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	02/11/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review the facility failed ensure a resident was allowed to dress in a manner of her choosing for 1 of 1 residents (R59) reviewed for dignity. Findings Include: R59's quarterly Minimum Data Set (MDS) dated [DATE], indicated R59 was severely cognitively impaired and required moderate assistance with dressing her upper body and was dependent with dressing her lower body. R59 had a diagnosis of hemiplegia (inability to move one side of her body) following a cerebral infarction (stroke) on her right dominate side. On 2/3/25 at 5:40 p.m., R59 was observed next to the nurse's station in a wheelchair with legs elevated and covered with a blanket, dressed in a hospital gown. R59's hair was brushed. On 2/4/25 at 3:17 p.m., R59 was observed sitting in a wheelchair next to the nurse's station with her legs elevated and covered with a blanket, dressed in a green hospital gown. R59 had a food tray with a lettuce salad on a tray in front of her and was holding a salmon-colored piece of paper. R59's fingernails on right hand were visible and were painted red. On 2/5/25 at 7:16 p.m., R59 was in a wheelchair in the hallway next to the nurse's station. R59's legs were elevated and covered with a blanket. R59 was wearing a pale blue hospital gown, awake and looking around. R59 did not appear agitated. During interview on 2/4/25 at 2:16 p.m., guardian (G)-A stated she visited R59 within the last month. G-A stated she spoke with the facility about R59 wearing a hospital gown and was informed R59 had a history of ripping her clothing, so they had started to put her in a hospital gown. G-A stated she had been attempting to speak with social worker (SW)-A regarding clothing for R59, but been playing phone tag. G-A stated she had concerns about R59 being in a public area in a hospital gown. During interview on 2/5/25 at 8:25 a.m., nurse manager (NM)-C stated R59 clothes had ripped and would fall off of her shoulders. NM-C stated R59 still wanted to wear her torn clothes. NM-C stated it was important for resident's to have their clothing preferences honored for dignity. NM-C stated staff would know a resident's preference because it would be noted on the care plan. (continued on next page)

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	During interview on 2/5/25 at 11:36 a.m., SW-A stated the facility would work with therapy, the family or guardian and look in the donation box if a resident did not have enough clothing. SW-A stated he did remember R59 had two dresses she preferred to wear. SW-A stated it should be care planned if a resident was more comfortable or preferred a hospital gown. SW-A confirmed R59's care plan did not specify she preferred a hospital gown. SW-A stated it was important for a resident's preferred style of dress to be honored for dignity. SW-A was unable to locate any notes regarding attempts to contact the guardian for R59. R59's care plan review date 1/13/25, included she had a self-care deficit related to a CVA and resident has her own style dress that is ripped on one side and don't change different style. Facility policy for clothing preferences requested and not provided.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review, the facility failed to properly assess 1 of 1 residents (R39) who wished to self-administer medications. Findings include: R39's quarterly Minimum Data Set (MDS) dated [DATE], included R39 was cognitively intact. R39 had diagnosis of congestive heart failure (CHF) and diabetes. R39 received high risk medications including anticoagulants (blood thinner) and diuretics (increases urine production). R39's care plan with review date 1/15/25, failed to include R39's ability to self-administer medications. R39's Self Administration of medication evaluation dated 1/27/21, indicated R39 was unsafe to administer medications independently. On 2/3/25 at 2:44 p.m., medications were observed on R39's dresser. One medication cup contained 4 grey and yellow capsules. A second medication cup contained two white oblong pills. During interview on 2/3/25 at 2:44 p.m., R39 identified the grey and yellow capsules as Tamiflu. He stated he had a reaction to the medication and was no longer taking it. He stated the facility was aware of the reaction and that he was no longer taking the medication. R39 identified the white pills as Tylenol. He stated he keeps them on his dresser until later in the day when his pain starts. During interview on 2/4/25 at 3:42 p.m., registered nurse (RN)-C stated it would be noted on the electronic medical record if a resident was able to have medications left in their room. RN-C confirmed R39 had 4 grey and yellow capsules on his dresser. During interview on 2/4/25 at 3:52 p.m., nurse manager (NM)-C stated a resident needed a self-administration assessment prior to medication being left in their room. NM-C was unable to locate a self-administration assessment or physician order for R39. NM-C confirmed R39 spoke with her about having an adverse reaction to the Tamiflu and that he would stop taking it. NM-C removed the medications from R39's room. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated medications could not be left in the patient's room unattended. The concern would be the patient taking them when not observed. Facility policy titled Self-Administration of Medications dated February 2024, included a comprehensive assessment from an interdisciplinary team would assess the cognitive and physical ability of a resident. The ability to safely self-administer medications would have been documented in the medical record and the care plan.

