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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Brighton Care Center	805 Sixth Avenue Northwest New Brighton, MN 55112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to develop and document a facility assessment that includes plans for the recruitment and retention of staff. This had the potential to affect all 43 residents.The provided facility assessment dated [DATE], included sections on how to obtain staffing records, a general staffing plan, staff assignments, staff training and competencies, however did not include a section on staff recruitment and retention. During interview on 11/18/25 at 4:20 p.m., the administrator confirmed the facility assessment did not include information on the facilities plan to maximize recruitment and retention of direct care staff. Facility policy for a facility assessment requested and not provided.

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.

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

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information based on payroll and other verifiable and auditable data, for 1 of 1 quarters reviewed (quarter 3), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This had the potential to affect all 43 residents residing at the facility.Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D for April 1st to June 30th 2025, identified Excessively Low Weekend Staffing, No registered nurse (RN) Hours, and Failed to have licensed nursing coverage 24 hours a day. Report also triggered for One Star Staffing Rating. Dates identified for no RN coverage include 5/4/25, 5/31/25, 6/15/25, 6/22/2025, 6/28/25, and 6/29/25. Dates identified for not having 24 hour licensed nursing coverage included 5/3/25, 5/4/25, 5/18/25, 5/31/25, 6/1/25, 6/15/25, 6/28/25, 6/29/25. Review of schedules for April 1st to June 30th 2025, included RN coverage for all dates, 24 hour licensed nursing coverage for all dates, and staffing equal to weekdays for weekend coverage. During interview on 11/18/25 at 4:01 p.m., human resources (HR)-A stated she submitted the PBJ data quarterly. She submitted the hours worked for exempt and non-exempt staff including all agency and contracted staff. HR-A stated she did not submit the Quarter 3 data because she started after that date, However, she had submitted successful since. During interview on 11/18/25 at 4:01 p.m., administrator stated a sister agency submitted the PBJ data for Quarter 3, so she was unsure exactly where the error took place. The administrator stated it was her guess that agency hours were not calculated and submitted. The administrator was aware of the discrepancy and has audited the hours to ensure all days had RN coverage, 24 hour licensed staffing and adequate weekend staffing. Faculty policy for PBJ reporting requested and not provided.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide ongoing communication to residents about their rights for 2 of 2 residents (R12, R28) who attended the resident council meetings.R12's admission minimum data set (MDS) dated [DATE], included R12 was cognitively intact and could understand others and make herself understood.R28's quarterly MDS dated [DATE], included R28 was cognitively intact and could understand others and make herself understood.Review of resident council meeting minutes for July 2025, August 2025, September 2025 and October 2025, failed to include information on resident rights.During a meeting about resident council on 11/19/25 at 1:30 p.m., R12 and R28 confirmed they did not discuss resident rights in the resident council meetings. R12 and R28 stated they do not remember going over the resident rights during admission. R12 and R28 were not aware resident rights were posted on a bulletin board in the building.During interview on 11/20/25 at 9:23 a.m., activities director (AD)-A confirmed she organized and runs the resident council meetings. AD-A stated they do not review resident rights as part of resident council meetings. However, would answer any questions about rights that a resident specifically brought up. AD-A confirmed the meeting minutes provided were an accurate summary of what was discussed at resident council meetings.Facility provided policy on resident council dated February 2011, failed to include information on reviewing resident rights.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. During observation, interview and document review, the facility failed to ensure food was prepared and distributed under sanitary conditions for 1 of 1 food trays dished up. During observation 11/19/25 starting at 11:10, cook (C - A was preparing the midday meal. C-A was wearing a pair of disposable gloves while setting up trays to be used for meal service.At 11:15 a.m., C-A left the kitchen by touching the door handle to open the door while keeping his gloves on. C-A returned less than 1 minute after holding a kitchen appliance with gloves still on his hands. C-A did not wash his hands or put new gloves on upon returning to the kitchen. C-A again opened the door with gloved hands and took a can of soup from a staff person to warm up for a resident. C-A did not wash hands or change his gloves.At 11:20, C-A placed oven mitts over gloves, took the temperature on breadsticks in the oven, and removed the oven mitts. C-A did not change his gloves or wash his hands.At 11: 23 a.m., C-A left the kitchen with gloves on by opening the door using the door knob and brushing his gloved right hand on the outside of the door. C-A returned to the kitchen wearing gloves and did not wash his hands or put on new gloves.At 11:27 a.m., C-A left the kitchen with some dirty cooking sheets with gloved hands. C-A returned to the kitchen wearing gloves and did not wash his hands or put on new gloves.At 11:35 a.m., C-A again left the kitchen with gloved hands by touching