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	04/08/2025

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

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 Based on observation, interview and document review, the facility failed to implement a process to supervise and monitor R3, who is known to smoke with oxygen on, to ensure he left the oxygen in the facility while he was smoking in the designated smoking patio resulting in risk of injury, burns, or fire which had the potential to cause serious harm, injury, impairment, or death to 1 out of 16 residents (R3) reviewed who smoked. The immediate jeopardy began on 4/4/25 when the failure to monitor and supervise R3's smoking, and was identified on 4/4/25. The administrator, director of nursing, and regional nurse consultant were notified of the immediate jeopardy at 4:10 p.m. on 4/4/25. The immediate jeopardy was removed on 4/4/25, but noncompliance remained at the lower scope and severity level of D - isolated, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R3's quarterly Minimum Data Set (MDS), dated [DATE], indicated R3 had diagnoses of acute respiratory failure with hypoxia (low blood oxygen), heart failure, asthma, and tobacco use. R3's MDS indicated he was cognitively intact. R3's care plan, dated 1/31/25, indicated R3 smoked at the facility unsafely with his oxygen tank on his scooter. Interventions identified: risk versus benefits completed with the resident, spoke about concerns of safety, and resident signed smoking plan. R3's Resident Safe Smoking Oxygen contract, dated 1/31/25, indicated R3 would remove oxygen tank, leaving it at the nursing station or entrance to smoking patio. Contract indicated nursing staff would assist or R3 had demonstrated independence with removal of the oxygen tank. Further, the contract indicated failure to abide by the contract would result in a smoking privilege review by the interdisciplinary team. R3's chart lacked follow up smoking assessments after the 1/31/25 incident. A progress note, dated 3/29/25, indicated R3 was observed multiple times smoking at unassigned times. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/4/25 at 10:00 a.m., family member (FM)-A stated she had observed a resident on a royal blue scooter on several occasions smoking with oxygen on the smoking patio. FM-A shared a photo with the surveyor, taken on 3/26/25, of R3 smoking with his oxygen tank in the front basket of his scooter. FM-A stated they had reported this to the facility social worker. On 4/4/25, at 10:12 a.m., R3 was observed to be smoking on the designated smoking patio with his oxygen on per nasal cannula (NC) at 3 liters (L). R3 stated it was his own oxygen tank, so it did not matter. On 4/4/25, at 10:28 a.m., Fire Marshall-A stated smoking while wearing oxygen posed a risk, as oxygen rich atmosphere can cause an intense fire quickly. On 4/4/25, at 11:06 a.m., RN-A stated there is not a plan to monitor the designated smoking area. On 4/4/25, at 11:44 a.m., R3 stated he has been told of the dangers of smoking with oxygen before but did not believe his personal oxygen tanks would blow up or cause a fire. Therefore, he was not leaving the oxygen in the building. On 4/4/25, R2 stated he had observed a few other residents smoking on a regular basis while wearing oxygen on the smoking patio. On 4/4/25, at 12:29 p.m., the administrator stated R3 had been observed smoking with oxygen on 1/31/25. The administrator stated this was addressed by providing R3 with education on the potential danger and risks of slow leak of oxygen. R3 agreed to leave oxygen in facility while going out to smoke. The administrator stated the designated smoking patio does not have direct supervision by staff but does have video surveillance available to view in the administrator's office. The administrator stated no other staff had access to view the video surveillance. The administrator stated the facility has not attempted to withhold smoking material or exchange smoking material for the oxygen tank. The administrator stated smoking with oxygen posed a potential risk of the oxygen tank exploding or propelling, burns or fires. The administrator stated she would observe the video surveillance when she was in her office, but did not offer a specific frequency. On 4/4/25, at 2:49 p.m., the nurse practitioner stated oxygen always poses a safety risk while smoking. She stated R3 was endangering other people by smoking while wearing oxygen. A facility document Resident Smoking Policy, dated 10/24, directed the facility was committed to providing the highest level of customer care and service while assuring residents' needs were being met in a safe manner. Any resident who did not comply with the policy may lose smoking privilege. The policy lacked direction regarding smoking with the use of oxygen. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate jeopardy began on 4/4/25, was removed on 4/4/25, when the facility conducted a smoking assessment for R3, revoked R3's smoking privileges at the facility, revised R3's care plan to indicate his smoking privileges had been revoked, reviewed the smoking policy with R3, notified R3's NP, received an order for nicotine lozenges and placed R3 on every 15 minute safety checks. The deficient practice was corrected on 4/4/25, after the facility provided education to all staff regarding designated smoking areas of the facility, no oxygen allowed on the smoking patio, the nurse assigned to the unit closest to the smoking patio's responsibility to monitor the smoking patio every two hours and document, any resident who used oxygen would be required to exchange their oxygen for their smoking materials with the nurse. The facility also held a quality assessment performance quality improvement (QAPI) meeting on 4/4/25 to review and determine a process to monitor for safe smoking practices. Further, the education instructed the staff to provide education to residents, notify the nurse if residents were non-compliant, document instances of non-compliance, and notify the administrator or nurse on-call. The facility also posted the smoking policy on the door to the smoking patio and a sign indicating no oxygen allowed in that area.