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	04/15/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and record review the facility failed to comprehensively assess and monitor a resident's g-tube site and provide interventions for skin irritations for 1 of 1 resident (R1) reviewed for non-pressure related skin concerns. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and no behaviors. She required substantial/moderate assistance for roll left/right, sit to lying, and lying to sitting, dependent upon staff for all transfers, toileting and personal hygiene, bathing, and lower body dressing, and used a manual wheelchair for mobility. She had a feeding tube. Active diagnoses included: stroke, aphasia (a language disorder that affects the ability to speak, read, write, and understand what others are saying caused by a stroke, brain injury, or progressive neurological disorders), hemiplegia/hemiparesis (weakness on one side), malnutrition, diabetes mellitus (DM), hypertension (HTN), and respiratory failure. At risk for pressure ulcers and no unhealed pressure ulcers or other ulcers, wounds, or skin problems identified. Skin and ulcer treatments included pressure reducing devices for chair and bed. She was administered insulin seven out seven days. R1's Braden Scale (a tool designed to assess a patient's risk for developing pressure ulcers dated 2/24/25 at 10:45 a.m. identified R1's score of 12 indicated high risk (at risk 15-18, moderate risk 13-14, high risk 10-12, and very high risk 9 or below) for a pressure ulcer. R1's care plan dated 3/1/25, identified she had diabetes mellitus, and staff were directed to monitor/document/report to medical doctor (MD) for signs/symptoms (s/sx) of infection to any open areas: redness, pain, heat, swelling, or pus formation. She had an alternation in mobility related to stroke. Staff were directed to provide a pressure redistribution mattress to bed and cushion to wheelchair. She was at risk for alteration in skin integrity related to limited mobility secondary to stroke. Staff were directed to monitor skin integrity daily during cares. Weekly skin inspections by nurse. Turn and reposition every two to three hours. Document on skin condition and keep MD or physician assistant (PA) informed of changes. R1's orders/treatment administration record (TAR) identified: -On 3/13/25 at 3:00 p.m. enteral feeding: monitor skin around tube feeding site and change dressing if applicable every shift (7 a.m. to 3 p.m., 3 p.m. to 11 p.m., 11 p.m. to 7 a.m.) for monitoring. Staff signed off all three shifts from 3/13/25 through 4/2/25, except for three shifts. (continued on next page)

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

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	04/15/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/30/25 at 5:30 a.m. weekly skin inspection by licensed nurse. Complete weekly skin inspection in point click care (PCC) in the morning every Thursday. Staff signed every Thursday 3/6/25, 3/13/25, 3/20/25, and 3/27/25. R1's weekly skin inspection completed from 3/13/25 through 3/27/25, by licensed practical nurse (LPN)-B identified: -On 3/13/25 at 12:30 p.m. instructions: it was the nurse's responsibility to evaluate the resident's skin at minimum once a week to ensure skin integrity. Implement interventions as applicable. Bath type: bed bath. Summary of current skin condition: bruises to the face and both hand [sic] due to a previous fall. -On 3/20/25 at 11:32 a.m. identified bath type: shower. Summary of current skin condition: no new skin issues noted. -On 3/27/25 at 1:55 p.m. identified bath type: bed bath. Summary of current skin condition: resident had no new skin conditions, skin intact. A and D (an ointment rich in vitamins A and D used for a for skin protection, moisturizes, seals, and speeds up the recovery of damaged skin) applied to redness on bottom. R1's progress notes on 4/3/25 identified: -at 7:54 a.m. identified follow up visit made by NP-B for anorexia and resumption of full TF diet . upon visit, R1 was slumped over in her wheelchair not responding, she was slumped so far over she was about to fall headfirst onto the floor. Breathing shallow, blood pressure (BP) 90/50, heart rate (HR) 121, unable to obtain pulse oximeter (ox). Instructed staff to call emergency medical services (EMS) for altered mental status (AMS). Concern for stroke or infection. -at 8:42 R1 sent to the emergency room (ER). R1's hospital medical records from 4/3/25 through 4/8/25 identified: -On 4/3/25 at 9:39 a.m. emergency department (ED) provider notes identified admitting diagnoses: systemic inflammatory response syndrome (SIRS) rules out urosepsis, closed fracture of neck of the left humerus from a previous fall, and cerebrovascular accident (CVA) (stroke). -On 4/5/25 at 11:42 p.m. comprehensive stroke evaluation impression: 1. subacute stroke in the setting known as intracranial atherosclerosis and hypotension due to infection. 2. Encephalopathy (brain dysfunction caused by an underlying condition) secondary to burden of prior stroke, acute stroke, and active infection. -On 4/6/25 at 1:39 p.m. GI: PEG fell out, 16 French (Fr) foley in place per patient care order. Skin: . Redness/purulent drainage at PEG insertion site, culture sent. (continued on next page)

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	04/15/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/7/25 seen by medical doctor (MD)-C presented from nursing home with altered medical status (AMS) for one week, hypotensive, and hypoxia. admitted for encephalopathy workup, found to have sepsis 2/2 proteus (a gram-negative common pathogen responsible for complicated urinary tract infections) bacteremia and sub-acute cardiovascular accident (CVA). Stable but elevated leukocytosis . there is some concern that sepsis may be of abdominal origin especially with some erythema (redness) and purulent discharge around the patient's g-tube, which incidentally fell out. G-tube swabbed for culture. -On 4/7/25 at 8:57 a.m. hospital wound registered nurse (RN)-A consult . left upper quadrant (LUQ) g-tube site: tube replaced on 4/7/25, peritubular (area surround the g-tube) assessment: erosion of epidermis, dermis and superficial scab that extends 0.3 centimeters (cm) from insertion site with serosanguinous (clear liquid mixed with blood) drainage. -On 4/8/25 at 12:18 p.m. Antimicrobial Stewardship Team note identified she presented to emergency department (ED) on 4/3/25 and initial testing revealed elevated white blood cells (WBC) and absolute neutrophils (AMC) (white blood cells that fight infection) . g-tube wound was cultures on 4/6/25 and currently growing 1+ pneumoniae (bacteria) and 1+ staphylococcus aureus (S aureus) (gram-positive bacteria). -On 4/8/25 at 2:06 p.m. identified she was initially seen on 4/7/25 by hospital registered nurse/WOC (RN)-A and a left upper gastrostomy tube site was identified with erosion of epidermis, dermis, and superficial scab extended 0.3 cm from insertion site with a small amount of serosanguinous (seen in wounds during the healing phase) drainage. During an interview on 4/11/25 at 9:13 a.m. nurse practitioner (NP)-B stated she was unaware R1's g-tube site was irritated and red and staff should have notified her. She would have expected the nurses to clean around the g-tube site daily, made sure the tube was patent, and monitor for signs and symptoms of infection, redness, drainage, and heat. The facility has chronic g-tubes and some of them have had surrounding skin redness and when addressed right away there were no further issues with it. During an interview on 4/11/25 at 1:16 p.m. LPN-B stated she completed R1's weekly skin assessments on 3/13/25, 3/20/25, and 3/27/25. She completed the skin assessment when R1 had a shower day and may have sat in a shower chair or while the nursing assistant changed her brief in bed, unsure of the last time she assessed her while she laid in bed. R1 sat in the wheelchair fully dressed and she visualized only the skin not covered by clothing. She was not always able to assess the skin and relied on the NA's and asked them if they saw any skin problems when they checked and changed, repositioned, or transferred her. She cleaned around the gastrostomy tube (G-tube) and placed Neosporin (antibiotic ointment used to reduce the risk of infections) and change the dressing. She was unsure as to what should have been included on the weekly assessments. When she removed the sponge dressing from around R1's G-tube she noted a minimal red bloody drainage dried onto the dressing, possibly for the past three weeks and was not documented. (continued on next page)