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27955 Based on interview and document review, the facility failed to ensure a system was in place to prevent the diversion of medications for 30 of 79 residents (R1, R5, R12, R15, R16, R27, R35, R41, R49, R50, R54, R58, R63, R73, R75, R76, R77, R141, R146, R149, R345, R25, R143, R144, R145, R147, R148, R150, and R151) reviewed for drug diversion and were free from misappropriation of their property when their medications to treat moderate to severe pain and other conditions were taken by a staff member. This resulted in diversion of 111 tablets of oxycodone 5 milligram (mg), 21 tablets of oxycodone 2.5 mg, 28 tablets of oxycodone 10 mg, 1 tablet Aderall, 6 tablets Percocet, and 4 tablets Ambien which resulted in the likelihood of serious harm or adverse event to residents prescribed controlled substances. The IJ began on 1/28/25, when registered nurse (RN)-A identified narcotics were given by trained medication assistant (TMA)-A via a G-Tube (flexible tube inserted in the abdomen and into the stomach) for R12 on a daily medication report. RN-A notified RN-B of the concern that TMA-A had given narcotic medication via the G-tube for a R12. The facility administrator and director of nursing (DON) were notified of the IJ on 2/11/25 at 3:45 p.m., which was identified at the scope and severity of K, pattern. The facility had implemented immediate corrective action on 1/30/25 to prevent recurrence, therefore the IJ was issued at past non-compliance. Findings include: Review of the facility narcotic record indicated TMA-A had signed out medications as removed from narcotic book and the medication cart, however TMA-A did not consistently document in the medication administration record (MAR) as administered. R1's annual Minimum Data Set (MDS), dated [DATE], indicated R1 was cognitively intact, and diagnoses included right-side paralysis following unspecified cerebrovascular disease and seizure disorder. R1's Order Summary Report, printed 2/11/25, indicated a physician order dated 12/17/24 for oxycodone (an opioid medication) 5 milligrams (mg) by mouth (po) every 24 hours as needed (PRN) for moderate to severe pain. R1's record indicated R1's oxycodone dosage was increased on 1/15/25 from 5 mg po every 24 hours PRN to 5 mg every 6 hours PRN with a maximum of 2 doses per day. R1's individual narcotic record indicated 25 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R1's Medication Administration Record (MAR), dated 1/1/25 to 1/31/25, indicated 19 doses of oxycodone were administered. Discrepancy of 6 doses. R5's quarterly MDS, dated [DATE], indicated R5 was cognitively intact, and diagnoses included atrial fibrillation (irregular heartbeat) and heart failure. R5's Order Summary Report, printed 2/11/25, indicated a physician order dated 10/2/24 for oxycodone 5 mg po two times a day (BID) PRN for moderate pain. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R5's individual narcotic record indicated 40 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R5's MAR dated 1/1/25 to 1/31/25, indicated 29 doses of oxycodone were administered. Discrepancy of 11 doses. R12's admission MDS, dated [DATE], indicated R12 was cognitively intact, and diagnoses included epilepsy, severe protein-calorie malnutrition, and muscle wasting and atrophy. R12's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/7/25 for oxycodone 5 mg via G-Tube (flexible tube inserted surgically through the abdominal wall into the stomach for delivering nutrition, fluids, and medications when a person is unable to eat/drink orally) every 4 hours PRN for pain. R12's individual narcotic record indicated 34 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25, with 7 doses signed out by TMA-A. However, R12's MAR dated 1/1/25 to 1/31/25, indicated 18 doses of oxycodone were administered, and 6 of the doses were administered by TMA-A. Additionally, R12's medications were ordered via G-tube, which required a nurse to administer R12's medications. TMA performing tasks not within their scope of practice. Discrepancy of 16 doses. R15's admission MDS, dated [DATE], indicated R15 was cognitively intact, and diagnoses included paraplegia (paralysis of all or part of the trunk, legs, and pelvic organs) and cerebral palsy. R15's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/10/25 for oxycodone 5 mg po every 6 hours PRN for pain; amphetamine-dextroamphetamine (Adderall) 5 mg po every morning related to attention and concentration deficit; and Adderall 5 mg po at noon PRN for attention and concentration deficit. R15's individual narcotic record indicated 3 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R15's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. Discrepancy of 1 dose. R15's individual narcotic record indicated 22 doses of Adderall were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R15's MAR dated 1/1/25 to 1/31/25, indicated 21 doses of Adderall were administered. Discrepancy of 1 dose. R16's quarterly MDS, dated [DATE], indicated R16 was cognitively intact, and diagnoses included acute osteomyelitis left femur (thigh bone infection) and intervertebral disc degeneration. R16's Order Summary Report, printed 2/11/25, indicated a physician order dated 9/30/24 for oxycodone 5 mg po every 6 hours PRN for pain. R16's individual narcotic record indicated 46 doses of oxycodone were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R16's MAR dated 1/1/25 to 1/31/25, indicated 33 doses of oxycodone were administered. Discrepancy of 13 doses. R27's admission