube feeding pole, and then removed the gloves.
-At 8:03 a.m. the RT acknowledged R3 was at risk for infection and he should have changed the gloves after picking something off the floor before he continued to assess R3.

Hand hygiene and gloving:
On 3/8/19, at 11:08 a.m. nursing assistant (NA)-A and NA-B both put on gloves and transferred R2 into bed and used a full body mechanical lift.
-At 11:12 p.m. RN-B asked the NA's to make sure they checked R2's pad.
-At 11:16 a.m. NA's turned R2 side to side and then NA-A stated R2's pad was soiled. RN-B suctioned R2 at 11:20 a.m. The NA's unfastened the pad then NA-A provided R2 with pericare in the front. NA-A then stated to R2 they were going to turn her over to the left. NA-B used a small wash towel to wipe stool off R2's bottom then put the wash towel in the plastic bag at the end of bed. With the same glove on the right hand, NA-A went over to the drawer opened it and took out a tube of skin barrier cream and brought the tube to R2's bedside. NA-A then squeezed some of the cream and applied it to R2's bottom with the same gloves. NA-A reached into R2's closet got a clean pad and a dress, then approached R2's bed. Still with the same gloves the NA's were observed to apply both the pad and dress.
-At 11:26 a.m. with the same gloves NA's boosted R2 in bed and adjusted R2's pillows then NA-A removed her gloves and applied another pair without washing her hands.
-At 11:29 a.m. NA-A removed the right hand glove and pulled the mechanical lift out of the room into the hallway. Still with the left gloved hand, NA-A walked down the hallway into the soiled utility room tossed the linen and garbage then used

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F 880	Continued From page 8 hand sanitizer on the way out. -At 11:32 a.m. when approached and asked about hand washing and glove use NA-A stated she was supposed to change gloves after she provided pericares and wash her hands. NA-A further stated she was not supposed to walk down the hallway with gloves used to provide care. -At 11:35 a.m. RN-B stated all staff weres supposed to wash hands in between and after cares. R2's care plan dated 1/3/19, identified R2 had the potential for infection related to the G-tube status and trach status. The care plan directed staff to maintain standard precautions when providing resident care. On 12:25 p.m. the director of nursing (DON) stated staff were supposed to change gloves and wash hands after pericare, when going from dirty to clean and staff are not supposed to walk down the hallway with gloves used to provide cares in the room. The DON further stated staff were supposed to wash their hands before and after entering a resident room. The facility Hand Hygiene Guideline policy dated 11/28/17, indicated hand hygiene continued to be the primary means to preventing the transmission of infection. The policy directed staff to complete hand hygiene when hands were visibly soiled with blood, and body fluids. In addition, the policy indicated according to the Center for Disease Control (CDC) strict adherence to glove use was the most effective means of preventing hand contamination.	F 880		
F 925	Maintains Effective Pest Control Program	F 925		4/2/19

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F 925 SS=E	Continued From page 9 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a pest free environment related to ants in resident rooms (R5, R6, R7, R8 and R9) in the north hallway. This has the potential to affect all residents who reside in the north hallway. Findings include: During observations on 3/8/19, the following was noted: -At 7:15 a.m. ants completely covered and crawled over a one inch piece of food on the floor near the doorway in R5's room. R5 sat in the doorway and staff walked in and out of the room and did not see the piece of food on the floor with ants on it. The piece of food was still on the floor at 8:25 a.m. -At 7:55 a.m. ants were observed in R8 and R9 shared room on the floor underneath the sink. During a second observation at 8:41 a.m. approximately 30 ants were observed in the crack of the floor below the closet door next to the sink and ants were also seen underneath the heat register. -At 8:26 a.m. ants were observed on the base of the toilet around the nut and bolt and on the floor in the shared bathroom for R6 and R7. Ants were also observed on the floor near the door jam	F 925	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing New Brighton a Villa Center's good faith, the facility offers the following Plan of Correction and have achieved substantial compliance in each of the areas addressed on April 2, 2019. R#5, #6, #7, #8, and #9 have had pest control services to extinguish ants in those rooms. Resident rooms have been checked for ants with appropriate removal as identified. Pest control services are rounding the building regularly to identify and treat any pest control issues as needed. Staff have been re-educated about pest control services and how to report pest control issues. LNHA/Designee will audit 3 rooms x 3 weeks then 3 rooms x 3 weeks to ensure pest control services are effective. Audit results will be reviewed at facility's QAPI.	

