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	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at New Brighton	825 First Avenue Northwest New Brighton, MN 55112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a system was in place to prevent the diversion of medications for 30 of 79 residents (R1, R5, R12, R15, R16, R27, R35, R41, R49, R50, R54, R58, R63, R73, R75, R76, R77, R141, R146, R149, R345, R25, R143, R144, R145, R147, R148, R150, and R151) reviewed for drug diversion and were free from misappropriation of their property when their medications to treat moderate to severe pain and other conditions were taken by a staff member. This resulted in diversion of 111 tablets of oxycodone 5 milligram (mg), 21 tablets of oxycodone 2.5 mg, 28 tablets of oxycodone 10 mg, 1 tablet Aderall, 6 tablets Percocet, and 4 tablets Ambien which resulted in the likelihood of serious harm or adverse event to residents prescribed controlled substances. The IJ began on 1/28/25, when registered nurse (RN)-A identified narcotics were given by trained medication assistant (TMA)-A via a G-Tube (flexible tube inserted in the abdomen and into the stomach) for R12 on a daily medication report. RN-A notified RN-B of the concern that TMA-A had given narcotic medication via the G-tube for a R12. The facility administrator and director of nursing (DON) were notified of the IJ on 2/11/25 at 3:45 p.m., which was identified at the scope and severity of K, pattern. The facility had implemented immediate corrective action on 1/30/25 to prevent recurrence, therefore the IJ was issued at past non-compliance. Findings include: Review of the facility narcotic record indicated TMA-A had signed out medications as removed from narcotic book and the medication cart, however TMA-A did not consistently document in the medication administration record (MAR) as administered. R1's annual Minimum Data Set (MDS), dated [DATE], indicated R1 was cognitively intact, and diagnoses included right-side paralysis following unspecified cerebrovascular disease and seizure disorder. R1's Order Summary Report, printed 2/11/25, indicated a physician order dated 12/17/24 for oxycodone (an opioid medication) 5 milligrams (mg) by mouth (po) every 24 hours as needed (PRN) for moderate to severe pain. R1's record indicated R1's oxycodone dosage was increased on 1/15/25 from 5 mg po every 24 hours PRN to 5 mg every 6 hours PRN with a maximum of 2 doses per day. R1's individual narcotic record indicated 25 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R1's Medication Administration Record (MAR), dated 1/1/25 to 1/31/25, indicated 19 doses of oxycodone were administered. Discrepancy of 6 doses. (continued on next page)

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

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R5's quarterly MDS, dated [DATE], indicated R5 was cognitively intact, and diagnoses included atrial fibrillation (irregular heartbeat) and heart failure. R5's Order Summary Report, printed 2/11/25, indicated a physician order dated 10/2/24 for oxycodone 5 mg po two times a day (BID) PRN for moderate pain. R5's individual narcotic record indicated 40 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R5's MAR dated 1/1/25 to 1/31/25, indicated 29 doses of oxycodone were administered. Discrepancy of 11 doses. R12's admission MDS, dated [DATE], indicated R12 was cognitively intact, and diagnoses included epilepsy, severe protein-calorie malnutrition, and muscle wasting and atrophy. R12's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/7/25 for oxycodone 5 mg via G-Tube (flexible tube inserted surgically through the abdominal wall into the stomach for delivering nutrition, fluids, and medications when a person is unable to eat/drink orally) every 4 hours PRN for pain. R12's individual narcotic record indicated 34 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25, with 7 doses signed out by TMA-A. However, R12's MAR dated 1/1/25 to 1/31/25, indicated 18 doses of oxycodone were administered, and 6 of the doses were administered by TMA-A. Additionally, R12's medications were ordered via G-tube, which required a nurse to administer R12's medications. TMA performing tasks not within their scope of practice. Discrepancy of 16 doses. R15's admission MDS, dated [DATE], indicated R15 was cognitively intact, and diagnoses included paraplegia (paralysis of all or part of the trunk, legs, and pelvic organs) and cerebral