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	04/15/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/25 at 8:46 a.m. facility wound provider/ nurse practitioner (NP)-A stated staff were expected to remove the residents clothing prior to completing a weekly skin assessment so that the entire body could have been viewed. She expected staff to make her aware of any resident skin concerns so that they could have been taken care of appropriately, prevented from getting worse and/or getting them in other areas. NP-A viewed R1's pictures of her wounds and stated those pictures are worrisome and if those areas are left untreated especially when she was a diabetic could have led to a bad outcome such as death. The sacral and heal wounds were from pressure and could have been from a lack of repositioning. R1 also had issues with malnutrition, would have made a wound get worse in a matter of hours or in a short period of time. Would have made it even more important to have reported the wounds to the nurse manager and her to assess it right away. During an interview on 4/15/25 at 12:15 p.m. director of nursing (DON) stated nursing staff were expected to complete the weekly skin assessments and whenever there was a change in skin condition identified. Nursing staff were expected to have completed a visual head to toe assessment of the resident without clothing on to identify problems areas, find any new skin issues, and prevent anything from getting worse. The NAs were expected to visualize the resident's skin and report any new concerns to the nurse and/or floor manager. The nurse would be expected to document any new skin concerns, where it was located and size on the assessment and in the progress notes so that interventions can be started immediately and help prevent skin tears/wounds/infections. R1's g-tube site was red, unsure if it was infected, and should have been documented on the weekly skin assessment form. The staff nurse would be expected to follow the g-tube nursing order: monitor skin around tube feeding site and change dressing if applicable every shift. Applicable would mean as needed (PRN) and staff nurses would have signed off if monitored and/or change dressing. The order did not indicate the g-tube site should be cleaned. Staff nurses are educated cleaning around the g-tube site would be included when dressing changed was completed. Nurse would not be expected to change dressing each shift if clean and dry. The nurse would have been expected document skin concerns and interventions in the progress notes so that the wound continues to be monitored, and make sure interventions were effective. During an interview on 4/15/25 at 12:23 p.m. with regional nurse consultant RN-B stated the weekly skin assessment were used to identify skin concerns. The staff nurse would be expected to visualize the resident's skin from head to toe. Any skin concerns such as rashes, bruises, and open areas should have been added to the weekly skin assessment documentation. R1's g-tube site would have been added only if there were concerns R1 was at a very high risk for pressure ulcers and had a protein deficiency and weight loss. The hospital did not document and take pictures of R1's skin including the g-tube site until after she was admitted . We did not have any documentation of g-tube being infected, drainage or any other wounds so it did not happen at the facility. Facility Enteral Tube Site Care Competency undated identified: -Perform hand hygiene -Apply gloves -Gently remove the dressing to prevent skin stripping or tearing and discard. -Remove gloves, perform hand hygiene, and apply new pair of gloves (continued on next page)

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	04/15/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Slide the tube's outer bumper carefully away from the skin about 1/2 (1.3 centimeter). Depress the skin surrounding the tube gently and inspect for leakage. -Assess the skin at the exit site for increasing pain and signs of skin breakdown, redness, edema, and purulent drainage. -Inspect tube for wear and tear. A tube that is worn out need to be replaced. -Clean the exit site with soap and water-moistened gauze pads and allow it to dry. -Rotate the out bumper 90 degrees to avoid applying the same tension to the same skin area and to prevent pressure injury formation at the exit site and slid the bumper back over the exit site. Ensure the outer bumper is not resting too tightly against the skin; one finger's breath should fit between the skin and the outer bumper. -If leakage appears at the PEG tube exit site, or if patient risks dislodging the tube, apply a sterile gauze or foam dressing and an external stabilization device around the site as needed. -Apply the dressing over the outer bumper, because applying I underneath the outer bumper creates pressure of the g-tube tract, which could lead to wound abscess. -Label dressing with date, time, and your initials. -Remove gloves perform hand hygiene, and document procedure.