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F 925	Continued From page 10 between the bathroom and the residents' room. The housekeeping director verified the observation of the ants on 3/8/19, at 8:53 a.m. The piece of food remained on the floor in the doorway to R5's room. The housekeeping director picked up the food item with a paper towel, determined it was a cheeto and threw it away. The housekeeping director wiped the floor with the paper towel to remove the ants. When the housekeeping director saw the ants on the floor in the room for R8 and R9, he lifted up a loose tile under the closet and several ants were observed. The housekeeping director wiped up the ants with a paper towel and put the loose tile back down. The housekeeping director indicated if housekeeping staff saw ants in a room they completed a report in the TELS (electronic maintenance reporting program) system to create a work order. The housekeeping director said all staff can put in a work order in the TELS system. The administrator and maintenance director verified the ants in the rooms for R5, R6, R7 and R8 at 9:39 a.m. The adminstrator indicated a pest control company came to the facility monthly. If a specific room was identified with a pest problem, the company went to that room to spray. The administrator indicated he completed a formal walk through the facility monthly to look for signs of pests. The pest control log was reviewed and the last onsite visit was 2/21/19, the invoice noted ants were outside of the kitchen and in a room two doors down from R8 and R9.	F 925		

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F 925	Continued From page 11 Although the pest control company came to the facility monthly and had sprayed a room close to R8 and R9, the facility did not identify other residents' rooms that could be affected by ants. The Pest Control policy (revised August 2008) idenfied the facility provided an ongoing pest control program to ensure the building was kept free of insects and rodents.	F 925		

Electronically delivered
March 25, 2019

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

Re: State Nursing Home Licensing Orders - Project Number H5164138

Dear Administrator:

The above facility was surveyed on March 8, 2019 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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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:

Susie Haben, Unit Supervisor
Metro A Survey Team
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: susie.haben@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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(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) COMPLETE DATE
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 3/8/19, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. The following complaint was found to be substantiated: H#5164138 Correction order(s) issued at MN	2 000		

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2 000	Continued From page 1 Rule 4658.0800 subp. 1, MN Rule 4658.1415 subp. 2, and MN Rule 4658.1415 subp. 11. 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. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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21375	Continued From page 2	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper handwashing and glove usage was implemented for 3 of 3 residents (R1, R3, R2) reviewed for trach cares and tube feeding. Findings include: Hand hygiene and glove use: On 3/8/19, at 7:38 a.m. R1 was observed seated in the wheelchair next to his bed. R1 was observed with a tracheostomy and the long tube was connected to a heater with water that provided humidity. Also R1 was observed with tube feeding infusing. When approached R1 was not able to respond. -At 8:05 a.m. registered nurse (RN)-A stated she was going to administer R1's medications. RN-A applied a gown and gloves then approached R1 and stated she was going to give him his medications. RN-A then went over to the sink and added 30 milliliter (ml) of water into the cup with all medications. RN-A stated R1 had an order to cocktail (mix all medications together) all the medications. Before RN-A administered the medications, she checked the placement of the Gastrostomy feeding tube (G-tube) then flushed the tube with 30 ml of water then gave the medications. After the medications, RN-A	21375	Corrected.	4/2/19

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connected the feeding tube at 8:21 a.m. RN-A then pulled the canister connected to the suctioning machine which was three quarter (3/4) filled with secretions and dumped the thick yellow secretions in the sink, rinsed the canister both inside and outside then set it back on the holder of the suction machine. With the same gloves, RN-A proceeded to adjust the tubing connected to the trach and set the nebulizer machine, ran it, then turned it off still wearing the same gloves.
-At 8:25 a.m. RN-A touched multiple things in the room including the trach and re-connected R1 to the humidifier tube as R1 sounded congested at this time. At 8:27 a.m. RN-A removed the gown, gloves and washed her hands with hand sanitizer before leaving the room.