MDS, dated [DATE], indicated R27 was cognitively intact, and diagnoses included cellulitis (skin infection) of left lower limb, and osteomyelitis of the tibia and fibula (long bones in the lower leg). (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R27's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 1/21/25 for oxycodone 2.5 mg po every 6 hours PRN for moderate to severe pain; a physician order dated 1/6/25 for Percocet - 1-tab po every 4 hours PRN for moderate pain; a physician order dated 1/7/25 for Ambien 10 mg po every 24 hours PRN for sleep; and a physician order dated 1/14/25 for Oxycontin 10 mg po BID for pain. R27's individual narcotic record indicated 9 doses of oxycodone were signed out of the narcotic log from 1/22/25 through 1/27/25. However, R27's MAR dated 1/1/25 to 1/31/25, indicated 6 doses of oxycodone were administered. Additionally, R27's individual narcotic record indicated 9 doses were sent with patient on 1/28/25. However, the document lacked a nurse's signature. Discrepancy of 12 doses. R27's individual narcotic record indicated 16 doses of Percocet were signed out of the narcotic log from 1/7/25 through 1/17/25. However, R27's MAR dated 1/1/25 to 1/31/25, indicated 10 doses of Percocet were administered. Discrepancy of 6 doses. R27's individual narcotic record indicated 7 doses of Ambien were signed out of the narcotic log from 1/12/25 through 1/27/25. However, R27's MAR dated 1/1/25 to 1/31/25, indicated 6 doses of Ambien were administered. Additionally, R27's individual narcotic record indicated 3 doses were sent with patient. However, the document contained 4 scribble marks and lacked a date. Discrepancy of 4 doses. R27's individual narcotic record indicated 2 doses of Oxycontin 10 mg were marked as sent with ex, error, multiple scribble marks, and distroid [sic]. However, the facility was unable to provide a Record of Disposal for the Oxycontin. Discrepancy of 2 doses. R35's admission MDS, dated [DATE], indicated R35 was cognitively intact, and diagnoses included fracture of right lower leg, osteoporosis, and heart failure. R35's MAR dated 1/1/25 to 1/31/25, indicated a physician order start date 12/31/24 for oxycodone 2.5 mg po every 24 hours PRN for pain, and discontinued date 1/20/25. R35's individual narcotic record indicated 11 doses of oxycodone were signed out of the narcotic log from 1/2/25 through 1/23/25, with 2 doses signed out on 1/23/25 (2 days after medication was discontinued). However, R35's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. Discrepancy of 9 doses. R41's quarterly MDS, dated [DATE], indicated R41 was cognitively intact, and diagnoses included right leg below knee amputation and heart failure. R41's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 1/25/25 for oxycodone 5 mg to 10 mg po every 4 hours PRN for pain. R41's individual narcotic record indicated 7 doses of oxycodone 5 mg were signed out of the narcotic log on 1/28/25. However, R41's MAR dated 1/1/25 to 1/31/25, indicated 6 doses of oxycodone 5 mg were administered on 1/28/25. Additionally, 6 doses of oxycodone 5 mg were signed out of the narcotic log on 1/29/25. However, R41's MAR dated 1/1/25 to 1/31/25, indicated 4 doses were administered on 1/29/25. Discrepancy of 3 doses. R49's admission MDS, dated [DATE], indicated R49 was cognitively intact, and diagnoses included fracture of left fibula and tibia (both long bones in lower leg) and respiratory failure. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R49's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/13/25 for oxycodone 5 mg po BID for pain. R49's individual narcotic record indicated 3 doses of oxycodone were signed out of the narcotic log from 1/14/25 through 1/18/25. However, R49's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. Discrepancy of 1 dose. R50's admission MDS, dated [DATE], indicated R50 was cognitively intact, and diagnoses included fracture of right femur (thigh bone) and asthma. R50's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 1/6/25 for oxycodone 5 mg po every 24 hours PRN for pain. R50's individual narcotic record indicated 20 doses of oxycodone were signed out of the narcotic log from 1/8/25 through 1/31/25. However, R50's MAR dated 1/1/25 to 1/31/25, indicated 14 doses of oxycodone were administered. Discrepancy of 6 doses. R54's admission MDS, dated [DATE], indicated R54 had mild cognitive impairment, and diagnoses included acute respiratory failure, osteoporosis, and R54 required tracheostomy care, suctioning, and a feeding tube. R54's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/8/25 for oxycodone 5 mg via PEG-tub every 6 hours PRN for moderate to severe pain. R54's individual narcotic record indicated 6 doses of oxycodone were signed out of the narcotic log from 1/24/25 through 1/25/25. However, R54's MAR dated 1/1/25 to 1/31/25, indicated 4 doses of oxycodone were administered. Discrepancy of 2 doses. R58's quarterly MDS, dated [DATE], indicated R58 was cognitively intact, and diagnoses included heart failure and right leg below knee amputation. R58's Order Summary Report, printed 2/11/25, indicated a physician order dated 7/22/24 for oxycodone 5 mg po PRN for pain. R58's individual narcotic record indicated 35 doses of oxycodone were signed out of the narcotic log from 1/7/25 through 1/23/25. However, R58's MAR dated 1/1/25 to 1/31/25, indicated 27 doses of oxycodone were administered. Discrepancy of 8 doses. R63's significant change MDS, dated [DATE], indicated R63 was cognitively intact, and diagnoses included left side hemiplegia and hemiparesis and rheumatoid arthritis. R63's MAR dated 1/1/25 to 1/31/25 indicated a physician order dated 1/3/25 for oxycodone 10 mg po every 4 hours PRN for moderate to severe pain. R63's individual narcotic record indicated 128 doses of oxycodone 10 mg were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R63's MAR dated 1/1/25 to 1/31/25, indicated 104 doses of oxycodone 10 mg were administered. Discrepancy of 24 doses. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R73's quarterly MDS, dated [DATE], indicated R73 was cognitively intact, and diagnoses included multiple fractures of pelvis, lumbar vertebra fracture, and multiple rib fractures. R73's Order Summary Report, printed 2/11/25, indicated a physician order dated 11/6/24 for oxycodone 5 mg po every 8 hours PRN for pain. R73's individual narcotic record indicated 60 doses of oxycodone 5 mg were signed out of the narcotic log from 1/1/25 through 1/31/25. However, R73's MAR dated 1/1/25 to 1/31/25, indicated 50 doses of oxycodone were administered. Discrepancy of 10 doses. R75's admission MDS, dated [DATE], indicated R75 had moderately impaired cognition, and diagnoses included pancreatic cancer and generalized abdominal pain. R75's Order Summary Report, printed 2/11/25, indicated a physician order dated 12/28/24 for oxycodone 5 mg po BID PRN for pain. R75's individual narcotic record indicated 5 doses of oxycodone 5 mg were signed out of the narcotic log from 1/17/25 through 1/20/25. However, R75's MAR dated 1/1/25 to 1/31/25, indicated 3 doses of oxycodone were administered. Discrepancy of 2 doses. R76's admission MDS, dated [DATE], indicated R76 was cognitively intact, and diagnoses included systemic lupus erythematosus (immune system attacks healthy tissues and organs), migraines, and cervicalgia (neck pain). R76's Order Summary Report, printed 2/11/25, indicated a physician order dated 12/24/24 for oxycodone 5 mg - 10 mg po every 6 hours PRN for pain. R76's individual narcotic record indicated 79 tabs of oxycodone 5 mg were signed out of the narcotic log from 1/2/25 through 1/31/25. However, R76's MAR dated 1/1/25 to 1/31/25, indicated 67 tabs oxycodone 5 mg were administered. Discrepancy of 12 doses. R77's quarterly MDS, dated [DATE], indicated R77 had severe cognitive impairment, and diagnoses included nontraumatic intracerebral hemorrhage (ruptured blood vessel causing bleeding in the brain), diabetes, and required a feeding tube. R77's Order Summary Report, printed 2/11/25, indicated a physician order dated 10/24/24 for oxycodone 5 mg via G-tube every 24 hours PRN for moderate pain. R77's individual narcotic record indicated 22 tabs of oxycodone 5 mg were signed out of the narcotic log from 1/1/25 through 1/29/25, with 12 tabs signed out by TMA-A. However, R77's MAR dated 1/1/25 to 1/31/25, indicated 12 tabs oxycodone 5 mg were administered, and 11 of the doses were administered by TMA-A. Additionally, R77's medications were ordered via G-tube, which required a nurse to administer R77's medications. TMA performing tasks not within her scope of practice. Discrepancy of 10 doses. In purple is this the surveyor adding this. R141's admission MDS, dated [DATE], indicated R141 had severe cognitive impairment, and diagnoses included cerebral infarction (stroke), left side hemiplegia, chronic pain, and R141 required a feeding tube. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R141's Order Summary Report, printed 2/11/25, indicated a physician order dated 1/22/25 for oxycodone 5 mg via G-tube every 6 hours as needed for severe pain. R141's individual narcotic record indicated 2 tabs of oxycodone 5 mg were signed out of the narcotic log from 1/23/25 through 1/24/25, with 1 tab signed out by TMA-A. However, R141's MAR dated 1/1/25 to 1/31/25, indicated 1 tab oxycodone 5 mg was administered, and the dose was administered by TMA-A. Additionally, R141's medications were ordered via G-tube, which required a nurse to administer R141's medications. TMA performing tasks not within her scope of practice. Discrepancy of 1 dose. R146's discharge MDS, dated [DATE], indicated R146 admitted to the facility on [DATE], and discharged from the facility on 12/13/24. R146's individual narcotic record #42, indicated 15 tabs of oxycodone 5 mg tabs were sent home with patient on 12/13/24, with TMA-A's signature and R146's signature noted. However, facility reported that investigation interview with R146 identified she received 7 tabs of oxycodone. Discrepancy of 8 doses. R146's individual narcotic record #17, indicated 8 tabs of oxycodone 10 mg tabs were destroyed on 11/22/24, with the initials SE and TMA-A's signature noted. Initials in question. However, during facility investigation interview RN-A stated the initials SE were forged because the nurse with the initials SE was out of the country on 11/22/24. discrepancy of 8 doses. R149's quarterly MDS, dated [DATE], indicated R149 was cognitively intact, and diagnoses included heart failure and chronic pain syndrome. R149's MAR dated 1/1/25 to 1/31/25, indicated a physician order dated 11/6/24 for oxycodone 5 mg po BID for pain, and an order dated 1/9/25 for oxycodone 5 mg po for acute one time only on 1/9/25. R149's individual narcotic record indicated 4 doses of oxycodone 5 mg were signed out of the narcotic log on 1/9/25. However, R149's MAR dated 1/1/25 to 1/31/25, indicated 3 doses of oxycodone were administered. Discrepancy of 1 dose. R345's admission MDS, dated [DATE], indicated R345 was cognitively intact, and diagnoses included fracture of sacrum, peritonitis (infection of membrane lining abdominal wall. R345's MAR, dated 1/1/25 to 1/31/25, indicated a physician order dated 1/17/25 for oxycodone 10 mg po every 8 hours PRN for pain. R345's individual narcotic record indicated 4 doses of oxycodone 10 mg were signed out of the narcotic log on 1/18/25, and 3 doses on 1/23/25. However, R63's MAR dated 1/1/25 to 1/31/25, indicated only 3 doses of oxycodone 10 mg were administered on 1/18/25, and 2 doses on 1/23/25. Discrepancy of 2 doses An interview on 2/5/25 at 1:53 p.m. with administrator stated RN-A had identified what she thought might be an issue on 1/29/25. RN-A sent an email to the regional nurse consultant (RN-B) and an investigation was started. TMA-A was suspended 1/29/25. (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	02/11/2025