palsy. R15's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/10/25 for oxycodone 5 mg po every 6 hours PRN for pain; amphetamine-dextroamphetamine (Adderall) 5 mg po every morning related to attention and concentration deficit; and Adderall 5 mg po at noon PRN for attention and concentration deficit. R15's individual narcotic record indicated 3 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R15's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. Discrepancy of 1 dose. R15's individual narcotic record indicated 22 doses of Adderall were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R15's MAR dated 1/1/25 to 1/31/25, indicated 21 doses of Adderall were administered. Discrepancy of 1 dose. R16's quarterly MDS, dated [DATE], indicated R16 was cognitively intact, and diagnoses included acute osteomyelitis left femur (thigh bone infection) and intervertebral disc degeneration. R16's Order Summary Report, printed 2/11/25, indicated a physician order dated 9/30/24 for oxycodone 5 mg po every 6 hours PRN for pain. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R16's individual narcotic record indicated 46 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R16's MAR dated 1/1/25 to 1/31/25, indicated 33 doses of oxycodone were administered. Discrepancy of 13 doses. R27's admission MDS, dated [DATE], indicated R27 was cognitively intact, and diagnoses included cellulitis (skin infection) of left lower limb, and osteomyelitis of the tibia and fibula (long bones in the lower leg). R27's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 1/21/25 for oxycodone 2.5 mg po every 6 hours PRN for moderate to severe pain; a physician order dated 1/6/25 for Percocet - 1-tab po every 4 hours PRN for moderate pain; a physician order dated 1/7/25 for Ambien 10 mg po every 24 hours PRN for sleep; and a physician order dated 1/14/25 for Oxycontin 10 mg po BID for pain. R27's individual narcotic record indicated 9 doses of oxycodone were signed out of the narcotic log from 1/22/25 through 1/27/25. However, R27's MAR dated 1/1/25 to 1/31/25, indicated 6 doses of oxycodone were administered. Additionally, R27's individual narcotic record indicated 9 doses were sent with patient on 1/28/25. However, the document lacked a nurse's signature. Discrepancy of 12 doses. R27's individual narcotic record indicated 16 doses of Percocet were signed out of the narcotic log from 1/7/25 through 1/17/25. However, R27's MAR dated 1/1/25 to 1/31/25, indicated 10 doses of Percocet were administered. Discrepancy of 6 doses. R27's individual narcotic record indicated 7 doses of Ambien were signed out of the narcotic log from 1/12/25 through 1/27/25. However, R27's MAR dated 1/1/25 to 1/31/25, indicated 6 doses of Ambien were administered. Additionally, R27's individual narcotic record indicated 3 doses were sent with patient. However, the document contained 4 scribble marks and lacked a date. Discrepancy of 4 doses. R27's individual narcotic record indicated 2 doses of Oxycontin 10 mg were marked as sent with ex, error, multiple scribble marks, and distroid [sic]. However, the facility was unable to provide a Record of Disposal for the Oxycontin. Discrepancy of 2 doses. R35's admission MDS, dated [DATE], indicated R35 was cognitively intact, and diagnoses included fracture of right lower leg, osteoporosis, and heart failure. R35's MAR dated 1/1/25 to 1/31/25, indicated a physician order start date 12/31/24 for oxycodone 2.5 mg po every 24 hours PRN for pain, and discontinued date 1/20/25. R35's individual narcotic record indicated 11 doses of oxycodone were signed out of the narcotic log from 1/2/25 through 1/23/25, with 2 doses signed out on 1/23/25 (2 days after medication was discontinued). However, R35's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. Discrepancy of 9 doses. R41's quarterly MDS, dated [DATE], indicated R41 was cognitively intact, and diagnoses included right leg below knee amputation and heart failure. R41's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 1/25/25 for oxycodone 5 mg to 10 mg po every 4 hours PRN for pain. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R41's individual narcotic record indicated 7 doses of oxycodone 5 mg were signed out of the narcotic log on 1/28/25. However, R41's MAR dated 1/1/25 to 1/31/25, indicated 6 doses of oxycodone 5 mg were administered on 1/28/25. Additionally, 6 doses of oxycodone 5 mg were signed out of the narcotic log on 1/29/25. However, R41's MAR dated 1/1/25 to 1/31/25, indicated 4 doses were administered on 1/29/25. Discrepancy of 3 doses. R49's admission MDS, dated [DATE], indicated R49 was cognitively intact, and diagnoses included fracture of left fibula and tibia (both long bones in lower leg) and respiratory failure. R49's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/13/25 for oxycodone 5 mg po BID for pain. R49's individual narcotic record indicated 3 doses of oxycodone were signed out of the narcotic log from 1/14/25 through 1/18/25. However, R49's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. Discrepancy of 1 dose. R50's admission MDS, dated [DATE], indicated R50 was cognitively intact, and diagnoses included fracture of right femur (thigh bone) and asthma. R50's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 1/6/25 for oxycodone 5 mg po every 24 hours PRN for pain. R50's individual narcotic record indicated 20 doses of oxycodone were signed out of the narcotic log from 1/8/25 through 1/31/25. However, R50's MAR dated 1/1/25 to 1/31/25, indicated 14 doses of oxycodone were administered. Discrepancy of 6 doses. R54's admission MDS, dated [DATE], indicated R54 had mild cognitive impairment, and diagnoses included acute respiratory failure, osteoporosis, and R54 required tracheostomy care, suctioning, and a feeding tube. R54's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/8/25 for oxycodone 5 mg via PEG-tub every 6 hours PRN for moderate to severe pain. R54's individual narcotic record indicated 6 doses of oxycodone were signed out of the narcotic log from 1/24/25 through 1/25/25. However, R54's MAR dated 1/1/25 to 1/31/25, indicated 4 doses of oxycodone were administered. Discrepancy of 2 doses. R58's quarterly MDS, dated [DATE], indicated R58 was cognitively intact, and diagnoses included heart failure and right leg below knee amputation. R58's Order Summary Report, printed 2/11/25, indicated a physician order dated 7/22/24 for oxycodone 5 mg po PRN for pain. R58's individual narcotic record indicated 35 doses of oxycodone were signed out of the narcotic log from 1/7/25 through 1/23/25. However, R58's MAR dated 1/1/25 to 1/31/25, indicated 27 doses of oxycodone were administered. Discrepancy of 8 doses. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R63's significant change MDS, dated [DATE], indicated R63 was cognitively intact, and diagnoses included left side hemiplegia and hemiparesis and rheumatoid arthritis. R63's MAR dated 1/1/25 to 1/31/25 indicated a physician order dated 1/3/25 for oxycodone 10 mg po every 4 hours PRN for moderate to severe pain. R63's individual narcotic record indicated 128 doses of oxycodone 10 mg were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R63's MAR dated 1/1/25 to 1/31/25, indicated 104 doses of oxycodone 10 mg were administered. Discrepancy of 24 doses. R73's quarterly MDS, dated [DATE], indicated R73 was cognitively intact, and diagnoses included multiple fractures of pelvis, lumbar vertebra fracture, and multiple rib fractures. R73's Order Summary Report, printed 2/11/25, indicated a physician order dated 11/6/24 for oxycodone 5 mg po every 8 hours PRN for pain. R73's individual narcotic record indicated 60 doses of oxycodone 5 mg were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R73's MAR dated 1/1/25 to 1/31/25, indicated 50 doses of oxycodone were administered. Discrepancy of 10 doses. R75's admission MDS, dated [DATE], indicated R75 had moderately impaired cognition, and diagnoses included pancreatic cancer and generalized abdominal pain. R75's Order Summary Report, printed 2/11/25, indicated a physician order dated 12/28/24 for oxycodone 5 mg po BID PRN for pain. R75's individual narcotic record indicated 5 doses of oxycodone 5 mg were signed out of the narcotic log from 1/17/25 through 1/20/25. However, R75's MAR dated 1/1/25 to 1/31/25, indicated 3 doses of oxycodone were administered. Discrepancy of 2 doses. R76's admission MDS, dated [DATE], indicated R76 was cognitively intact, and diagnoses included systemic lupus erythematosus (immune system attacks healthy tissues and organs), migraines, and cervicalgia (neck pain). R76's Order Summary Report, printed 2/11/25, indicated a physician order dated 12/24/24 for oxycodone 5 mg - 10 mg po every 6 hours PRN for pain. R76's individual narcotic record indicated 79 tabs of oxycodone 5 mg were signed out of the narcotic log from 1/2/25 through 1/31/25. However, R76's MAR dated 1/1/25 to 1/31/25, indicated 67 tabs oxycodone 5 mg were administered. Discrepancy of 12 doses. R77's quarterly MDS, dated [DATE], indicated R77 had severe cognitive impairment, and diagnoses included nontraumatic intracerebral hemorrhage (ruptured blood vessel causing bleeding in the brain), diabetes, and required a feeding tube. R77's Order Summary Report, printed 2/11/25, indicated a physician order dated 10/24/24 for oxycodone 5 mg via G-tube every 24 hours PRN for moderate pain. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R77's individual narcotic record indicated 22 tabs of oxycodone 5 mg were signed out of the narcotic log from 1/1/25 through 1/29/25, with 12 tabs signed out by TMA-A. However, R77's MAR dated 1/1/25 to 1/31/25, indicated 12 tabs oxycodone 5 mg were administered, and 11 of the doses were administered by TMA-A. Additionally, R77's medications were ordered via G-tube, which required a nurse to administer R77's medications. TMA performing tasks not within her scope of practice. Discrepancy of 10 doses. In purple is this the surveyor adding this. R141's admission MDS, dated [DATE], indicated R141 had severe cognitive impairment, and diagnoses included cerebral infarction (stroke), left side hemiplegia, chronic pain, and R141 required a feeding tube. R141's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/22/25 for oxycodone 5 mg via G-tube every 6 hours as needed for severe pain. R141's individual narcotic record indicated 2 tabs of oxycodone 5 mg were signed out of the narcotic log from 1/23/25 through 1/24/25, with 1 tab signed out by TMA-A. However, R141's MAR dated 1/1/25 to 1/31/25, indicated 1 tab oxycodone 5 mg was administered, and the dose was administered by TMA-A. Additionally, R141's medications were ordered via G-tube, which required a nurse to administer R141's medications. TMA performing tasks not within her scope of practice. Discrepancy of 1 dose. R146's discharge MDS, dated [DATE], indicated R146 admitted to the facility on [DATE], and discharged from the facility on 12/13/24. R146's individual narcotic record #42, indicated 15 tabs of oxycodone 5 mg tabs were sent home with patient on 12/13/24, with TMA-A's signature and R146's signature noted. However, facility reported that investigation interview with R146 identified she received 7 tabs of oxycodone. Discrepancy of 8 doses. R146's individual narcotic record #17, indicated 8 tabs of oxycodone 10 mg tabs were destroyed on 11/22/24, with the initials SE and TMA-A's signature noted. Initials in question. However, during facility investigation interview RN-A stated the initials SE were forged because the nurse with the initials SE was out of the country on 11/22/24. discrepancy of 8 doses. R149's quarterly MDS, dated [DATE], indicated R149 was cognitively intact, and diagnoses included heart failure and chronic pain syndrome. R149's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 11/6/24 for oxycodone 5 mg po BID for pain, and an order dated 1/9/25 for oxycodone 5 mg po for acute one time only on 1/9/25. R149's individual narcotic record indicated 4 doses of oxycodone 5 mg were signed out of the narcotic log on 1/9/25. However, R149's MAR dated 1/1/25 to 1/31/25, indicated 3 doses of oxycodone were administered. Discrepancy of 1 dose. R345's admission MDS, dated [DATE], indicated R345 was cognitively intact, and diagnoses included fracture of sacrum, peritonitis (infection of membrane lining abdominal wall. R345's MAR, dated 1/1/25 to 1/31/25, indicated a physician order dated 1/17/25 for oxycodone 10 mg po every 8 hours PRN for pain. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R345's individual narcotic record indicated 4 doses of oxycodone 10 mg were signed out of the narcotic log on 1/18/25, and 3 doses on 1/23/25. However, R63's MAR dated 1/1/25 to 1/31/25, indicated only 3 doses of oxycodone 10 mg were administered on 1/18/25, and 2 doses on 1/23/25. Discrepancy of 2 doses An interview on 2/5/25 at 1:53 p.m. with administrator stated RN-A had identified what she thought might be an issue on 1/29/25. RN-A sent an email to the regional nurse consultant (RN-B) and an investigation was started. TMA-A was suspended 1/29/25. An interview on 2/5/25 at 2:23 p.m., RN-A stated RN-A stated each morning a report was ran for missed medications. She looked in the progress notes to read the documentation about why the medication was missed. RN-A stated the report showed TMA-A repeatedly had given oxycodone. RN-A