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview, and record review the facility failed to provide necessary care, treatment, and services to prevent pressure ulcer development for 1 of 3 residents (R1). This resulted in an immediate jeopardy (IJ) who presented to the emergency room (ER) on 4/3/25 with multiple pressure ulcers and wound infections. R1 remained hospitalized . The IJ began on 4/3/25, when the facility failed to assess, report to the provider, and treat pressure ulcers. R1 was found unresponsive and presented to the hospital emergency roiagnom on [DATE], and it was discovered she had multiple pressure ulcers and wound infections. R1 remained hospitalized . The facility administrator and director of nursing (DON) were notified of the IJ at 4:00 p.m. on 4/15/25. The facility implemented corrective action by 4/9/25, prior to the start of the survey and was issued as past non-compliance. Findings Include: R1's Braden Scale (a tool designed to assess a patient's risk for developing pressure ulcers) dated 2/24/25 at 10:45 a.m. identified sensory perception as slightly limited and responded to verbal commands. Skin was often moist, and linens had to be changed at least once a shift. She was chair fast, unable to bear own weight. Mobility was very limited and made occasional slight changes in body or extremity position. Nutrition was probably inadequate and would take occasional dietary supplements. Required moderate to maximum assistance in moving, frequently slid down in bed/chair, required frequent repositioning with maximum assistance. Spasticity, contractures, or agitation led to almost constant friction. R1's Braden score was 12 and indicated high risk (at risk 15-18, moderate risk 13-14, high risk 10-12, and very high risk 9 or below) for development of a pressure ulcer. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and no behaviors. She required substantial/moderate assistance for roll left/right, sit to lying, and lying to sitting, dependent upon staff for all transfers, toileting and personal hygiene, bathing, and lower body dressing, and used a manual wheelchair for mobility. She was frequently incontinent of bladder and always incontinent of bowel. She had a feeding tube. Active diagnoses included: stroke, aphasia (a language disorder that affects the ability to speak, read, write, and understand what others are saying caused by a stroke, brain injury, or progressive neurological disorders), hemiplegia/hemiparesis (weakness on one side), malnutrition, diabetes mellitus (DM), hypertension (HTN), and respiratory failure. At risk for pressure ulcers and no unhealed pressure ulcers or other ulcers, wounds, or skin problems identified. Skin and ulcer treatments included pressure reducing devices for chair and bed. She was administered insulin 7 out 7 days. R1's hospital physician notes dated 2/28/25 at 8:28 a.m. identified skin/wounds: WOCN (wound, ostomy, and continence nurse) not followed currently. Per chart, large head laceration repaired by trauma team. Per nursing notes: BUE (bilateral upper extremity extremities) bruising, head laceration, preventive Mepilex (a foam dressing used to reduce the risk of skin breakdown) on sacrum, LLE (lower leg extremity) edema leg wrap (wrap not removed due to pain/fracture), two plus pulses present bilaterally. (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's care plan dated 3/1/25, identified she had diabetes mellitus, and staff were directed to monitor/document/report to medical doctor (MD) for signs/symptoms (s/sx) of infection to any open areas: redness, pain, heat, swelling, or pus formation. She had an alternation in mobility related to stroke. Staff were directed to provide a pressure redistribution mattress to bed and cushion to wheelchair. She was at risk for alteration in skin integrity related to limited mobility secondary to stroke. Staff were directed to monitor skin integrity daily during cares. Weekly skin inspections by nurse. Turn and reposition every two to three hours. Document on skin condition and keep MD or physician assistant (PA) informed of changes. R1's goal outcome evaluation for plan of care dated 3/2/25 at 7:49 a.m. completed by hospital registered nurse prior to discharge back to facility. Skin: no new deficits noted. Repositioned carefully as movement caused a lot of discomfort. R1's discharge summary dated 3/2/25 at 2:21 p.m. hospital stay from 2/27/25 through 3/2/25 due to an accident when she fell out of her wheelchair trying to grab an object. Known skin injury: forehead laceration repaired with sutures. Physical exam identified periorbital (around eyes) ecchymosis (bruising) and skin warm and dry. R1's orders/treatment administration record (TAR) identified: -On 11/26/25 at 3:00 p.m. air mattress-monitor working order and replace as needed every shift. Staff signed off all shift from 3/1/25 through 4/2/25, except 4 shifts. -On 12/4/25 at 7:00 a.m. Prosource TF20 ENfit compatible enteral liquid (20 grams of high-quality protein to a feeding tube). Give 1 packet by mouth every day shift for supplement. Staff signed off every morning from 3/3/25 through 4/2/25. -On 3/3/25 at 3:00 p.m. monitor for skin breakdown around the nose and behind the ears caused by oxygen tubing every shift. Staff signed off all three shifts from 3/3/25 through 4/2/25, except for 4 shifts. -On 3/13/25 at 3:00 p.m. enteral feeding: monitor skin around tube feeding site and change dressing if applicable every shift (7 a.m. to 3 p.m., 3 p.m. to 11 p.m., 11 p.m. to 7 a.m.) for monitoring. Staff signed off all three shifts from 3/13/25 through 4/2/25, except for 3 shifts. -On 1/30/25 at 5:30 a.m. weekly skin inspection by licensed nurse. Complete weekly skin inspection in point click care (PCC) in the morning every Thursday. Staff signed every Thursday 3/6/25, 3/13/25, 3/20/25, and 3/27/25. -On 3/28/25 at 11:00 p.m. barrier cream to peri area with brief changes every shift for skin care. Staff signed off all shifts 3/28/25 through 4/2/25, except for 1 time. R1's weekly skin inspection completed from 3/13/25 through 3/27/25, by licensed practical nurse (LPN)-B identified: (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 3/13/25 at 12:30 p.m. instructions: it was the nurse's responsibility to evaluate the resident's skin at minimum once a week to ensure skin integrity. Implement interventions as applicable. Bath type: bed bath. Summary of current skin condition: bruises to the face and both hand [sic] due to a previous fall. On 3/20/25 at 11:32 a.m. identified bath type: shower. Summary of current skin condition: no new skin issues noted. On 3/27/25 at 1:55 p.m. identified bath type: bed bath. Summary of current skin condition: resident had no new skin conditions, skin intact. A and D (an ointment rich in vitamins A and D used for a for skin protection, moisturizes, seals, and speeds up the recovery of damaged skin) applied to redness on bottom. R1's progress notes from 3/2/25 through 4/3/25, identified: -On 3/3/25 at 10:16 a.m. readmission visit by nurse practitioner (NP)-B following a hospitalization after a fall with head strike. R1 was found to have a right frontal subarachnoid hemorrhage (SAH) (bleeding in the space below one of the thin layers that cover and protect your brain), forehead laceration, and humeral (upper arm) neck fracture. Ordered forehead sutures to be removed on 3/6/25 . -On 3/5/25 at 2:07 p.m. had purple bruising on her face and sutures over her right eye . -On 3/5/25 at 8:45 p.m. R1 needs to be encouraged to be up two times daily, once on a.m.'s once on p.m.'s no exceptions every day and evening shift for monitoring since fall. She is weak and has been bed bound. -On 3/6/25 at 11:07 a.m. acute visit for pain made by NP-B . was recently taken off TF due to good oral (PO) intact but not continues to demonstrate problems with dysphagia (trouble with swallowing) . well developed in no acute distress . -On 3/12/25 at 7:49 a.m. follow up visit to assess bolus TF tolerance . tolerating bolus feedings and uninterested in food . -On 3/24/25 at 9:26 a.m. primary provider medical doctor (MD) came to see her and was told she had gone to a doctor's appointment. He did not see her today . past surgery history: percutaneous endoscopic gastrostomy (PEG) tube (a tube placed into the stomach through the abdominal wall most commonly to provide a means of feeding when oral intake is not adequate) was placed on 6/20/23 . -On 3/27/25 at 5:46 p.m. assisted with lunch today. Continued to pocket all food. Very slow to take liquids thru straw. Mighty shake given as she was not swallowing any food. Nurse practitioner (NP) made aware, and dietician notified. - On 3/28/25 at 2:52 p.m. The writer noticed the resident could not seat comfortably and hold her head in the chair. Writer asked the aid to put he back to bed for safety. -On 4/2/25 at 1:09 p.m. Interdisciplinary team (IDT) reported R1 was not eating or drinking anything orally. Nursing informed husband was ok with tube feeding (TF) to provide all nutrition needs. Currently received bolus feed two times a day (bid) but will increase to meet all her needs. (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 4/3/25 at 7:54 a.m. follow up visit made by NP-B for anorexia and resumption of full TF diet . upon visit, R1 was slumped over in her wheelchair not responding, she was slumped so far over she was about to fall headfirst onto the floor. Breathing shallow, blood pressure (BP) 90/50, heart rate (HR) 121, unable to obtain pulse oximeter (ox). Instructed staff to call emergency medical services (EMS) for altered mental status (AMS). Concern for stroke or infection. -On 4/3/25 at 8:42 R1 sent to the emergency room (ER). R1's progress notes lacked documentation of skin assessments. R1's hospital medical records from 4/3/25 through 4/8/25 identified: -On 4/3/25 hospital admission history and physical identified sacral pressure wound. Nursing notified primary team of large necrotic pressure wound to her sacrum with various other lesions to the perineum and surrounding erythema. Area has been cleansed and Mepilex added. Pictures in media lab. WOC consult placed. Clinical impressions: SIRS (systemic inflammatory response syndrome) (an exaggerated defense response of the body to a noxious stressor such as infection, trauma, survey, acute inflammation, ischemia or reperfusion, or malignancy, can be life threatening and affects the entire body) and CVA. Physical exam identified scattered bruising on left arm and small abrasion to nose. -On 4/3/25 at 9:39 a.m. emergency department (ED) provider notes identified admitting diagnoses: systemic inflammatory response syndrome (SIRS) rules out urosepsis, closed fracture of neck of the left humerus from a previous fall, and cerebrovascular accident (CVA) (stroke). -On 4/3/25 at 6:54 p.m. documented by a registered nurse (RN) identified during incontinence care for stool upon transfer, grapefruit-sized blackened pressure wound noted on sacrum alongside redness and areas of open skin on and around perineum. Picture obtained and placed in chart. Gently cleaned area and applied sacral Mepilex for protection. Provider also notified, WOC consult placed to follow-up. -On 4/5/25 at 11:42 p.m. comprehensive stroke evaluation impression: 1. subacute stroke in the setting known as intracranial atherosclerosis and hypotension due to infection. 2. Encephalopathy (brain dysfunction caused by an underlying condition) secondary to burden of prior stroke, acute stroke, and active infection. -On 4/6/25 at 1:39 p.m. GI: PEG fell out, 16 French (Fr) foley in place per patient care order. Skin: bruising to face, bilateral upper extremities, and abdomen. Scabs to chest nose, thigh, and buttocks. Pressure wound to sacrum and left heel Peeling/scaling to bilateral feet. Redness/purulent drainage at PEG insertion site, culture sent. Right ear lobe swollen. Left groin open area. Left ear abrasion. (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 4/7/25 seen by medical doctor (MD)-C presented from nursing home with altered medical status (AMS) for one week, hypotensive, and hypoxia. admitted for encephalopathy workup, found to have sepsis 2/2 proteus (a gram-negative common pathogen responsible for complicated urinary tract infections) bacteremia and sub-acute cardiovascular accident (CVA). Stable but elevated leukocytosis and worsening . urinalysis was consistent with E. Coli (bacteria) urinary tract infection, urine culture with no growth, blood cultures initially showing Proteus. there is some concern that sepsis may be of abdominal origin especially with some erythema (redness) and purulent discharge around the patient's g-tube, which incidentally fell out. G-tube swabbed for culture. nursing notified primary team of large necrotic pressure would to patient's sacrum with various other lesions to the perineum and surround erythema. Area has been cleansed and Meplix added. Picture in media lab. 4/7/25 wound/ostomy/colostomy (WOC) reached out and recommended surgery consult for debridement . Physical exam skin: erythema around g-tube, no purulent drainage. Sacral wound necrotic and softening edges per WOC registered nurse (RN). Left heel pressure wound without skin break. -On 4/7/25 at 8:57 a.m. hospital wound registered nurse (RN)-A consult . left upper quadrant (LUQ) g-tube site: tube replaced on 4/7/25, peritubular (area surround the g-tube) assessment: erosion of epidermis, dermis and superficial scab that extends 0.3 centimeters (cm) from insertion site with serosanguinous (clear liquid mixed with blood) drainage . -On 4/8/25 a computed tomography (CT) (imaging test used to obtain detained internal images of the body) was completed to evaluate the sacral wound and underlying abscess and possible osteomyelitis. Impression: wound overlying the sacrum with extensive subcutaneous fat stranding fluid, and emphysema extending laterally within the subcutaneous fat superficial to the right gluteal maximus musculature, suspicious for tracking abscess. Particularly given the areas of rim enhancement. Additional pressure wounds are visualized overlying the ischium tuberosities (the bone in the lower pelvis that absorbs weight when you sit). Nonconvincing CT evidence of osteomyelitis. -On 4/8/25 at 12:18 p.m. Antimicrobial Stewardship Team note identified she presented to emergency department (ED) on 4/3/25 and initial testing revealed elevated white blood cells (WBC) and absolute neutrophils (AMC) (white blood cells that fight infection), as well as a positive urinalysis (UA) for nitrites and leukocyte esterase (white blood cells that indicate infection and inflammation). A head CT in ED showed a new subacute appearing infarct in the medial left occipital lobe . culture of nares was collected on 4/5/25 and tested positive for methicillin-resistant staphylococcus aureus (MRSA) (a bacterial infection many antibiotics don't work on). g-tube wound was cultures on 4/6/25 and currently growing 1+ pneumoniae (bacteria) and 1+ staphylococcus aureus (S aureus) (gram-positive bacteria). (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 4/8/25 at 2:06 p.m. identified she was initially seen on 4/4/25 by hospital registered nurse/WOC (RN)-A and sacrum and perineum skin issues were identified. Pictures were taken on 4/4/25 of identified pressure injuries of the sacrum/right buttock, and left thigh. On 4/9/25 pictures and measurements were taken of those same areas. Sacrum measured 10 centimeters (cm) x 13 cm x 0.1 cm, right buttock 4 cm x 2 cm x 0.1 cm, left thigh 10 cm x 6 cm x 0.1 cm, no tunneling, peri wound skin (surrounding skin) erythema (redness) blanchable (blood flow noted to the area). Sacrum wound was identified as a pressure injury, unstageable and present upon admission. The wound base of the sacrum wound was 95% eschar (a hardened, dry black or brown dead tissue and usually indicates a more advanced wound) /purple epidermis (outer most layer of skin), 5% dermis (the layer of skin found deep to the epidermis that supports and adds strength and pliability to the skin) and slough (a biproduct of the inflammatory phase and a barrier and delay to wound healing). A photo and measurements were taken on 4/7/25 of the deep tissue pressure injury (DTPI) located on the left heel and present on admission per bedside RN on 4/5/25. Measures were taken on 4/7/25 of left heel DTPI and identified 5 cm x 6.5 cm x 0 cm with a wound base 100% maroon, purple and epidermis. Peri wound dry and scaly, no pain and no drainage. Additionally, on 4/7/25 a left upper gastrostomy tube site was identified with erosion of epidermis, dermis, and superficial scab extended 0.3 cm from insertion site with a small amount of serosanguinous (seen in wounds during the healing phase) drainage. During an interview on 4/10/25 at 11:03 a.m. hospital registered wound nurse (RN)-A stated R1 was admitted to the hospital on 4/3/25 with systemic inflammatory response syndrome (SIRS) and possible stroke. R1 had been hospitalized at the end of February 2025 and discharge on 3/2/25 without any wounds other than surgical at that time. She had seen R1 three times since she was admitted to the hospital on 4/3/25 and again today. The sacral wound was deteriorating with two open areas with tunneling. The sacral wound was unstageable and measured 3.5. centimeters (cm) x 2.5 cm x .1 cm, the right buttock was stage 2 and measured 3.5 cm x 2.5 cm x .1 cm, left posterior thigh was a deep tissue injury and measured 7.5 cm x 4.5 cm x 0, and the left heel was a deep tissue injury and measured 5 cm x 6.5 cm x 0. The sacral had tan serosanguinous drainage with a mild odor. R1's skin damage was already there prior to being admitted to the hospital and was one of the largest wounds she had ever seen as a wound nurse in 8 years. When a deep tissue injury occurred, it took up to 72 hours to show up and sometimes it looked like a discoloration and then opened. The sacrum wound is located midline and when left on her back too long seemed like it was consistent with that position to develop. This sacral wound most likely will not have a chance to heal without surgery to clean out the dead/eschar/necrotic tissue and will 100% affect her morbidity and mortality. Today R1 had tunneling in her sacral wound which meat it had stared to release from inside out and had lots of soupy drainage. During an interview on 4/10/25 at 3:29 p.m. hospital social worker (SW) stated R1 was admitted to the hospital on 4/3/25 and pictures were taken of her skin with numerous skin concerns right away. R1 had reddened areas on her bottom and thigh and a large wound located on the sacrum that measured approximately three inches by three inches with a black necrotic center. Hard to believe the nurse's that provided care for R1 and assessed her skin did not notice some type of skin condition changes especially the large one the sacrum. The sacrum wound required treatment and not something only barrier cream would have taken care of. It was very disturbing to see the extensive damage to her skin. (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/11/25 at 9:13 a.m. facility NP-A stated standard nursing care provided by nursing staff were expected to have visibility observed the resident's skin every time during cares and weekly skin assessments for skin breakdown and reported it to the nurse or nurse manager. Right before R1 was admitted to the hospital on 4/3/25 she had received a handwritten note from the floor manager LPN-C indicating R1 had the start of a coccyx injury/pressure ulcer caused by prolong immobility and malnutrition. We have a wound team to assess skin concerns such as this. LPN-C indicated she had alerted the wound team. Standing orders should have been placed until staff nurse told me it was worse or required my assistance. She relied on staff nurses to inform and update her and made her aware of changes. She stated things were getting missed by staff and R1's sacral wound could have been prevented. NP-A verified there was a huge gap of communication among staff regarding R1's skin issues and lacked documentation in her electronic medical record progress notes. NP-A viewed the hospital pictures taken of R1's skin and stated the sacrum wound have developed over several weeks and did not happen overnight. R1's left heel had the start of necrosis, malnourished, and most likely could have developed in a couple of days to a week but not overnight, that was for sure. Her expectation would have been to be notified when there was a change in condition right away or at least within the shift depending on how severe it was. She identified R1's wounds and condition as severe, very disturbing to her, and made her worry about how staff were assessing the resident's skin. R1's wounds could have been prevented if caught earlier and thorough skin assessments had been completed. There was harm done here and she was very worried about R1. During an interview on 4/11/25 at 11:22 a.m. NA-C stated R1 was unable to reposition herself in bed and was incontinent of bowel and bladder. Staff were expected to check and change and reposition her every two hours. On 4/1/25, while providing cares to R1 he noticed a little hole (about the size of top of a pen) in her bottom located on the left side of her buttock. He told the floor manager LPN-C and was told to leave her in bed the wound provider was there, did not see anything on her heels. Unable to identify staff that placed a dressing on her sacral area, no drainage, no odor, no pain. R1 had air mattress on her bed but no pressure relieving cushion on her wheelchair. He usually placed a folded blanket in her wheelchair to take pressure off her bottom. During an interview on 4/11/25 at 11:45 a.m. NA-B stated R1 was not able to reposition herself and always incontinent of bowel and bladder. R1 was dependent upon staff to check and change and reposition her every two to three hours. We were expected to document that each time in the electronic medical record. During cares, she noticed a wound on R1's bottom three weeks prior to her going to the hospital on 4/3/25. The wound on her bottom was dark black and approximately 2 to 3 inches in diameter, opened on one side, surround skin was slightly red without drainage. There was an odor to it, unsure how to explain that. She reported the wound to the nurse on the evening shift. A day later she noticed a dressing over R1's wound on her bottom was falling off and the trained medication aide (TMA) told her to leave it on and she would let the nurse manager know. R1 had a thin cushion in her wheelchair. Husband visited often and pushed her around in the wheelchair. (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/11/25 at 12:35 p.m. hospital medical doctor (MD) stated R1 was admitted to the hospital with stroke, septic from blood infection from sacral wound and possible urinary tract infection (UTI). A sacral wound as large as R1's wound has most likely resulted from a pressure injury due to lack of repositioning. He questioned if appropriate care had been given to the resident at the facility and was suspicious of her cares the way she presented when brought to hospital by EMS. R1's prognosis was very poor and most likely will be placed on end of life care and very likely may result in death. The main cause was the sacral wound. There were other concerns of her not really waking up, unsure if it was the infection they were treating. The neurology team was being consulted. After R1 was discharged from the hospital to the facility beginning of March 2025, there were no skin issues identified. During an interview on 4/11/25 at 1:16 p.m. LPN-B stated she completed R1's weekly skin assessments on 3/13/25, 3/20/25, and 3/27/25. She completed the skin assessment when R1 had a shower day and may have sat in a shower chair or while the nursing assistant changed her brief in bed, unsure of the last time she assessed her while she laid in bed. R1 sat in the wheelchair fully dressed and she visualized only the skin not covered by clothing. She was not always able to assess the skin and relied on the NA's and asked them if they saw any skin problems when they checked and changed, repositioned, or transferred her. She cleaned around the gastrostomy tube (G-tube) and placed Neosporin (antibiotic ointment used to reduce the risk of infections) and change the dressing. She was unsure as to what should have been included on the weekly assessments. When she removed the sponge dressing from around R1's G-tube she noted a minimal red bloody drainage dried onto the dressing, possibly for the past three weeks. R1's bottom was red, and ointment was applied but lately that area had opened. Last time she saw R1's bottom was the Tuesday 4/1/25, before she was sent into ER. She thought R1 had been seen by the wound team and the floor nurse manager was aware of it. She had not received any education on skin assessments. During an observation on 4/11/25 at 3:20 p.m. LPN-A walked down to R1's room with surveyor and verified her wheelchair did not have a pressure relieving cushion on it and there was a thin pillow approximately 1/4 inches thick with a cover placed on it located in the seat of her wheelchair. She stated R1 should have had a pressure relieving cushion in her wheelchair to prevent pressure ulcers. She verified R1 wore gripper socks while in her wheelchair and shoes when she went out of facility with her husband. (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/14/25 at 2:54 p.m. licensed practical nurse (LPN)-C clinical coordinator stated nursing staff would be expected to have completed a weekly skin assessment on each resident. The weekly skin assessment was usually scheduled on the same day as their bath day while in the shower without clothing on or if in the morning while the resident laid in bed so that the entire body and especially their bottom could be assessed. Nursing staff would be expected to have written up a risk management report, documented in the progress notes including measurements, called the provider and request an order to treat those area that were concerning. During the following morning meeting new skin concerns would have been reviewed, then reviewed by risk management and arranged for resident to be seen weekly by the wound care provider to have followed up. The family should have been notified along with the provider so that interventions could have been identified to help prevent the identified area(s) from getting worse and/or prevention of any new areas. R1 had not had skin issues until the week before she went into the hospital on (since last skin check 3/27/25) so floating her heels while in bed was not required, could have been an intervention but what they were doing was working. Although apparently it was not working after what happened to her skin. She had a wheelchair cushion . we give everyone one when they come in should have been a pressure redistribution cushion looks like a foam cushion or air filled with the little finger things that stick up on it. She had a foam one, not sure. The last weekly skin assessment competed on R1 identified she had redness to her bottom, started treating it with A and D ointment (house barrier cream) with brief changes on 3/28/25. There were no specific details placed in the weekly skin assessment such as size of reddened area or progress notes written. If a resident's bottom had been identified with a new skin problem such as a red area that would have been considered a change in condition and the provider should have been notified. On 3/31/25, she was informed by NA-C R1 had a red area on her bottom. During an observation on 4/14/25 at 3:30 p.m. LPN-C and surveyor entered R1's room together. LPN-C confirmed R1 had a pressure relieving mattress on her bed. Located on the manual wheelchair was a lawn chair cushion approximately 1/4 inch thick with a cover over it. She stated thought R1 had a thicker cushion on her chair unable to identify when she had used it. She looked in R1's closets and stated it would have been a nursing intervention, like a standing order. Usually, a pressure relieving cushion was placed in the resident chair and does not leave the room but may have been sent down to the laundry, not sure. During an interview on 4/15/25 at 4:30 a.m. NA-D stated she had cared for R1 on 3/15/25, 3/21/25, 3/24/25, 4/1/25, and 4/3/25. She completed morning cares, washed her up and NA-C assisted her. There was a wound on R1's bottom with a dressing on it all five days she worked. NA-C informed her he had reported the wound to the floor manager LPN-C. Surrounding skin around dressing (approximately 2 inches by 2 inches) was pink, dry, and intact. On 4/3/35, she had arrived at work and R1 laid in bed with her heels positioned on a pillow. On 4/1/25 or 4/3/25 she was not asked by LPN-A to put R1 back to bed and was most likely feeding residents. During an interview on 4/15/25 at 5:00 a.m. NA-E stated he provided cares to R1 and when he positioned her in bed her heels rested on a pillow. She was at risk for pressure ulcers. During cares he noticed for the first time about one month ago a sore on R1's bottom located on the left side of her buttock unsure of the size, unable to really explain it well, was a dark area on her body located on the left side of her buttocks. He had told the nurse (LPN-D), and she informed him the next time we checked and changed here she wanted to see the sore, treat it, and placed a bandage dressing on it. He stated she was checked and changed at least three times during the night shift and sometimes more often. (continued on next page)