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

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on 2/5/25 at 2:23 p.m., RN-A stated RN-A stated each morning a report was ran for missed medications. She looked in the progress notes to read the documentation about why the medication was missed. RN-A stated the report showed TMA-A repeatedly had given oxycodone. RN-A stated she had first noticed around 1/28/25, when the G-tube medications caught her eye as they were signed out by TMA-A. RN-A discussed oxycodone with R35. However, R35 did not know what oxycodone was for nor did she have any pain. RN-A discussed daily oxycodone use with R77. R77 told RN-A that TMA-A told R77 that she had to have her oxyodone via her G-tube but R77 stated she was to have orally to see how she did with oral medications, as they wanted to remove her G-tube. RN-A stated R77 had gotten her medication via G-tube but was charted given orally by TMA-A. It was not uncommon for TMA-A to request keys to the medication cart and staff handed them over. RN-A stated it was out of the TMA's scope of practice to destroy medications or to administer G-tube medications. Therefore, RN-A emailed RN-B and an audit was completed for all resident receiving oxycodone on the transitional care unit (TCU). RN-A stated the TMA-A was suspended on 1/29/25 at the end of her shift. An interview on 2/10/25 at 12:43 p.m., TMA-A stated she was the staffing coordinator and would fill in as a TMA on the unit. TMA-A stated she had set up medications for the nurses. TMA-A denied giving any G-tube medication to resident. TMA-A stated she was not to sign out medications that she had not given. TMA-A denied she had given residents their discharged medications. TMA-A indicated she counted narcotics with the licensed staff and was not sure why the licensed staff had not signed out when they had counted the narcotics. TMA-A denied documenting other staff initials in the narcotic book or in the MAR. TMA-A stated she had given narcotics to residents without talking with the licensed staff. TMA-A indicated she had been suspended since 1/30/25, then was terminated on 2/10/25. An interview on 2/11/25 at 10:04 a.m. TMA-B stated she did not have anyone set up any medications for her to give to the residents. TMA-B stated TMA's do not give any G-tube medications and no liquid morphine. TMA-B indicated that only the nurses destroy medications when they are discontinued. TMA-B stated TMA's do not sign out any narcotics going home with discharge residents. An interview on 2/11/25 at 10:51 a.m. RN-E stated TMA's do not destroy medications, only licensed staff could do that. RN-E stated TMA's do not sign out narcotics and give to residents who were discharged . RN-E stated she did not have TMA's set up medications then RN-A administered them. RN-E stated TMA's cannot give heparin, insulin, or any G-tube medications. An interview on 2/11/25 at 11:11 a.m. care coordinator (CC)-C stated TMA's could not give insulin, injections, nor G-tube medications. CC-C stated TMA's have to talk to licensed staff before giving any as needed medication to a resident. The the licensed staff needed to evaluate the resident. The facility policy Medication Administration dated 4/2018, indicated The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident ' s medication administration record (MAR) are compared with the medication label. It indicated the person who prepares the dose for administration is the person who administers the dose. The individual who administers the medication dose records the administration on the resident ' s MAR/eMAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A facility policy Preparation and General Guidelines of Controlled Substances dated 5/2022, indicated Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration (MAR, Accountability Record). 2) Amount administered (Accountability Record). 3) Remaining quantity (Accountability Record). 4) Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record). A facility policy Medication Storage in the Facility, Controlled Substance Storage dated 5/2022, indicated At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented. The emergency supply may be verified by assuring that the seal on the supply has not been broken. The facility initiated corrective action prior to the start of survey including; education on 1/30/25, the staff were educated not to give the medication cart keys to anyone until the end of the shift to on coming staff. The medication cart and narcotic lock box keys were change out. TMA's were given education on what the expectations of the TMA's can and cannot do. TMA's cannot give narcotics without discussion with licensed staff and the licensed staff have to document their assessment of the resident. Staff must verify in PCC if narcotic given. Audits completed to make sure they are accurate with documentation of the narcotic medications. 44645