stated she had first noticed around 1/28/25, when the G-tube medications caught her eye as they were signed out by TMA-A. RN-A discussed oxycodone with R35. However, R35 did not know what oxycodone was for nor did she have any pain. RN-A discussed daily oxycodone use with R77. R77 told RN-A that TMA-A told R77 that she had to have her oxyodone via her G-tube but R77 stated she was to have orally to see how she did with oral medications, as they wanted to remove her G-tube. RN-A stated R77 had gotten her medication via G-tube but was charted given orally by TMA-A. It was not uncommon for TMA-A to request keys to the medication cart and staff handed them over. RN-A stated it was out of the TMA's scope of practice to destroy medications or to administer G-tube medications. Therefore, RN-A emailed RN-B and an audit was completed for all resident receiving oxycodone on the transitional care unit (TCU). RN-A stated the TMA-A was suspended on 1/29/25 at the end of her shift. An interview on 2/10/25 at 12:43 p.m., TMA-A stated she was the staffing coordinator and would fill in as a TMA on the unit. TMA-A stated she had set up medications for the nurses. TMA-A denied giving any G-tube medication to resident. TMA-A stated she was not to sign out medications that she had not given. TMA-A denied she had given residents their discharged medications. TMA-A indicated she counted narcotics with the licensed staff and was not sure why the licensed staff had not signed out when they had counted the narcotics. TMA-A denied documenting other staff initials in the narcotic book or in the MAR. TMA-A stated she had given narcotics to residents without talking with the licensed staff. TMA-A indicated she had been suspended since 1/30/25, then was terminated on 2/10/25. An interview on 2/11/25 at 10:04 a.m. TMA-B stated she did not have anyone set up any medications for her to give to the residents. TMA-B stated TMA's do not give any G-tube medications and no liquid morphine. TMA-B indicated that only the nurses destroy medications when they are discontinued. TMA-B stated TMA's do not sign out any narcotics going home with discharge residents. An interview on 2/11/25 at 10:51 a.m. RN-E stated TMA's do not destroy medications, only licensed staff could do that. RN-E stated TMA's do not sign out narcotics and give to residents who were discharged . RN-E stated she did not have TMA's set up medications then RN-A administered them. RN-E stated TMA's cannot give heparin, insulin, or any G-tube medications. An interview on 2/11/25 at 11:11 a.m. care coordinator (CC)-C stated TMA's could not give insulin, injections, nor G-tube medications. CC-C stated TMA's have to talk to licensed staff before giving any as needed medication to a resident. The the licensed staff needed to evaluate the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate an allegation of sexual abuse for 1 of 1 residents (R57) who reported an alleged sexual assault. Findings include: R57's annual Minimum Data Set (MDS) dated [DATE], identified she was cognitively intact, did not have issues with mood and did not have any behavior concerns. R57 was dependent on staff or required maximal assistance for most activities of daily living (ADL's) and did not walk. R57's diagnoses included heart failure and depression. R57's plan of care, with a last review date of 01/23/25, indicated R57 was categorically a vulnerable adult while residing in a skilled nursing facility. Staff were to be aware of statements or signs/symptoms of abuse, and if present update primary care provider, director of nursing (DON), and administrator immediately. Additionally, under a focus area of history of refusing activities of daily living (ADL's), the care plan indicated cares in pairs at all times with an initiation date of 7/7/2023. Progress noted dated 12/29/24 at 05:36 a.m., indicated family member (FM)-A reported he had seen certified nursing assistant (CNA)-A coming from R57's room. FM-A accused him of uncovering R57 and sexually abusing her. FM-A alleged CNA-A ejaculated in R57's mouth during the shift. The note indicated the supervisor, manager and administrator were updated on the incident. During interview on 2/4/25 at 8:30 a.m., R57 was visibly upset, her leg was shaking rapidly and was fidgeting with right hand. R57 stated there was an incident on 12/29/24. R57 deferred the story to her significant other, FM-A. FM-A stated on the morning of 12/29/24 he left R57's room to