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	04/15/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/15/25 at 8:46 a.m. facility wound provider/ nurse practitioner (NP)-A stated staff were expected to remove the residents clothing prior to completing a weekly skin assessment so that the entire body could have been viewed. She expected staff to make her aware of any resident skin concerns so that they could have been taken care of appropriately, prevented from getting worse and/or getting them in other areas. NP-A viewed R1's pictures of her wounds and stated those pictures are worrisome and if those areas are left untreated especially when she was a diabetic could have led to a bad outcome such as death. The sacral and heel wounds were from pressure and could have been from a lack of repositioning. R1 also had issues with malnutrition, would have made a wound get worse in a matter of hours or in a short period of time. Would have made it even more important to have reported the wounds to the nurse manager and her to assess it right away. During an interview on 4/15/25 at 11:05 a.m. LPN-D stated staff nurses were expected to complete the weekly skin audits and visualize all resident's skin when completed. The assessment should have included any new and current skin issues/wounds/g-tube sites. The weekly skin assessment was important to avoid pressure sores and infection. She had filled in one night and worked as an NA the end of March 2025. She assisted with check and changes and repositioning R1 every two to three hours. She identified a wound on R1's bottom to the left side sacral area, was the size of a baseball, edges looked ruff/ridged, was open in the middle and along the inside of the outer edge approximately 1/4 inch all the way around was black, and dry without drainage. The left heals had an area the size of a quarter, looked new, slightly discolored, felt soft/boggy, and intact skin. She informed the floor manager LPN-C the next day when she came back to work the evening shift. LPN-C was leaving for the day, and she stopped her, informed her R1 had a wound that needed attention LPN-C stated ok and left the building. The following day she reminded LPN-C again and went to R1's room with her, had NA's transfer her to the bed, removed her clothing so we could assess all her skin. LPN-C stated Oh my God no one had told her about R1's sacral wound, left the room and walked to the treatment cart. LPN-D showed LPN-C R1's left heel and she sounded shocked and disappointed. LPN-D left R1's room, completed the medications passes, and unsure if LPN-D returned. The provider should have been notified for orders to treat her sacral wound. During a follow-up interview on 4/15/25 at 11:56 a.m. hospital wound RN-A stated the surgeon at the hospital deemed that R1 would not be able to tolerate surgery on the infected sacral wound and would most likely be transitioned to Hospice. She would not have identified R1's sacral[TRUNCATED]