On 3/8/19, at 9:12 a.m. RN-A acknowledged after she had poured the secretions in the sink and rinsed the canister inside and outside she had not changed her gloves and completed hand hygiene. RN-A stated "we are supposed to change gloves and wash hands."

R1's care plan dated 1/19/19, identified R1 had the potential for infection related to history of cystic Pseudomonas of sputum, trach status and G-tube status. The care plan directed staff to maintain standard precautions when providing resident care.

Gloving:
On 3/8/19, at 7:54 a.m. the respiratory therapist (RT) was observed to suction R3 using one hand sterile technique. At 7:55 a.m. the RT removed the gloves, and cleansed his hands with hand sanitizer then re-applied another pair of gloves.
-At 7:56 a.m. R3 asked the RT to remove the inner cannula of the trach to check if it was clean. The RT twisted and pulled it out slowly and

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21375	Continued From page 4 showed it to R3. The RT then re-inserted it back in, removed the gloves again and cleansed hands with hand sanitizer. -At 7:58 a.m. R3 dropped her reading glasses on the floor and this surveyor picked them off the floor for her. Surveyor observed a Kleenex lying on the floor right next to the bedside table. -At 7:59 a.m. the RT was observed to pick the Kleenex from the floor with his right hand and tossed it to the garbage. Then the RT, still wearing the same gloves, approached R3 reached for the stethoscope from around his neck and listened to R3's lungs. The RT, with the same gloves, adjusted the blue trach humidifier tubing and the tube feeding pole, and then removed the gloves. -At 8:03 a.m. the RT acknowledged R3 was at risk for infection and he should have changed the gloves after picking something off the floor before he continued to assess R3. Hand hygiene and gloving: On 3/8/19, at 11:08 a.m. nursing assistant (NA)-A and NA-B both put on gloves and transferred R2 into bed and used a full body mechanical lift. -At 11:12 p.m. RN-B asked the NA's to make sure they checked R2's pad. -At 11:16 a.m. NA's turned R2 side to side and then NA-A stated R2's pad was soiled. RN-B suctioned R2 at 11:20 a.m. The NA's unfastened the pad then NA-A provided R2 with pericare in the front. NA-A then stated to R2 they were going to turn her over to the left. NA-B used a small wash towel to wipe stool off R2's bottom then put the wash towel in the plastic bag at the end of bed. With the same glove on the right hand, NA-A went over to the drawer opened it and took out a tube of skin barrier cream and brought the tube to R2's bedside. NA-A then squeezed some of the cream and applied it to R2's bottom with the	21375		

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21375	Continued From page 5 same gloves. NA-A reached into R2's closet got a clean pad and a dress, then approached R2's bed. Still with the same gloves the NA's were observed to apply both the pad and dress. -At 11:26 a.m. with the same gloves NA's boosted R2 in bed and adjusted R2's pillows then NA-A removed her gloves and applied another pair without washing her hands. -At 11:29 a.m. NA-A removed the right hand glove and pulled the mechanical lift out of the room into the hallway. Still with the left gloved hand, NA-A walked down the hallway into the soiled utility room tossed the linen and garbage then used hand sanitizer on the way out. -At 11:32 a.m. when approached and asked about hand washing and glove use NA-A stated she was supposed to change gloves after she provided pericares and wash her hands. NA-A further stated she was not supposed to walk down the hallway with gloves used to provide care. -At 11:35 a.m. RN-B stated all staff weres supposed to wash hands in between and after cares. R2's care plan dated 1/3/19, identified R2 had the potential for infection related to the G-tube status and trach status. The care plan directed staff to maintain standard precautions when providing resident care. On 12:25 p.m. the director of nursing (DON) stated staff were supposed to change gloves and wash hands after pericare, when going from dirty to clean and staff are not supposed to walk down the hallway with gloves used to provide cares in the room. The DON further stated staff were supposed to wash their hands before and after entering a resident room.	21375		

