STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER: The Villas at New Brighton		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide an opportunity for 1 of 3 residents (R1) reviewed for care planning to participate in the development of the plan of care.Findings Include: During an observation on 3/20/26, at 8:30 a.m., R1 was seated at the edge of the floor mattress. Her breakfast tray was positioned to her left side on the floor mattress. R1 was leaning on her left elbow as she reached with a fork, using her right hand to eat the food from her tray. Food was observed falling on to the mattress as she tried to eat. R1's admission Minimum Data Set (MDS), dated [DATE], indicated she had diagnoses of heart failure and respiratory failure, she had severe cognitive impairment, was Hmong speaking, and was dependent for all cares and transfers. R1's care plan, dated 2/18/26, indicated she was a fall risk and had a fall mat at her bedside. She required assistance with cares including eating, bed mobility, and transfers, using two staff and a full body mechanical lift. R1's electronic medical record lacked documentation of a care conference and indicated she was admitted on [DATE]. During an interview on 3/19/26, at 4:30 p.m., the administrator stated conferences were offered within three weeks of admission and then quarterly. During an interview on 3/20/26, at 8:35 a.m., NA-B stated R1 frequently crawled off her bed to the mattress on the floor. Staff only put R1 in her wheelchair when her family would be present so they could watch her. She stated they give R1 bed baths because it would take up to three staff to give her a shower. During an interview on 3/20/26, at 8:48 a.m., NA-A stated R1 was eating her breakfast on the floor mattress because they were serving breakfast trays and there was not time to get R1 back into her bed. She was unsure whether it bothered R1. NA-A stated, some cultures, like Hmong, like to be on the floor. During an interview on 3/20/26, at 10:04 a.m., the social services director (SSD) stated resident preferences are elicited during the initial assessments and a care conference within the first 21 days and then held quarterly. R1 should have had a care conference but did was unable to locate the documentation. She stated it would be located in the forms section of the electronic medical record and mentioned in the progress notes. During an interview on 3/20/26, at 10:16 a.m., the clinical leader/licensed practical nurse (LPN)-A stated care conferences were intended to discuss medications, concerns with cares, comfort, and complaints. She thought care conferences should occur within seven days of admission and quarterly. The floor mattress was intended as a fall prevention intervention when R1 was admitted . She stated R1 seemed comfortable on the floor mattress and liked to sit on it, so she care planned for that. During an interview on 3/20/26, at 1:30 p.m., the DON stated resident preferences were determined by their initial assessments and care conferences. The care conferences are held within five days and after that every quarter. R1 had not had a care conference since she was admitted on [DATE] but should have had one. The DON stated the purpose of the care conference was to ensure the residents were comfortable, happy and the facility was meeting their needs. It gave an opportunity to keep the residents and family informed. During an interview on 3/20/26, at 3:15 p.m., FM-A stated she was never offered a care conference. She was in favor of a mattress on the floor next to R1's bed so she would not get hurt but she was not pleased that R1 was left on the floor mattress for hours, she would prefer for R1 to be offered the (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: 245164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toilet or commode, would prefer R1 to have a shower instead of a bed bath, and it was not their culture to eat on the floor. During an interview on 3/20/26, at 3:55 p.m., the administrator stated there had not been a care conference for R1. A facility policy, Resident Rights, dated 11/2025, directed it is the practice of this facility to uphold the rights of all residents. The policy included a link to the Combined Federal and State [NAME] of Rights, dated 12/22/2025, which directed the resident has the right to be informed of, and participate in, their treatment, including: -The right to participate in the development and implementation of their person-centered plan of care, including but not limited to:-The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.-The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.-The right to be informed, in advance, of changes to the plan of care.-The right to receive the services and/or items included in the plan of care.-The right to see the care plan, including the right to sign after significant changes to the plan of care.The facility shall inform the residents of the right to participate in their treatment and shall support the residents in this right. The planning process must: facilitate the inclusion of the resident and/or resident representative, include an assessment of the resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing goals of care. A facility policy, Care Planning, dated 11/2024, directed each resident will have a person-centered care plan developed by the interdisciplinary team IDT) for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The IDT, in conjunction with the resident and the resident representative, will develop a comprehensive care plan no later than the 21st day of admission of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER The Villas at New