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on interview and record review the facility failed to immediately report an allegation of sexual abuse to the state agency and law enforcement for 1 of 2 residents (R57) reviewed for abuse. In addition, the facility failed to immediately protect R57 from further abuse. Findings include: R57's annual Minimum Data Set (MDS) dated [DATE], identified cognitively intact, did not have issues with mood and did not have any behavior concerns. R57 was dependent on staff or required maximal assistance for most activities of daily living (ADL's) and did not walk. R57's diagnoses included heart failure and depression. R57's plan of care, with a last review date of 01/23/25, indicated R57 was categorically a vulnerable adult while residing in a skilled nursing facility. Staff were to be aware of statements or signs/symptoms of abuse, and if present update primary care provider, director of nursing (DON), and administrator immediately. Progress noted dated 12/29/24 at 05:36 a.m., indicated family member (FM)-A reported he had seen certified nursing assistant (CNA)-A coming from R57's room. FM-A accused him of uncovering R57 and sexually abusing her. FM-A alleged CNA-A ejaculated in R57's mouth during the shift. The note indicated the supervisor, manager and administrator were updated on the incident. During interview on 2/4/25, at 8:30 a.m. R57 was visibly upset, her leg was shaking rapidly and was fidgeting with right hand. R57 stated there was an incident on 12/29/24. R57 deferred the story to her significant other, family member, (FM)-A. FM-A stated on the morning of 12/29/24 he left R57's room to get her a sandwich. He was directed to the kitchen by NA-A. The kitchen was locked and when he returned to her unit, he observed NA-A coming out of R57's room. FM-A confronted NA-A and asked, What are you doing in there? NA-A denied being in R57's room. FM-A entered R57's room and noted white substance on left outer corner of R57's mouth. Her blankets were pulled back and her brief was pushed aside. During interview on 2/4/25, at 11:47 a.m. the administrator stated she had been notified of the allegation of abuse via text message sometime on the 28th. However, the administrator did not address this until her next business day of 12/30/24. Administrator stated she reviewed video of the hallway and observed NA-A go into the vacant room adjacent to R57's room for approximately thirty seconds. The administrator stated NA-A was not in the room long enough to have ejaculated on R57 and therefore she did not believe the allegation and as such did not report the incident to the police, nor the state agency. Administrator stated all facility staff were required to report any suspected or reported allegations of abuse to the SA. She expected staff to follow facility policies and procedures for reporting any allegation of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/4/25, at 1:40 p.m. the SW-1 stated FM-A made him aware of the allegation on 12/30/25 in the morning via text message. The SW stated FM-A was tricky and not credible and therefore, he had not reported this to law enforcement or the state agency. SW-1 stated he reported this to the administrator at approximately 9:30 a.m. on 12/30/24. SW-1 stated his understanding as a mandated reporter was to notify the SA of all abuse allegations. During interview on 2/4/25, at 2:01 p.m. R57 stated that during the night of 12/28/24 into 12/29/24, she had been awoken when NA-A was standing over her bed and reaching across her body, he was lifting her sheet between her knees and groin. She had asked NA-A what he was doing, and he stated he was checking to see if she was cold. R57 stated this made her angry and felt weird. R57 stated she had not put on her call light to request assistance and did not know why NA-A came into her room. R57 was tearful and stated she is very uncomfortable because NA-A still, works here, and she is fearful of him. During interview on 2/4/25, at 4:25 p.m. NA-A stated no facility staff had ever talked to him about the accusation by FM-A on 12/29/24. He continued to work with R57, and was never removed from caring for her or other residents. During a telephone interview on 2/5/25, at 8:30 a.m. licensed practical nurse (LPN)-A stated on 12/29/25 at approximately 1:45 a.m., LPN-A was working when NA-A and FM-A came to the nurse's station and were arguing, FM-A said NA-A was in R57's room and had removed her covers. NA-A stated he was in the adjacent room looking at furniture (this room was empty and joined to R57's room via the bathroom). NA-A and FM-A walked away and a few minutes later NA-A returned to the desk and told LPN-A that the FM-A had accused him of ejaculating in R57's mouth. LPN-A did not immediately report to the state agency. LPN-A did not contact the police. LPN-A did not remove NA-A from providing cares. LPN-A contacted the administrator sometime between 12:00 a.m. and 3:00 a.m. on 12/29/24 and reported the allegation of sexual abuse. LPN-A stated she had received education on mandated reporting and 'if you see something, you should report it and document it'. LPN-A stated reported incidents of physical abuse, sexual abuse, verbal abuse, and neglect were examples of a reportable incident. The facility policy titled Abuse Prohibition/Vulnerable Adult Policy with a last review date of 3/24 indicated the purpose of the policy was to protect residents