get her a sandwich. He was directed to the kitchen by CNA-A. The kitchen was locked and when he returned to her unit, he observed CNA-A coming out of R57's room. FM-A confronted CNA-A and asked, What are you doing in there? CNA-A denied being in R57's room. FM-A entered R57's room and noted white substance on left outer corner of R57's mouth. Her blankets were pulled back and her brief was pushed aside. FM-A stated he took pictures and sent them to SW-A. During interview on 2/4/25 at 11:47 a.m., and follow up interview the same date at 12:25 p.m., the administrator stated she had been notified of the allegation of abuse via text message sometime on the 28th or 29th. However, the administrator did not address this until her next business day of 12/30/24. Administrator stated she reviewed video of the hallway and observed CNA-A go into the vacant room adjacent to R57's room for approximately thirty seconds. The administrator stated CNA-A was not in the room long enough to have ejaculated on R57 and therefore she did not believe the allegation. She did not feel the need to investigate any further. Furthermore, the administrator stated she had not interviewed the resident or the reporting staff regarding the alleged incident. She did not interview any other residents or staff. Administrator stated the investigation file contained only two pieces of paper; a nursing progress note from the night of the incident and a form the SW had filled out 2/4/25 after being asked about the incident. Administrator stated everything the facility did for the investigation was in those two pieces of paper. (continued on next page)

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	245164	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at New Brighton	825 First Avenue Northwest New Brighton, MN 55112

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 2/4/25 at 12:24 p.m. and 1:40 p.m., the SW-1 stated FM-A made him aware of the allegation on 12/30/25 in the early morning via text message. SW confirmed he received pictures, however, he was not able to find them or the text message at this time. The SW stated FM-A was tricky and not credible. Therefore, no report was made to the State Agency (SA) or police. SW-1 stated he reported the allegation to the administrator at approximately 9:30 a.m., on 12/30/24. SW-1 stated his understanding of the facility abuse policy was to investigate all allegations of abuse and report any reportable events to the SA. SW-1 stated his investigation included an interview with R57 and review of video footage. During interview on 2/4/25 at 1:06 p.m., New [NAME] police department detective (D)-A stated he was first informed of the incident on January 26th by FM-A. D-A stated he had spoke to the administrator and was told he would be sent the facilities internal investigation but had not yet received it and did not have any further information regarding an active investigation. During interview on 2/4/25 at 2:01 p.m., R57 stated that during the night of 12/28/24 into 12/29/24, she had been awoken when NA-A was standing over her bed and reaching across her body, he lifted the sheet between her knees and groin. She had asked NA-A what he was doing, and he stated he was checking to see if she was cold. R57 stated this made her angry and felt weird. R57 stated she had not put on her call light to request assistance and did not know why NA-A came into her room. R57 was tearful and stated she was very uncomfortable because NA-A still, works here, and she was fearful of him. During interview on 2/4/25, at 4:25 p.m. CNA-A stated no facility staff had ever talked to him about the accusation by FM-A on 12/29/24. He stated he had not been suspended after the incident nor received any education. CNA-A continued to work with R57 when FM-A was not around. During a telephone interview on 2/5/25, at 8:30 a.m. licensed practical nurse (LPN)-A stated on 12/29/25 at approximately 1:45 a.m., LPN-A was working when CNA-A and FM-A came to the nurse's station and were arguing, FM-A said CNA-A was in R57's room and had removed her covers. CNA-A stated he was in the adjacent room looking at furniture (this room was empty and joined to R57's room via the bathroom). CNA-A and FM-A walked away and a few minutes later CNA-A returned to the desk and told LPN-A that FM-A had accused him of ejaculating in R57's mouth. LPN-A did not remove CNA-A from providing cares. LPN-A contacted the administrator sometime between 