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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to ensure licensed nurses demonstrated and/or acknowledged required competency skills for completion of weekly skin assessments for 1 of 3 residents (R1) identified to have worsening skin conditions. This had the potential to affect all 83 residents who resided in the facility. Findings include: R1's Braden Scale (a tool designed to assess a patient's risk for developing pressure ulcers) dated [DATE] at 10:45 a.m. identified R1's score was 12 and indicated high risk (at risk ,d+[DATE], moderate risk ,d+[DATE], high risk ,d+[DATE], and very high risk 9 or below). R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and no behaviors. She required substantial/moderate assistance for roll left/right, sit to lying, and lying to sitting, dependent upon staff for all transfers, toileting and personal hygiene, bathing, and lower body dressing, and used a manual wheelchair for mobility. She was frequently incontinent of bladder and always incontinent of bowel. She had a feeding tube. Active diagnoses included: stroke, aphasia (a language disorder that affects the ability to speak, read, write, and understand what others are saying caused by a stroke, brain injury, or progressive neurological disorders), hemiplegia/hemiparesis (weakness on one side), malnutrition, diabetes mellitus (DM), hypertension (HTN), and respiratory failure. At risk for pressure ulcers and no unhealed pressure ulcers or other ulcers, wounds, or skin problems identified. Skin and ulcer treatments included pressure reducing devices for chair and bed. She was administered insulin 7 out 7 days. R1's hospital physician notes dated [DATE] at 8:28 a.m. identified skin/wounds: WOCN (wound, ostomy, and continence nurse) not followed currently. Per chart, large head laceration repaired by trauma team. Per nursing notes: BUE (bilateral upper extremity extremities) bruising, head laceration, preventive Mepilex (a foam dressing used to reduce the risk of skin breakdown) on sacrum, LLE (lower leg extremity) edema leg wrap (wrap not removed due to pain/fracture), two plus pulses present bilaterally. R1's care plan dated [DATE], identified she had diabetes mellitus, and staff were directed to monitor/document/report to medical doctor (MD) for signs/symptoms (s/sx) of infection to any open areas: redness, pain, heat, swelling, or pus formation. She had an alternation in mobility related to stroke. Staff were directed to provide a pressure redistribution mattress to bed and cushion to wheelchair. She was at risk for alteration in skin integrity related to limited mobility secondary to stroke. Staff were directed to monitor skin integrity daily during cares. Weekly skin inspections by nurse. Turn and reposition every two to three hours. Document on skin condition and keep MD or physician assistant (PA) informed of changes. R1's goal outcome evaluation for plan of care dated [DATE] at 7:49 a.m. completed by hospital registered nurse. Skin: no new deficits noted. Repositioned carefully as movement caused a lot of discomfort. (continued on next page)