Brighton		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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** Based on interviews and document reviews, the facility failed to ensure care was delivered in accordance with professional standards and care planning for 1 of 3 residents (R1) reviewed for quality of care. R1 had severe cognitive impairment and frequently crawled out of bed to the floor. This resulted in Psychosocial harm for R1 when staff would drag R1 from the floor to the bed for repositioning without the care planned use of a mechanical lift. A reasonable person concept is applied in determining what the psychosocial outcome would have on a reasonable person in a similar situation to suffer because of the noncompliance. Findings Include: Observation of R1's room on 3/19/26 at 2:40 p.m., was a shared room, where her space was closest to the door with a privacy curtain between her side and her roommate's side. R1's bed was against the wall, lengthwise. There was a hospital bed mattress located on the floor along R1's bed, which was approximately six inches lower than the bed, as the bed was in the lowest position. There was a bedside table against the wall immediately next to the door and an oxygen concentrator located near the foot of the bed. Review of video from R1's room, on 3/9/26 at 7:45 a.m. was approximately 1 minute 30 seconds. R1's bed was in a low position. R1's body was partially on the bed and on the floor. She was lying on her back, face up, at the width of the bed, with her hips and legs on the floor, and her waist, chest, and head on the bed. R1 was dressed in a gown with no undergarments. Nursing assistant (NA)-A was standing at the center of R1's bed, bending over at her waist, grabbing the front of R1's hospital gown with both hands near each armpit dragging R1 from the mattress on the floor onto the bed. NA-A paused when R1 was partially on the bed, facing up from her midback to her head. R1's left hand appeared to be grasping for NA-A's forearm. Then NA-A walked off R1's bed. NA-A and NA-B pushed R1's right leg up and over her left side on to the bed. NA-A then pushed R1's left hip, with the help of NA-B pushing R1's left leg, to rotate R1 into the center of the bed lengthwise in a prone. R1's head was now at the head of the bed and her feet at the bottom of the bed, she was face down, with her left arm tucked under her chest and right arm off to her right side. R1 moans when NA-A pulled R1's left arm out from under R1's chest. R1 was left in the prone position on her bed, exposed from the waist down without undergarments. R1's hospital admission history and physical, dated 2/11/26, indicated R1 was [AGE] years old who had cognitive impairment, limited capacity to understand instructions, was very hard of hearing, and required the use of a translator. R1 had been declining for months due to pain and had not been ambulatory using a wheelchair for mobility. R1 was currently living in an assisted living facility. R1 was evaluated and treated for heart failure and would need placement at a skilled nursing facility. R1's admission Minimum Data Set (MDS), dated [DATE], indicated she had diagnoses of heart failure and respiratory failure, severe cognitive impairment, was Hmong speaking, and was dependent on all cares and transfers. R1 was on hospice. R1's care plan, dated 2/18/26, indicated she was a fall risk and had a goal to be safe and free from falls. Interventions included R1 to use a soft touch call light for assistance, a fall mat at bedside when in bed, keeping the bed in a low position and to monitor R1 for falls determining possible root causes. R1 had an alteration in mobility with a goal to move safely within her environment. Interventions included to assist with movement in bed and in/out of bed, and assistance of two staff with a Hoyer lift and medium sling size. R1's NA guide, undated, indicated she required assistance from two staff and mechanical lift for transfers with medium sling size. Assistance of one staff to turn and reposition R1 every two to three hours, offer a bed pain or check and change her incontinent brief upon rising, before or after meals, at bedtime and as needed. R1 frequently removes incontinent brief, reapply when observed. She was a fall risk with bed in low position and a floor mat beside bed. R1 lies on floor mat occasionally per preference. Hmong speaking with translator phone numbers were listed. A facility staff schedule dated 3/9/26, indicated NA-A and NA-B were both working 6:30 a.m. to 2:30 p.m. on 3/9/26. During an interview on 3/19/26, at 3:33 p.m., family member (FM)-A stated she could hear R1 saying hurt, hurt in Hmong when she watched (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	the video of the transfer on 3/9/26. She stated she felt it was abusive and thought R1 was scared and in pain. FM-A stated the staff were supposed to use the mechanical lift to move her. Following another interview with FM-A on 3/20/26 at 3:15 p.m. she had not been offered a care conference or asked for preference of care. She stated it was not R1's preference or culture to stay on the floor. During an interview on 3/20/26, at 8:35 a.m., NA-B stated R1 frequently crawled off her bed to the mattress on the floor. She was aware R1 was to be transferred with the mechanical lift and two staff but there was no room to bring the mechanical lift into the room and fit it around the large floor mattress. She and NA-A were frequently transferring R1 back to bed in a similar manner, without using a mechanical lift, over the previous weeks. NA-B stated neither she nor NA-A told the nurses, clinical leader or director of nursing (DON) they