12:00 a.m. and 3:00 a.m. on 12/29/24 to report the allegation of sexual abuse. LPN-A did not report the incident to the SA. LPN-A did not interview R57. LPN-A did not interview any other residents or staff. LPN-A stated she had received education on mandated reporting and 'if you see something, you should report it and document it'. LPN-A stated reported incidents of physical abuse, sexual abuse, verbal abuse, and neglect were examples of a reportable incident. The facility policy titled Abuse Prohibition/Vulnerable Adult Policy with a last review date of 3/24 indicated the purpose of the policy was to protect residents against abuse by anyone, including, but not limited to facility staff, other residents; to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. Further, the policy indicated any staff under investigation of suspected or alleged abuse will be immediately suspended until the investigation is completed and HR will be notified. The policy went on to say the following: *Investigation will begin immediately in accordance with federal law (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment form occurring while the investigation is in progress. *The facilities investigation team will review all incident reports regarding residents including those that indicate an injury of unknown origin, abuse. *The designated person will notify the designated agency in the state as soon as possible after reviewing the Vulnerable adult Report. The designated person will also complete and submit any reports required by the state agency. *All documentation will be kept in a confidential file in the facility in accordance with State Law. A summary which identifies trends or patterns will be forwarded to the QAPI committee at least quarterly. *Administration or other designated staff will report the results of all investigations to the State Survey and Certification Agency and other officials in accordance with State Law, and within five (5) working days of the incident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure medications were administered according to provider order and within professional standards for 1 of 1 residents (R2) observed during medication passes with parameters. Findings include: R2 quarterly Minimum Data Set (MDS) dated [DATE], included R2 was severely impaired cognitively. R2 had diagnoses of coronary artery disease (common form of heart disease where blood flow to the heart is limited), hypertension (high blood pressure) and dementia. R2's order summary report dated 2/10/25, included an order for metoprolol tartrate (a medication that affects the flow of blood to the arteries and veins) Tablet 25 MG Give 12.5 mg by mouth two times a day for hypertension with parameters to hold for apical pulse less than 60 beats per minute. During observation on 2/5/25 at 7:25 a.m., licensed practical nurse (LPN)-C obtained R2's blood pressure and pulse with an automatic blood pressure cuff after setting up medication in medication cup. Blood pressure reading was 150/89 with a pulse of 55. LPN-C gave R2 all medications including metoprolol tartrate. During interview on 2/5/25 at 7:25 a.m., LPN-C confirmed the pulse was below the parameter for giving the metoprolol tartrate and it should not have been given. R2's medication administration record dated 11/1/24 - 11/30/24, included an order for metoprolol tartrate 12. 5 mg twice a day with 59 administrations recorded. Seven of the 59 administrations noted a pulse below the 60 beats per minute parameter. However, lacked indication the medication was held as ordered. R2's medication administration record dated 12/1/24 - 12/31/24, included an order for metoprolol tartrate 12. 5 mg twice a day with 61 administrations recorded. Each administration included a recording for pulse, with 10 records with a pulse below 60 beats per minute. However, lacked indication the medication was held as ordered. R2's medication administration record dated 1/1/25 - 1/31/25, included an order for metoprolol tartrate 12.5 mg twice a day with 62 administrations recorded. Each administration included a recorded pulse, with 14 records with a pulse below the 60 beats per minute parameters. However, lacked indication the medication was held as ordered. During interview on 2/5/25 at 8:17 a.m., nursing manager (NM)-C stated she expected nurses to collect the pulse and confirm it is within the parameters prior to giving medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated all medication needed to be administered according to provider orders. The risk of the incorrect medication dose or timing of medication could lead to side effects, such as a low pulse rate. He stated staff should have verified the label of the medication against the electronic medication administration record (EMAR) prior to preparing and giving any medication. DON stated education was recently provided on the rights of medication administration. Facility medication administration policy dated January 2018, included a triple check of the five rights (right resident, right drug, right dose, right route and right time) was recommended when medication was prepared for administration. Medication was to be administered in accordance with written orders.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure they were free of medication error rate of five percent or greater. The facility had a mediation error rate of 8% with 2 errors out of 25 opportunities for errors involving 2 of 6 residents (R2, R240) observed during medication passes. Findings include: R2 quarterly Minimum Data Set (MDS) dated [DATE], included R2 was severely impaired cognitively. R2 had diagnoses of coronary artery disease (common form of heart disease where blood flow to the heart is limited), hypertension (high blood pressure) and dementia. R2's order summary report dated 2/10/25, included an order for metoprolol tartrate (a medication that affects the flow of blood to the arteries and veins) Tablet 25 MG Give 12.5 mg by mouth two times a day for hypertension with parameters to hold for apical pulse less than 60 beats per minute. During observation on 2/5/25 at 7:25 a.m., licensed practical nurse (LPN)-C obtained R2's blood pressure and pulse with an automatic blood pressure cuff after setting up medication in medication cup. Blood pressure reading was 150/89 with a pulse of 55. LPN-C gave R2 all medications including metoprolol tartrate. During interview on 2/5/25 at 7:25 a.m., LPN-C confirmed the pulse was below the parameter for giving the metoprolol tartrate and it should not have been given. During interview on 2/5/25 at 8:17 a.m., nursing manager (NM)-C stated she expected nurses to collect the pulse and confirm it was within the parameters prior to giving medication. During interview on 2/6/25 at 10:39 a.m., nurse practitioner (NP)-A stated the risk for giving metoprolol tartrate outside of the parameters is worsening bradycardia (slow heart rate) and in severe cases could lead to death. R240 admission record dated 2/10/25, included diagnoses of unspecified psychosis and dementia with behavioral disturbance. R240 order summary report dated 2/10/25, included an order for Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 12.5 mg by mouth in the afternoon for hospice care and seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth every 4 hours as needed for agitation and hallucinations for 14 Days. During observation on 2/6/25 at 12:52 p.m., LPN-D was passing scheduled medication for R240. LPN-D prepared quetiapine fumarate 25 mg tablet with other scheduled medication and brought all medications into R240 to administer. During interview on 2/6/25 at 1:05 p.m., LPN-D compared medications in medication cup to blister pack cards. LPN-D confirmed she prepared and was going to give the incorrect dose of quetiapine fumarate. LPN-D confirmed she was going to give the unscheduled higher dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/10/25 at 10:10 a.m., consultant pharmacist (CP) stated the risk of giving an incorrect dose would have been increased risk of side effects for the resident and the error could have been avoided by completing the proper checks prior to administering. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated all medication needed to be administered according to provider orders. The risk of the incorrect medication dose or timing of medication could lead to side effects, such as a low pulse rate. He stated staff should have verified the label of the medication against the electronic medication administration record (EMAR) prior to preparing and giving any medication. DON stated education was recently provided on the rights of medication administration. Facility medication administration policy dated January 2018, included a triple check of the five rights (right resident, right drug, right dose, right route and right time) was recommended when medication was prepared for administration.