STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. Building B. Wing	02/23/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to develop care plans for 2 of 3 residents (R2, R3) reviewed for baths/ showers. R2 and R3 refused baths/showers and their care plans did not include interventions for refusals. Findings include: R2's quarterly MDS dated [DATE] indicated intact cognition, paralysis on one side of the body related to stroke, was fully dependent upon staff assistance for bathing, and identified no refusals of bathing/showering. R2's care plan dated 7/7/23 indicated a self-care deficit related to stroke and left-sided weakness, had a history of refusing ADLs, and starting 7/12/23 required assistance of one staff for bathing/showers. The care plan lacked interventions for refusal of bathing and/or showers. R2's Weekly Skin Assessments dated 1/26/26, 2/2/26, 2/9/26, indicated R2 refused showers. During an interview on 2/20/26 at 3:55 p.m., NA-A stated R2 refused showers frequently, but did not know why. NA-A stated staff should offer another shower time when R2 refused but did not know if alternate times were offered. Further, NA-A stated if residents refused showers, the nurse managers should be notified. During an interview on 2/20/26 at 4:03 p.m., during an interview NA-B stated R2 only allowed certain staff to assist with showers and the care plan should indicate that preference. During an interview on 2/23/26 at 1:56 p.m., LPN-A acknowledged R2 missed baths, had a history of refusing baths, and should have a risk/benefit form in place for refusals of showers, but did not. LPN-A stated when residents refused showers, staff should continue to offer showers at another time or day, but acknowledged the medical record lacked indication staff offered other times. LPN-A stated the care plan lacked interventions for staff to follow for R2's bath refusals but acknowledged care plans should have interventions for staff to try when residents refused baths. R3's quarterly MDS dated [DATE] indicated intact cognition, and diagnoses that included traumatic brain injury, a seizure disorder, heart disease, and lung disease. R3 required supervision or touch assistance with bathing and identified no refusals of bathing/showering. R3's care plan dated 6/4/25, indicated R3 had a self-care deficit related to weakness but was independent with bathing, but lacked indication R3 required supervision or touch assistance with bathing. Weekly Skin Inspections dated 1/13/26, 1/20/26, 1/27/26, and 2/3/26 indicated R3 refused showers. During an interview and observations on 2/20/26 at 5:18 p.m., R3 appeared disheveled, and had body odor. R3 stated he did not bathe weekly because he did not feel physically strong enough some weeks, and staff did not offer to help or ask if he showered. R3 was unsure when he last showered. During an interview on 2/23/26 at 12:24 p.m., RN-A acknowledged R3 had a self-care deficit related to weakness, did not bathe weekly, refused showers four weeks in a row, and had no independent showers documented from 1/13/26 to 2/3/26. RN-A stated she was not aware R3 refused showers but may now need reminders and set-up for showers to ensure he bathed regularly. RN-A acknowledged R3's care plan lacked interventions to promote bathing when R3 refused or when R3 did not perform bathing independently. During an interview on 2/23/26 at 1:56 p.m., LPN-A stated she witnessed R3 perform (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showers on his own but did not see where they were documented. LPN-A acknowledged R3's Weekly Skin Inspections indicated showers were refused from 1/13/26 to 2/3/26 LPN-A stated if R3 refused showers, staff should provide education to R3 about the risks and benefits of not keeping clean, and the care plan should indicate a risk/benefits discussion for refusals and interventions for staff to try in the case of refusals. During an interview on 2/23/26 at 4:37 p.m., the director of nursing (DON)stated when residents refuse a bath, the expectation was for staff to do a risk/benefit with education to the resident, notify the resident's provider, notify the power of attorney, and try different interventions and approaches. The interventions that were successful should be on the resident's care plan. The DON stated care plans should be updated when changes to care are made. Further, the DON stated she was not aware R2 and R3 missed baths for several weeks and acknowledged neither had interventions in their care plans to address care refusals but should have. The Care Planning policy dated 11/2024 indicated the care plan would be used in developing the residents' daily care routines and utilized by staff for the purpose of providing care to the residents. The care plan is to be modified and updated as the condition and care needs of the residents change.