were not using the mechanical lift to transfer R1 into bed from her floor mattress because it was difficult. During an interview on 3/20/26, at 8:48 a.m., NA-A stated she and NA-B had R1 crawl up on the bed on 3/9/26, then pushed her hip to roll her over and never dragged R1 by her clothing. She stated she was aware R1 was to be transferred with the mechanical lift and two staff. She stated she thought they were doing the right thing and did not talk to a nurse, clinical leader, or DON regarding transferring R1 into bed from her floor mattress. During an interview on 3/20/26, at 9:55 a.m., the nurse practitioner (NP) stated she was informed of an inappropriate transfer but had not seen the video. Transferring R1 with the mechanical lift was the safest manner to avoid orthopedic injuries such as dislocation and muscle strains. During an interview on 3/20/26, at 10:16 a.m., the clinical leader/licensed practical nurse (LPN)-A stated R1 was to be transferred with assistance of two staff and a mechanical lift. She was not made aware of any challenges staff had with transfers. During an interview on 3/20/26, at 12:25 p.m., the administrator stated R1 appeared uncomfortable during the transfer seen on the video from 3/9/26 and none of the staff had previously approached her about challenges with transferring R1 back into her bed. During an interview on 3/20/26, at 1:30 p.m., the DON stated R1 required a mechanical lift and assistance from two staff because she could not stand on her own or bear her own weight. She stated the video demonstrated an improper transfer and R1 should always be transferred with the mechanical lift and two staff. She stated NA-A and NA-B should have asked a manager if they were not sure how to safely transfer R1. The facility Safe Resident Handling policy, dated 11/2025, directed all resident care will be provided in a safe, appropriate, and timely manner in accordance with the individual resident's care plan. Manual lifting of all residents who are unable to bear weight will be minimized. Residents identified as totally dependent or extensive assistance, for example, will be transferred by means of lift equipment and/or other resident assistance devices instead of a manual lift. The facility Care Planning, dated 11/2024, directed the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purpose of providing care or services to the residents. The plan of care will be utilized to provide care for the residents. The care plan is to be modified and updated as the condition and care needs of the resident changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER The Villas at New Brighton		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on interview and record review the facility failed to follow established infection control practices for 1 of 3 residents (R1) reviewed for hand hygiene when staff failed to perform hand hygiene.Findings Include: During an observation on 3/19/26, at 2:40 p.m., nursing assistant (NA)-C and NA-D performed incontinence cares for R1 in her bed. NA-D assisted with positioning of R1 in her bed as NA-C removed the soiled brief, wiped R1's perineum and buttocks, then discarded the brief and wipes. She failed to remove her gloves and perform hand hygiene. NA-C proceeded to place a clean brief under R1, apply barrier cream to her perineum, fasten the brief, position draw sheet, assist to lift R1 with NA-D, position bedding, clip the call light to the bedding, positioned R1's oxygen tubing in her nostrils, moved the bed back to its original location and positioned the privacy curtain before NA-C removed her soiled gloves and performed hand hygiene. R1's admission Minimum Data Set (MDS), dated [DATE], indicated she had diagnoses of heart failure and respiratory failure, severe cognitive impairment, was frequently incontinent of bowel and bladder, and was dependent on facility staff for all cares and transfers, and was Hmong speaking. R1's care plan, dated 2/18/26, indicated she required assistance with cares including bed mobility, transfers, and incontinent care. R1's NA guide, undated, indicated she required assistance with incontinence care every 2 - 3 hours. A facility grievance/complaint form, dated 3/16/26, indicated LPN-A was aware staff were not changing gloves between changing R1's brief and adjusting her oxygen tubing in her nose. During an interview on 3/19/26, at 2:52 p.m., NA-C stated she should have changed her gloves and performed hand hygiene after performing peri care to prevent infection. During an interview on 3/19/26, at 3:33 p.m., family member (FM)-A stated she had observed staff not changing their gloves after performing peri care on the camera she had set up in R1's room. She stated this was shared with the clinical leader/licensed practical nurse (LPN)-A on 3/16/26. During an interview on 3/20/26, at 10:16 a.m., LPN-A stated gloves should be changed between dirty and clean tasks. Hand hygiene should be performed any time gloves are changed. LPN-A stated she received a grievance regarding R1's cares and staff failing to change their gloves after changing her brief on 3/16/26 and provided verbal education to nursing staff. During an interview on 3/20/26, at 1:30 p.m., the director of nursing (DON) stated gloves should be changed before and after providing care and after changing briefs. Hand hygiene should be performed before and after each care provided to the residents to reduce infection risk. A facility document, Handwashing Policy, dated 11/2019, directed proper hand washing techniques should be used to protect the spread of infection: after changing incontinent products. When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.