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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's discharge summary dated [DATE] at 2:21 p.m. hospital stay from [DATE] through [DATE] due to an accident when she fell out of her wheelchair trying to grab an object. Known injury: forehead laceration repaired with sutures. Physical exam identified periorbital (around eyes) ecchymosis (bruising) and skin warm and dry R1's weekly skin inspection completed from [DATE] through [DATE], by licensed practical nurse (LPN)-B identified: -On [DATE] at 12:30 p.m. instructions: it was the nurse's responsibility to evaluate the resident's skin at minimum once a week to ensure skin integrity. Implement interventions as applicable. Bath type: bed bath. Summary of current skin condition: bruises to the face and both hand [sic] due to a previous fall. On [DATE] at 11:32 a.m. identified bath type: shower. Summary of current skin condition: no new skin issues noted. On [DATE] at 1:55 p.m. identified bath type: bed bath. Summary of current skin condition: resident had no new skin conditions, skin intact. A and D (an ointment rich in vitamins A and D used for a for skin protection, moisturizes, seals, and speeds up the recovery of damaged skin) applied to redness on bottom. R1's triage notes dated [DATE] at 9:29 a.m. identified she arrived at ED via emergency medical services (EMS). Nurse practitioner (NP) found her unresponsive, hypotensive (low blood pressure), hypoxic (low levels of oxygen in the body) and tachycardiac (fast heart rate). R1's hospital progress notes on [DATE] at 6:54 p.m. documented by a registered nurse (RN) identified during incontinence care for stool upon transfer, grapefruit-sized blackened pressure wound noted on sacrum alongside redness and areas of open skin on and around perineum. Picture obtained and placed in chart. Gently cleaned area and applied sacral Mepilex for protection. Provider also notified, WOC consult placed to follow-up. R1's hospital admission history and physical dated [DATE] identified sacral pressure wound. Nursing notified primary team of large necrotic pressure wound to her sacrum with various other lesions to the perineum and surrounding erythema. Area has been cleansed and Mepilex added. Pictures in media lab. WOC consult placed. Clinical impressions: SIRS (systemic inflammatory response syndrome) (an exaggerated defense response of the body to a noxious stressor such as infection, trauma, survey, acute inflammation, ischemia or reperfusion, or malignancy, can be life threatening and affects the entire body) and CVA. Physical exam identified scattered bruising on left arm and small abrasion to nose. (continued on next page)