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21375	Continued From page 6 The facility Hand Hygiene Guideline policy dated 11/28/17, indicated hand hygiene continued to be the primary means to preventing the transmission of infection. The policy directed staff to complete hand hygiene when hands were visibly soiled with blood, and body fluids. In addition, the policy indicated according to the Center for Disease Control (CDC) strict adherence to glove use was the most effective means of preventing hand contamination. Suggested Method of Correction: The director of nursing (DON) or designee could review and/or revise policies and procedures and educate the appropriate staff on the policies/procedures for handwashing and glove use during personal cares. The DON or designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Twenty-one (21) days.	21375		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a clean environment for 4 of 4 residents (R1, R2, R3, R4)	21685	Corrected.	4/2/19

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21685	Continued From page 7 who received nutrition through tube feeding and had dirty feeding tube stands. Findings include: R1's room was observed on 3/8/19, at 9:46 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. R2's room was observed on 3/8/19, at 9:47 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. R3's room was observed on 3/8/19, at 9:49 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. R4's room was observed on 3/8/19, at 9:51 a.m. and the three pronged feeding tube stand had dried yellow/brown tube feeding on the base of the stand. An anonymous family member submitted photos of dried tube feeding on the base of the stands and was upset with the lack of cleanliness in the facility. On 3/8/19, at 9:51 a.m. the administrator verified the tube feeding stands were dirty and said they were cleaned on an as needed basis and there was not a set schedule to clean the stands. The administrator stated when a resident who had tube feeding was discharged the stand was cleaned and prepared for the next resident that may need it. The administrator stated the yellow/brown substance was dried tube feeding and may have dripped down the pole and onto	21685		

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21685	Continued From page 8 the stand when staff changed the tube feeding bag. The policies entitled 5 Step Daily Patient Room Cleaning and Complete Room Cleaning (dated 1/1/2000) were reviewed and did not identify when to clean a tube feeding stand. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel.	21730		4/2/19

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21730	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a pest free environment related to ants in resident rooms (R5, R6, R7, R8 and R9) in the north hallway. This has the potential to affect all residents who reside in the north hallway. Findings include: During observations on 3/8/19, the following was noted: -At 7:15 a.m. ants completely covered and crawled over a one inch piece of food on the floor near the doorway in R5's room. R5 sat in the doorway and staff walked in and out of the room and did not see the piece of food on the floor with ants on it. The piece of food was still on the floor at 8:25 a.m. -At 7:55 a.m. ants were observed in R8 and R9 shared room on the floor underneath the sink. During a second observation at 8:41 a.m. approximately 30 ants were observed in the crack of the floor below the closet door next to the sink and ants were also seen underneath the heat register. -At 8:26 a.m. ants were observed on the base of the toilet around the nut and bolt and on the floor in the shared bathroom for R6 and R7. Ants were also observed on the floor near the door jam between the bathroom and the residents' room. The housekeeping director verified the observation of the ants on 3/8/19, at 8:53 a.m. The piece of food remained on the floor in the doorway to R5's room. The housekeeping	21730	Corrected.	

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21730	Continued From page 10	21730		

director picked up the food item with a paper towel, determined it was a cheeto and threw it away. The housekeeping director wiped the floor with the paper towel to remove the ants. When the housekeeping director saw the ants on the floor in the room for R8 and R9, he lifted up a loose tile under the closet and several ants were observed. The housekeeping director wiped up the ants with a paper towel and put the loose tile back down.

The housekeeping director indicated if housekeeping staff saw ants in a room they completed a report in the TELS (electronic maintenance reporting program) system to create a work order. The housekeeping director said all staff can put in a work order in the TELS system.

The administrator and maintenance director verified the ants in the rooms for R5, R6, R7 and R8 at 9:39 a.m. The adminstrator indicated a pest control company came to the facility monthly. If a specific room was identified with a pest problem, the company went to that room to spray. The administrator indicated he completed a formal walk through the facility monthly to look for signs of pests.

The pest control log was reviewed and the last onsite visit was 2/21/19, the invoice noted ants were outside of the kitchen and in a room two doors down from R8 and R9.

Although the pest control company came to the facility monthly and had sprayed a room close to R8 and R9, the facility did not identify other residents' rooms that could be affected by ants.

The Pest Control policy (revised August 2008) idenfied the facility provided an ongoing pest

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21730	Continued From page 11 control program to ensure the building was kept free of insects and rodents. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative pest control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		