the door knob. C-A returned to the kitchen wearing gloves and did not wash his hands or put on new gloves. C-A again put oven mitts over his gloved hands to open the oven and temp a lasagna. C-A removed oven mitts, and wrote down the temperature of the lasagna with gloved hands. Gloves were not changed and hands were not washed.At 11:50 a.m., C-A starts to serve up food onto resident trays for service. C-A plated bread sticks by picking them up with gloved hand and placing them on the resident's plate.During interview on 11/19/25 12:00 p.m., the administrator stated gloves should have been changed every time a kitchen staff entered the kitchen or went from a dirty to clean task and that hands should be washed when gloves were changed.During interview on 11/20/25 at 9:02 a.m., dietary manager (DM)-D stated all employees complete infection control training online when they first start and yearly. DM-D stated she does do spot checks to ensure gloves are being worn during meal prep and services, but has not completed an audit of a meal prep for an extended period of time to ensure proper hand hygiene was being completed. During interview on 11/20/25 at 12:46 p.m., C-A confirmed he did not wash his hands and change his gloves every time he exited and reentered the kitchen. C-A stated they were taught to wash hands and change gloves whenever he went from a dirty to clean task and any time he enters the kitchen. Facility policy titled Food Preparation and Service dated 2022, included food preparation staff must adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Gloves were to be worn when handling food directly and changed between tasks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure proper personal protective equipment (PPE) was used when providing cares for 1 of 1 resident (R37) reviewed for enhanced barrier precautions (EBP). Further, the facility failed to properly disinfect shared equipment between use for 1 of 1 glucometer (medical device used to check blood sugar levels) reviewed during medication administration.R37's admission minimum data set (MDS) dated [DATE], included R37 received nutrition through a parenteral or tube feeding source while a resident. R37's care plan dated 11/21/25, included R37 was on EBP due to his gastronomy tube (G tube or a surgically placed tube that provides direct access to the stomach for feeding, hydration or medications) . During observation on 11/19/25 at 7:04 a.m., registered nurse (RN)-A and the director of nursing (DON) entered R37's room after preparing medications for tube feeding administration. R37's door had signage for enhanced barrier precautions (EBP) including which PPE should be applied while providing cares. RN-A and DON did not don gown or gloves upon entering R37's room. RN-A and DON boosted R37 in bed by grasping draw sheet and repositioning him higher up in bed for comfort. Both RN-A and DON where in contact with bedding and resident during repositioning. RN-A completed administration of tube feeding medications while wearing gloves and following proper hand hygiene and gloving procedures. During interview on 11/19/25 at 8:00 a.m., RN-A confirmed she was not wearing a gown during administration of medications via tube feeding. RN-A confirmed R37 was on EBP and stated she had received education on EBP. RN-A stated she would wear additional PPE if she were to be doing wound care or assisting the nurse aides with changing a brief. During interview on 11/19/25 at 8:05 a.m., DON confirmed proper PPE was not worn during repositioning or administration of tube feeding medications. Facility policy for Infection Prevention and Control for Transmission-Based Precautions dated 2023, included the purposed of EBP was to prevent opportunities for transfer of multi-drug resistant organisms (MDRO) to employee's hands or clothing during cares. The policy included PPE should have been worn when providing care involving a feeding tube, or during transfers. Glucometer R36's quarterly MDS dated [DATE], included R36 was conatively intact and had diagnoses of diabetes mellitus (a disease where the body either does not produce enough insulin or not use insulin effectively), depression and arthritis. R36's order summary report dated 11/22/25, included blood glucose monitoring four times per day. During observation of medication administration on 11/19/25 at 8:14 a.m., licensed practical nurse (LPN)-A completed a blood sugar check using a shared glucometer on R36. R36 brought the shared glucometer out of R36's room and placed it on top of the medication cart in a box of glucometer testing supplies. LPN-A did not immediately clean the glucometer. At 8:27 a.m., LPN-A collected a purple top (Super Sani-Cloth germicidal) disinfecting wipe container form the nurses' station and cleaned the glucometer. LPN-A cleaned the glucometer by wiping down both sides for a total of approximately 10 seconds and discarding the wipe. During interview on 11/19/25 at 8:48 a.m., LPN-A stated he cleaned the glucometer for approximately 30 seconds. LPN-A stated he was unsure what the required contact time was for cleaning but usually cleaned for about 1 minute. LPN-A confirmed he did not clean for the 2 minutes the label specified. During interview on 11/19/25 at 10:20 a.m., director of nursing (DON) confirmed glucometers should be cleaned with a purple top disinfecting wipe per the label direction to ensure proper contact time. The DON stated it was important for infection control. The DON stated the glucometer should be wiped down immediately after use before putting it away. Facility policy for disinfecting blood glucose monitors dated 2001, included the surface should be wiped 3 times horizontally, 3 times vertically, discard the wipe and get a new one, repeat the steps followed by wrapping the meter with a disinfecting towelette for 2 minutes prior to the next use.