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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's hospital progress notes dated [DATE] at 2:06 p.m. identified she was initially seen on [DATE] by hospital registered nurse/WOC (RN)-A and sacrum and perineum skin issues were identified. Pictures were taken on [DATE] of identified pressure injuries of the sacrum/right buttock, and left thigh. On [DATE] pictures and measurements were taken of those same areas. Sacrum measured 10 centimeters (cm) x 13 cm x 0.1 cm, right buttock 4 cm x 2 cm x 0.1 cm, left thigh 10 cm x 6 cm x 0.1 cm, no tunneling, peri wound skin (surrounding skin) erythema (redness) blanchable (blood flow noted to the area). Sacrum wound was identified as a pressure injury, unstageable and present upon admission. The wound base of the sacrum wound was 95% eschar (a hardened, dry black or brown dead tissue and usually indicates a more advanced wound) /purple epidermis (outer most layer of skin), 5% dermis (the layer of skin found deep to the epidermis that supports and adds strength and pliability to the skin) and slough (a biproduct of the inflammatory phase and a barrier and delay to wound healing). A photo and measurements were taken on [DATE] of the deep tissue pressure injury (DTPI) located on the left heel and present on admission per bedside RN on [DATE]. Measures were taken on [DATE] of left heel DTPI and identified 5 cm x 6.5 cm x 0 cm with a wound base 100% maroon, purple and epidermis. Peri wound dry and scaly, no pain and no drainage. Additionally, on [DATE] a left upper gastrostomy tube site was identified with erosion of epidermis, dermis, and superficial scab extended 0.3 cm from insertion site with a small amount of serosanguinous (seen in wounds during the healing phase) drainage. During an interview on [DATE] at 11:03 a.m. hospital registered wound nurse (RN)-A stated R1 was admitted to the hospital on [DATE] with systemic inflammatory response syndrome (SIRS) and possible stroke. R1 had been hospitalized at the end of February 2025 and discharge on [DATE] without any wounds other than surgical at that time. She had seen R1 three times since she was admitted to the hospital on [DATE] and again today. The sacral wound was deteriorating with two open areas with tunneling. The sacral wound was unstageable and measured 3.5. centimeters (cm) x 2.5 cm x .1 cm, the right buttock was stage 2 and measured 3.5 cm x 2.5 cm x .1 cm, left posterior thigh was a deep tissue injury and measured 7.5 cm x 4.5 cm x 0, and the left heel was a deep tissue injury and measured 5 cm x 6.5 cm x 0. The sacral had tan serosanguinous drainage with a mild odor. R1's skin damage was already there prior to being admitted to the hospital and was of the largest wounds she had ever seen as a wound nurse in 8 years. When a deep tissue injury occurred, it took up to 72 hours to show up and sometimes it looked like a discoloration and then opened. During an interview on [DATE] at 3:29 p.m. hospital social worker (SW) stated R1 was admitted to the hospital on [DATE] and pictures were taken of her skin with numerous skin concerns right away. She had reddened areas on her bottom and thigh and a large wound located on the sacrum that measured approximately three inches by three inches with a black necrotic center. Hard to believe the nurse's that provided care for R1 and assessed her skin did not notice some type of skin condition changes especially the large one the sacrum. The sacrum wound required treatment and not something only barrier cream would have taken care of. It was very disturbing to see this extensive damage to her skin. (continued on next page)

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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:13 a.m. facility NP-A stated standard nursing care provided by nursing staff were expected to have visibility observed resident's skin every time during cares and weekly skin assessments for skin breakdown and reported it to the nurse or nurse manager. NP-A verified there was a huge gap of communication among staff regarding R1's skin issued and lacked documentation in her electronic medical record progress notes. NP-A viewed the hospital pictures taken of R1's skin and stated the sacrum wound have developed over several weeks and did not happen overnight. R1's left heel had the start of necrosis, was malnourished, and most likely could have developed in a couple of days to a week but not overnight, that was for sure. Her expectation would have been to be notified when there was a change in condition right away or at least within the shift. R1's wounds could have been prevented if caught earlier and thorough skin assessments had been completed. There was harm done here and she was very worried about R1. During an interview on [DATE] at 1:16 p.m. LPN-B stated she completed R1's weekly skin assessments on [DATE], [DATE], and [DATE]. She completed the skin assessment when R1 had a shower day and may have sat in a shower chair or while the nursing assistant changed her brief in bed, unsure of the last time she assessed her while she laid in bed. R1 sat in the wheelchair fully dressed and she visualized only the skin not covered by clothing. She was not always able to assess the skin and relied on the NA's and asked them if they saw any skin problems when they checked and changed, repositioned, or transferred her. She cleaned around the gastrostomy tube (G-tube) and placed Neosporin (antibiotic ointment used to reduce the risk of infections) and change the dressing. She was unsure as to what should have been included on the weekly assessments. When she removed the sponge dressing from around R1's G-tube she noted a minimal red bloody drainage dried onto the dressing, possibly for the past three weeks. R1's bottom was red, and ointment was applied but lately that area had opened up. Last time she saw R1's bottom was the Tuesday [DATE], before she was sent into ER. She thought R1 had been seen by the wound team and the floor nurse manager was aware of it. She had not received any education on skin assessments. During a follow-up interview on [DATE] at 2:15 p.m. LPN-B stated she should have completed her weekly skin assessments only after visually seeing all of R1's skin and not relied on the NA's for an assessment of her skin. She was aware of skin issues on R1's bottom during the three weekly skin assessments she completed in March. She had documented R1 had a red area but did not document the area had opened, was black in color on her sacrum and should have documented and updated the floor manager. (continued on next page)

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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:54 p.m. licensed practical nurse (LPN)-C clinical coordinator stated nursing staff would be expected to have completed a weekly skin assessment on each resident. The weekly skin assessment was usually scheduled on the same day as their bath day while in the shower without clothing on or if in the morning while the resident laid in bed so that the entire body and especially their bottom could be assessed. Nursing staff would be expected to have written up a risk management report, documented in the progress notes including measurements, called the provider and request an order to treat those area that were concerning. During the following morning meeting new skin concerns would have been reviewed, then reviewed by risk management and arranged for resident to be seen weekly by the wound care provider to have followed up. R1 had not had skin issues until the week before she went in to the hospital on (since last skin check [DATE]), floating her heels while in bed was not required, could have been an intervention but what were doing was working. Although, appartently it wasn't working after what happened to her skin. The family should have been notified along with the provider so that interventions could have been identified to help prevent the identified area(s) from getting worse and/or prevention of any new areas. The last weekly skin assessment competed on R1 identified she had redness to her bottom, started treating it with A and D ointment (house barrier cream) with brief changes on [DATE]. There were no specific details placed in the weekly skin assessment such as size of reddened area or progress notes written. When a resident's bottom had been identified with a new skin problem such as a red area that would have been considered a change in condition and the provider should have been notified. On [DATE], she was informed by NA-C R1 had a red area on her bottom. During an interview on [DATE] at 8:46 a.m. facility wound provider/ nurse practitioner (NP)-A stated staff were expected to remove the residents clothing prior to completing a weekly skin assessment so that the entire body could have been viewed. She expected staff to make her aware of any resident skin concerns so that they could have been taken care of appropriately, prevented from getting worse and/or getting them in other areas. NP-A viewed R1's pictures of her wounds and stated those pictures are worrisome and if those areas are left untreated especially when she was a diabetic could have led to a bad outcome such as death. During an interview on [DATE] at 12:15 p.m. director of nursing stated nursing staff were expected to complete the weekly skin assessments after they have completed a thorough skin assessment without the resident's clothes on. The NA's were expected to visualize the resident's skin and report any new concerns to the nurse and/or floor manager. The nurse would be expected to document any new skin concerns, where it was located and size on the assessment and in the progress notes. Previous skin concerns such as wounds and/or G-tube sites would not be included on the weekly skin assessment forms. All new skin concerns should have been reported to the floor manager, wound team, and provider and family notified. The floor manager should have followed up and assessed R1's skin when concerns were brought to her from staff. Review of licensed practical nurse (LPN)-B's education records from [DATE] through [DATE] identified courses completed: patient bill of rights, advanced directives, abuse/neglect, infection control, Alzheimer's, bloodborne pathogens, dementia, body mechanics, stopping the spread of infection and disease, fraud/waste and abuse in behavioral health settings, and tuberculosis awareness and control strategies. Review of her competencies dated [DATE], identified an annual skill fair included: hand washing, enteral feeding, colostomy care, wound care, medication administration, intravenous/peripherally inserted catheter (PICC) line, blood glucose monitoring, provider orders for lift sustaining treatment (POLST)/cardiopulmonary resuscitation (CPR), risk management, care of the actively dying, and post death checklist. (continued on next page)

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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Skin Assessment and Wound Management dated ,d+[DATE], identified a pressure ulcer risk assessment (Braden Scale) will be completed per facility's assessment schedule/Grid. Implement appropriate preventive skin measures (e.g. repositioning plan, pressure distribution plan). Skin evaluation and skin risk factors form is completed before initial MDS, annually, and upon significant change. Staff will perform routine skin inspections with daily care. Nurses are to be notified if skin changes are identified. A weekly skin inspection will be completed by licensed staff. When a significant alteration in skin integrity or new skin problem was notified (i.e. large or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken. 1. Notify provider/treatment ordered 2. Notify resident representative 3. Complete education with resident/resident representative including risks and benefits. 4. Initiate skin and wound evaluation. 5. Notify nurse manager/wound nurse. 6. Refer to dietary and therapies, if appropriate. 7. Review and update care plan involving interviews. 8. Update resident care lists 9. Update care plan to identify risks for skin breakdown.

