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	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at New Brighton	825 First 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interview and record review, the facility failed to notify resident's family of changes in condition for one of one resident (R2) reviewed. R2 had a left toe ulcer that developed on [DATE] and R1's power of attorney was not notified until R1 had to have the toe amputated on [DATE]. Findings include: R2's Facesheet indicated R1 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R1's additional diagnoses included protein-calorie malnutrition, anorexia, type two diabetes mellitus with diabetic nephropathy and retinopathy without macular edema, vascular dementia, and human immunodeficiency virus. R2's power of attorney (POA) paperwork dated [DATE] indicated R2 appointed family member (FM)-A and FM-B to be R2's representatives. The POA paperwork indicated the paperwork wound not have expired. R2's treatment administration record (TAR) dated [DATE] indicated nurses were to complete skin prep to left great toe twice a day every morning and at bedtime for monitoring. This record was treatment was discontinued on [DATE]. The record indicated staff were completing this treatment twice a day. R2's wound care progress note dated [DATE] indicated R2 had bilateral great toe diabetic ulcer that was cleaned and dressed. The nurse practitioner (NP) noted the wounds were stable upon assessment, R2 to continue with the wound care team weekly, and R2 was a high-risk patient and staff needed to watch carefully for signs and symptoms of infection. R2's wound care progress note dated [DATE] indicated R2 had bilateral great toe diabetic ulcer that was cleaned and dressed. NP noted the wounds were stable upon assessment, R2 to continue with the wound care team weekly, and R2 was a high-risk patient and staff needed to watch carefully for signs and symptoms of infection. R2's brief interview for mental status (BIMS) dated [DATE] indicated R2 had a score of zero, which indicated R1 had severe cognitive impairment. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's wound care progress note dated [DATE] indicated R2 had bilateral great toe diabetic ulcer that was cleaned and dressed. NP noted the wounds were stable upon assessment, R2 to continue with the wound care team weekly, and R2 was a high-risk patient and staff needed to watch carefully for signs and symptoms of infection. NP noted R2's wound had minimal improvements due to patient's condition. R2's weekly skin inspection dated [DATE] indicated R2's areas on her toes remained discolored, R2 was being followed by the wound care team, and all other skin was intact. R2's wound care progress note dated [DATE] indicated R2 had bilateral great toe diabetic ulcer that was cleaned and dressed. NP noted the wounds were stable upon assessment, R2 to continue with the wound care team weekly, and R2 was a high-risk patient and staff needed to watch carefully for signs and symptoms of infection. NP noted R2's wound had minimal improvements due to patient's condition. R2's weekly skin inspection dated [DATE] did not have any information about a skin being completed. R2's wound care progress note dated [DATE] indicated R2 had bilateral great toe diabetic ulcer that was cleaned and dressed. NP noted the wounds were stable upon assessment, R2 to continue with the wound care team weekly, and R2 was a high-risk patient and staff needed to watch carefully for signs and symptoms of infection. NP noted R2's wound had minimal improvements due to patient's condition. R2's skin and wound evaluation dated [DATE] indicated R2 had a diabetic wound on her left dorsum on her first digit. The wound measured two centimeters in length, one centimeter wide, and zero point one centimeter deep. The wound had a moderate amount of serous exudate with attached edges and skin intact. The record indicated NP was notified. R2's weekly skin inspection dated [DATE] indicated R2 had multiple open areas on both toes. R2's progress note dated [DATE] indicated R2 was noted to have a stage one pressure ulcer on bilateral great toes, measuring approximately two centimeters by three centimeters. The progress note indicated the areas were cleaned with wound cleaner, betadine was applied, and covered with dressing. The progress note indicated the wounds had a small amount of serosanguinous drainage and had a foul odor. The progress note indicated the writer left a message for a nurse manager to ask for wound care team to evaluate the ulcers. R2's progress note dated [DATE] indicated R2 had been sweating heavily with labored breathing. The progress note indicated R2's skin was cold to the touch. The progress note indicated R2 was sent to the emergency department for further evaluation and family was aware. R2's hospital records dated [DATE] indicated R2 was admitted to the hospital for altered mental status and concern regarding the left toe wound. The records indicated podiatry was consulted and performed a left great toe amputation due to osteomyelitis of great toe. The records indicated FM-B agreed to this procedure. R2's progress notes indicated no communication with family regarding wounds from [DATE] to [DATE]. Attempted to interview R2 on [DATE] and she did not respond to questions asked. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:25 p.m., licensed practical nurse (LPN)-A stated R2 was non-verbal. LPN-A stated staff communicates with R2 by asking her yes or no questions. During an interview on [DATE] at 9:53 a.m., NP stated R2 was sent to the hospital due to a change in condition because she was acting differently so the facility staff sent her to the hospital. NP stated R2 had her left great toe amputated but didn't know what led to the amputation. NP stated R2 had poor blood flow and circulation throughout her body. NP stated R2 didn't have any infection in her toes that he saw. NP stated he had never had any contact with R2's family. NP stated R2 had a slow decline for about six months to a year. NP stated R2's toes were very hard to treat due to her poor vasculature. NP stated he would expect the facility nurse who would be doing the wound care rounds with him to address the resident's families and keep them informed about the wound's progression. Attempted to contact FM-B on [DATE] at 10:11 a.m. but was unsuccessful. During an interview on [DATE] at 10:14 a.m., FM-A stated himself nor FM-B knew she had wounds on her toes. FM-A stated he was also text messaging FM-B during the interview because FM-B was unable to talk when the attempt was made to interview him. FM-A stated he visited R2 at the facility several times and none of the facility staff talked to him or FM-A about R2's wounds. FM-A stated he got a text message from FM-B that stated R2 was confused and staff would be sending her to the hospital for evaluation. FM-A stated he got to the hospital, and he spoke with the hospital nurse in which she stated R2 was admitted to the hospital due to her toe being infected and needed an amputation. FM-A stated he was confused because the facility staff hadn't told him or FM-B about R2's toe wounds. FM-A stated he nor FM-B knew that R2 was being seen by a wound care clinic. During the interview, FM-A asked FM-B through a text message asking if he knew R2 was being seen by a wound care clinic and FM-B told FM-A that he knew she was being seen by the wound care clinic, but he was not sure where her wounds were. FM-A stated himself nor FM-B ever received wound care clinic paperwork or a phone call from the facility nurses or the NP regarding R2's wounds. During an interview on [DATE] at 10:33 a.m., the nurse manager (NM)-A stated the NP comes every week from an outside agency to assess wounds, treat wounds, and write new orders for wounds if application. NM-A stated when a resident has new skin concerns, the facility nurses would update the family. NM-A stated the facility does not update the resident's families every time NP sees the resident. During an interview on [DATE] at 10:38 a.m., NM-B stated NP had been following R2's toe wounds for a while. NM-B stated the facility does not update the family weekly about resident's wounds. NM-B stated the facility would update the family about if the resident had an infection or needed to be sent to the hospital. NM-B stated the facility talked to FM-B about hew new toe ulcers. NM-B stated the facility had a care conference and her wounds was one of the topics that was discussed. NM-B could not state when the care conference was. NM-B stated, everything we talk about should be in the interdisciplinary team (IDT) care conference notes. NM-B stated the facility nurses would document that they had spoken with a resident's family regarding wounds in a progress note. Attempted to contact registered nurse (RN)-B on [DATE] at 11:31 a.m. but was unsuccessful. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:32 a.m., FM-B stated he did not know about the wounds on R2's toes. FM-B stated he got a call from the hospital stating the facility sent R2 to the hospital for evaluation about confusion and had discovered R2's toes were infected. FM-B stated he had to give consent for the amputation procedure. FM-B stated he never got updates from the facility nursing staff or NP regarding the progression of R2's wounds. During an interview on [DATE] at 12:07 p.m., DON stated she was unsure about the process of updating families when it came to wounds. DON stated, she would think NP would update families regarding updates. DON stated she would expect the NP to update resident's families regarding wounds. DON stated the NM would provide notifications to resident's families if there were medication changes. DON stated resident families who visited more often probably get notified more. DON stated she knew R2 had her toe amputated, but she did not know to which extent R2's family knew about the wound. DON stated she had spoken to FM-A about the hospital stay and the amputation and DON stated FM-A stated he was not expecting an amputation. DON stated she was unsure if the family was notified about the extent of the wounds. DON stated she did not have communication with R2's family regarding the progression of the wounds. DON stated she would expect staff to put in a progress note regarding would care treatment and progress. During an interview on [DATE] at 12:15 p.m., the administrator stated if there was a change in a resident's wound progress, she would expect nurses to notify the resident's family. The administrator stated she would expect there to be a progress note if a resident's family was communicated with about wound progress. The facility's Notification of Changes policy dated ,d+[DATE] indicated nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident. The policy stated the objective of the notification policy is to ensure the facility staff makes appropriate notification to the physician and delegated non-physician practitioner and notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The facility's Skin Assessment and Wound Management policy dated ,d+[DATE] indicated when there was a new skin problem, the provider and the resident representative would be notified. The policy indicated when a resident had ongoing skin issues, the facility was to update the provider and resident or resident representative as needed.