against abuse by anyone, including, but not limited to facility staff, other residents; to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. The policy went on to indicate all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. The policy indicated suspected abuse shall be reported to Office of Health Facility Complaints (OHFC) not later than 2 hours after forming the suspicion of abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on interview and record review the facility failed to thoroughly investigate an allegation of sexual abuse for 1 of 1 residents (R57) who reported an alleged sexual assault. Findings include: R57's annual Minimum Data Set (MDS) dated [DATE], identified she was cognitively intact, did not have issues with mood and did not have any behavior concerns. R57 was dependent on staff or required maximal assistance for most activities of daily living (ADL's) and did not walk. R57's diagnoses included heart failure and depression. R57's plan of care, with a last review date of 01/23/25, indicated R57 was categorically a vulnerable adult while residing in a skilled nursing facility. Staff were to be aware of statements or signs/symptoms of abuse, and if present update primary care provider, director of nursing (DON), and administrator immediately. Additionally, under a focus area of history of refusing activities of daily living (ADL's), the care plan indicated cares in pairs at all times with an initiation date of 7/7/2023. Progress noted dated 12/29/24 at 05:36 a.m., indicated family member (FM)-A reported he had seen certified nursing assistant (CNA)-A coming from R57's room. FM-A accused him of uncovering R57 and sexually abusing her. FM-A alleged CNA-A ejaculated in R57's mouth during the shift. The note indicated the supervisor, manager and administrator were updated on the incident. During interview on 2/4/25 at 8:30 a.m., R57 was visibly upset, her leg was shaking rapidly and was fidgeting with right hand. R57 stated there was an incident on 12/29/24. R57 deferred the story to her significant other, FM-A. FM-A stated on the morning of 12/29/24 he left R57's room to get her a sandwich. He was directed to the kitchen by CNA-A. The kitchen was locked and when he returned to her unit, he observed CNA-A coming out of R57's room. FM-A confronted CNA-A and asked, What are you doing in there? CNA-A denied being in R57's room. FM-A entered R57's room and noted white substance on left outer corner of R57's mouth. Her blankets were pulled back and her brief was pushed aside. FM-A stated he took pictures and sent them to SW-A. During interview on 2/4/25 at 11:47 a.m., and follow up interview the same date at 12:25 p.m., the administrator stated she had been notified of the allegation of abuse via text message sometime on the 28th or 29th. However, the administrator did not address this until her next business day of 12/30/24. Administrator stated she reviewed video of the hallway and observed CNA-A go into the vacant room adjacent to R57's room for approximately thirty seconds. The administrator stated CNA-A was not in the room long enough to have ejaculated on R57 and therefore she did not believe the allegation. She did not feel the need to investigate any further. Furthermore, the administrator stated she had not interviewed the resident or the reporting staff regarding the alleged incident. She did not interview any other residents or staff. Administrator stated the investigation file contained only two pieces of paper; a nursing progress note from the night of the incident and a form the SW had filled out 2/4/25 after being asked about the incident. Administrator stated everything the facility did for the investigation was in those two pieces of paper. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 2/4/25 at 12:24 p.m. and 1:40 p.m., the SW-1 stated FM-A made him aware of the allegation on 12/30/25 in the early morning via text message. SW confirmed he received pictures, however, he was not able to find them or the text message at this time. The SW stated FM-A was tricky and not credible. Therefore, no report was made to the State Agency (SA) or police. SW-1 stated he reported the allegation to the administrator at approximately 9:30 a.m., on 12/30/24. SW-1 stated his understanding of the facility abuse policy was to investigate all allegations of abuse and report any reportable events to the SA. SW-1 stated his investigation included an interview with R57 and review of video footage. During interview on 2/4/25 at 1:06 p.m., New [NAME] police department detective (D)-A stated he was first informed of the incident on January 26th by FM-A. D-A stated he had spoke to the administrator and was told he would be sent the facilities internal investigation but had not yet received it and did not have any further information regarding an active investigation. During interview on 2/4/25 at 2:01 p.m., R57 stated that during the night of 12/28/24 into 12/29/24, she had been awoken when NA-A was standing over her bed and reaching across her body, he lifted the sheet between her knees and groin. She had asked NA-A what he was doing, and he stated he was checking to see if she was cold. R57 stated this made her angry and felt weird. R57 stated she had not put on her call light to request assistance and did not know why NA-A came into her room. R57 was tearful and stated she was very uncomfortable because NA-A still, works here, and she was fearful of him. During interview on 2/4/25, at 4:25 p.m. CNA-A stated no facility staff had ever talked to him about the accusation by FM-A