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	08/04/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a dignified living existence for 3 of 3 residents (R1, R2, and R3) reviewed. Staff failed to respond timely to the residents, leaving them incontinent of stool in their beds while waiting on staff assistance. Findings include: Upon observation and interview on 8/4/25 at 10:35 a.m. R1 was lying on her back in her bed. R1's room smelled of bowel movement (BM) odor. R1 stated she had a BM, turned on her light at approximately 9:00 a.m. A nursing assistant (NA) came into her room, turned off the light and had not returned. R1 stated that was the practice every morning. R1 stated she felt inhuman sitting in her own feces every morning. At 10:39 a.m. R1 put on her call again. At 10:43 NA-A came into her room, turned off her call light and stated she would go the other NA to assist her. At 10:48 a.m. NA-A and NA-B returned to assist R1. NA-A and NA-B changed R1's incontinent brief that consisted of wet BM saturated into the incontinent pad and dried BM on R1's labial folds (folds in her vaginal region). R1's bed sheets had dried BM on them. The NA's washed R1 and changed R1's incontinent brief. R1 directed her care telling the NA's where to put the lotions and powder. R1 was then put into the mechanical lift and seated in her wheelchair. This process ended at 11:35 a.m. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 did not have any behaviors of physical or verbal behaviors directed towards other. R1 was totally dependent upon staff assistance with toileting hygiene, showing, lower body dressing and transferring from bed to chair. R1 required moderate assistance with rolling in bed and sitting to lying in bed. R1 was frequently incontinent of bowel and bladder. R1's pertinent diagnoses were fracture of the right femur (hip), morbid obesity, acute respiratory failure, and muscle weakness. R1's care plan dated 7/26/25 indicated R1 required assistance of two staff with toileting, provide incontinence products and assist to change, monitor bowel movements as they occur, check, and change R1's incontinent brief prior to getting out bed in the morning. R2's annual MDS dated [DATE] indicated R2's BIMS score was a 15 indicating he was cognitively intact. R2 was totally dependent upon staff assistance with toileting hygiene, showering, lower body dressing, personal hygiene, and transferring from sit to stand and bed to chair. He required moderate assistance with sitting to lying in bed and dressing upper body. R2 had a foley indwelling catheter and was frequently incontinent of stool. R2's pertinent diagnoses were acute and chronic respiratory failure, morbid obesity, and blindness of both eyes at different category levels. R2's care plan dated 8/4/25 indicated R2 required assistance of 1-2 with toileting, pad changes and peri-care, provide incontinence products (brief) and assist to change, monitor bowel movements as they occur. Upon interview on 8/4/25 at 1:09 p.m. R2 stated he had concerns at the facility. He stated his concern was long wait times and he believed it was due to staffing. On 8/1/25 he had a BM at around 2:00 a.m. and put on his call light, an unidentified NA answered the light and turned it off and told R2 she was busy and returned to change his incontinent brief after 3:00 a.m. R2 stated it was not just he felt undignified, but having to wait with bowel incontinence kept him awake while waiting and then angry about the waiting the rest of the night. The other time he stated he waited in my own filth was about a week before that on the evening shift. He stated he could not recall the exact day or time, but that time his light was not answered in over an hour as he sat incontinent of BM. R3's quarterly MDS dated [DATE] indicated R3 had a BIMS score of 15 indicating R3 was cognitively intact. R3 was dependent on staff assistance with bed mobility, transferring, toileting hygiene, and lower body dressing. R3's was frequently incontinent of bowel and bladder. R3's pertinent diagnoses were Type 2 Diabetes, morbid obesity, and lymphedema (swelling in the arms and legs caused by lymphatic system blockage). R3's care plan dated 8/4/25 indicated R3 required assistance of two staff with toileting, staff was to provide assistance with peri-care in the morning, bedtime, and as needed, monitor bowel movements as they occur. Upon interview on 8/4/25 at 2:15 p.m. R3 stated she felt the average wait time for her call light to be answered was 30 - 60 minutes. R3 had diarrhea often and when staff make her sit in it R3 would keep turning the call light on after staff would turn it off until she was cleaned up. She stated, I can't even venture to say how often it happens. Upon interview on 8/4/25 at 12:09 nursing assistant (NA)-A stated in the mornings between 6:30 am to 7:30 the NA's are busy getting residents up and to the dining room for breakfast. Then they pass breakfast trays to residents who stay in their rooms before the food gets cold. R1 did have BM's every morning and her cares required 2 staff members and at least 45 minutes each morning. Staff does not get R1 cleaned up and out of bed until around 10:00 a.m. in the mornings. The unit is staffed