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	04/15/2025

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 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** 43367 Based on observation, interview, and document review the facility failed to ensure appropriate personal protective equipment (PPE) practices were performed during a high contact care activity for 1 of 2 residents (R3) in enhanced barrier precautions (EBP) with an indwelling device. Findings include: R3's annual Minimum Data Set, dated dated dated [DATE], identified intact cognition without behaviors. He had a functional limitation of range of motion in lower bilaterally and used an electric wheelchair for mobility. He was dependent upon nursing staff for all personal cares, transfers and toileting and personal hygiene. He had an indwelling urinary catheter and frequently incontinent of bowel. He had medical diagnoses of diabetes mellitus (DM), cerebral palsy, neurogenic bladder, paraplegia (paralysis of the lower extremities), arthritis and on anticoagulants (blood thinners). R3's care plan dated 3/6/25, identified he was on enhanced barrier precautions (EBP) related to indwelling urinary catheter with a history of urinary tract infections (UTI) and wounds. Staff were directed to follow EBP and don and doff PPE when providing cares. During an interview/observation on 4/10/25 at 9:55 a.m. R3 sat in an electric wheelchair slightly reclined backward with his feet/legs elevated. He was born with cerebral palsy and used a wheelchair for over [AGE] years. He had a neurogenic bladder, indwelling urinary catheter for over [AGE] years, and urinary tract infections every now and then. His catheter had been pulled out and had to be reinserted a few days ago during cares. The catheter bag was usually emptied by the staff at the end of the shift. (continued on next page)

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	04/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation 4/10/25 at 2:15 p.m. nursing assistant (NA)-A stood in hallway in front of R3's room with a mask on, sanitized her hands, grabbed gloves from a box located on top of an PPE cart with drawers, and applied the gloves. Located on the outside of his door was signage titled Enhanced Barrier Precautions: staff required to place on PEE (gown and gloves) to complete any cares with a resident and/or work with a wound, insertion sites such as a gastrostomy (g-tube) (a tube surgically placed through the stomach wall to administer supplemental feedings, medications, and hydration) and indwelling catheters, and colostomies. NA-A entered the room and explained she planned to empty his urinary catheter bag. NA-A went into the bathroom picked up the empty container located on the backside of the toilet, paper towels, and alcohol wipes. She placed the paper towels on the floor and empty container on top of them. She reached for the catheter bag that hung underneath his electric wheelchair, laid it between his lower legs, removed the catheter tip from the bag holder, and struggled to open the spout to drain the urine. R3 had approximately 400 milliners (ml) of blood-tinged urine in the collection bag. After many attempts, without wiping off the end of the catheter tubing, turned the clamp, and urine flowed into the container located on the floor. Once the collection bag was emptied, she attempted to close the spout and the end of the tubing flipped back and forth, touched the inside of the container, into the urine that had been collected, and caused splashes of urine onto the floor and paper towels. There was a strong odor to the urine. Once the clamp was secured, she wiped off the end of the tubing and placed it back into the holder located on the collection bag. She picked up the collection container, dumped the urine into the bathroom toilet, and placed the container on the back of the toilet. She removed her gloves, washed her hands with soap and water, picked up the empty container with her bare hands, turned on the water and ran water into it from the bathroom sink. She swished it around, dumped it into the toilet, placed container on the backside of the toilet, and washed her hands with soap and water. With bare hands she hung the catheter collection bag underneath the electric wheelchair and adjusted his clothing. She went back into the bathroom and applied a pair of gloves, picked up the urine splattered paper towels from the floor, wiped up the urine on the floor, and discarded the paper towels in the garbage. She removed her gloves, washed her hands with soap and water, asked him if he needed anything else, and exited the room. She verified the urine was blood tinged, had a strong odor to it, and planned to update the nurse. No protective gown was worn. During an interview on 4/10/25 at 2:30 p.m. NA-A stated R3 was dependent upon nursing staff for the care of his indwelling urinary catheter and emptying the collection bag. She had emptied many urinary catheters and was aware of the precaution signs located on resident doors but did not fully understand why R3 was included and unsure what and when those precautions should have been followed. She walked back to his room and read the enhanced barrier sign located on his door. She stated an isolation gown should have been worn while she worked with the urinary catheter to protect herself and resident from the spread of germs. She should have worn gloves when collection container was rinsed out and wiped off the end of the catheter tubing prior to emptying the urine from it to prevent the spread of bacteria which caused infection. She had a hard time opening the catheter spout, urine went all over the floor and made quite the mess. During an interview on 4/11/25 at 11:45 a.m. NA-B stated staff were expected to wear an isolation gown and gloves when they emptied a urinary indwelling catheter bag to help prevent the spread of germ and infection. Staff emptied the catheter bags at the end of each shift. Residents with a catheter should have been placed in enhanced barrier precautions, a sign posted outside the door with an isolation cart that contained PPE supplies. (continued on next page)

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	04/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/25 at 2:20 p.m. licensed practical nurse (LPN)-A stated nursing staff were expected to wear PPE when a resident was placed on enhanced barrier precautions and emptied a urinary catheter bag to help prevent the spread of germ and urinary tract infections. The end of the catheter tube should have been cleaned off with an alcohol swab prior to emptying the urine out of the bag and after to prevent bacteria from entering the catheter bag. During a conversation on 4/10/25 at 4:00 p.m. director of nursing (DON) stated she was made aware of the incident NA and lacked wearing PPE during working with an indwelling urinary catheter. Education was provided to staff right away on 4/10/25 on precautions, proper donning, and doffing of PPE. A full house audit of the facility was completed. She ensured precaution signs were placed, and proper supplies were placed in rooms and hallways. Facility policy Indwelling Catheter Care Procedure dated 7/21/23, identified when emptying the catheter bag, don new gloves, uncap bottom outlet of bag, drain urine into measuring container, cleanse outlet with alcohol swab, and recap outlet. Measure and dispose of it in toilet. Remove gloves and wash hands. Facility policy Enhanced Barrier Precautions dated 4/1/24, identified it is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms (MDRO). Definition of enhanced barrier precautions refers to the use of gown and gloves for use during high contact resident cares activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Clear signage would be posted on the door or wall outside of the resident's room including type of precautions. Implement enhanced barrier precautions for residents with any of the following: 1. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers). 2. Indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if a resident was not known to be infected or colonized with MDRO. Implementation of enhanced barrier precautions: the infection preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. High-contact resident care activities include dressing, bathing, transferring, provide hygiene, changing linens and briefs, assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, and tracheostomy/ventilators, and wound care and any skin opening requiring a dressing.