on 12/29/24. He stated he had not been suspended after the incident nor received any education. CNA-A continued to work with R57 when FM-A was not around. During a telephone interview on 2/5/25, at 8:30 a.m. licensed practical nurse (LPN)-A stated on 12/29/25 at approximately 1:45 a.m., LPN-A was working when CNA-A and FM-A came to the nurse's station and were arguing, FM-A said CNA-A was in R57's room and had removed her covers. CNA-A stated he was in the adjacent room looking at furniture (this room was empty and joined to R57's room via the bathroom). CNA-A and FM-A walked away and a few minutes later CNA-A returned to the desk and told LPN-A that FM-A had accused him of ejaculating in R57's mouth. LPN-A did not remove CNA-A from providing cares. LPN-A contacted the administrator sometime between 12:00 a.m. and 3:00 a.m. on 12/29/24 to report the allegation of sexual abuse. LPN-A did not report the incident to the SA. LPN-A did not interview R57. LPN-A did not interview any other residents or staff. LPN-A stated she had received education on mandated reporting and 'if you see something, you should report it and document it'. LPN-A stated reported incidents of physical abuse, sexual abuse, verbal abuse, and neglect were examples of a reportable incident. The facility policy titled Abuse Prohibition/Vulnerable Adult Policy with a last review date of 3/24 indicated the purpose of the policy was to protect residents against abuse by anyone, including, but not limited to facility staff, other residents; to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. Further, the policy indicated any staff under investigation of suspected or alleged abuse will be immediately suspended until the investigation is completed and HR will be notified. The policy went on to say the following: *Investigation will begin immediately in accordance with federal law (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment form occurring while the investigation is in progress. *The facilities investigation team will review all incident reports regarding residents including those that indicate an injury of unknown origin, abuse. *The designated person will notify the designated agency in the state as soon as possible after reviewing the Vulnerable adult Report. The designated person will also complete and submit any reports required by the state agency. *All documentation will be kept in a confidential file in the facility in accordance with State Law. A summary which identifies trends or patterns will be forwarded to the QAPI committee at least quarterly. *Administration or other designated staff will report the results of all investigations to the State Survey and Certification Agency and other officials in accordance with State Law, and within five (5) working days of the incident.

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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** 49035 Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan that addressed resident dialysis care for 1 of 1 residents (R72). Further, the facility failed to address clothing preference and passive range of motion (PROM) for 1 of 1 resident's (R59) reviewed for care plan. Findings include: R72's dialysis patient summary report dated 12/12/24, included both AV fistula on left forearm with placement date of 10/2/24 and central venous catheter listed under active dialysis accesses. R72's quarterly Minimum Data Set (MDS) dated [DATE], included R72 was cognitively intact. R72 had diagnoses included end stage renal disease and heart failure. R72's care plan with review date 1/2/25, included R72 was at risk for complications of end-stage renal disease and received dialysis at Davita Dialysis in [NAME] three times a week. Interventions included to monitor for signs of bleeding central dialysis catheter port site. However, the care plan failed to mention R72 received dialysis through fistula on left arm, to avoid taking blood pressure on left arm, to avoid lab draws from left arm, and to monitor for a thrill and bruit at the fistula site. During observation and interview on 2/5/25 at 2:00 p.m., R72 was noted to have a pressure dressing over fistula access site on left arm. R72 stated he had been receiving dialysis from the fistula on his left arm for a while. He last received dialysis the previous day. At time of interview, R72's physician orders did not indicate he had a fistula on his left arm. During interview on 2/5/25 at 2:03 p.m., dialysis registered nurse (DRN)-A stated R72 had his fistula placed on 10/2/24 and started to receive dialysis with the fistula on 12/23/24. During interview on 2/5/25 at 2:39 p.m., nurse manager (NM)-G stated she was unsure how long R72 had a fistula or how long he was receiving dialysis with it. NM-G stated she was unaware of any staff noticing a pressure dressing from dialysis on R72's arm after appointments. She confirmed there were no orders or nursing tasks to remove pressure dressing. During interview on 2/5/25 at 2:49 p.m., director of nursing (DON) stated a resident who was receiving dialysis should have had daily weight and vital signs along with daily monitoring of the dialysis site. DON stated blood pressure and lab draws should not have been collected from the arm with a fistula. DON stated this would be communicated with staff through the care plan. Facility dialysis policy dated 11/22/19, included information included on the care plan would include but was not limited to, the location and frequency of dialysis treatments, the type and location of the dialysis access site, medications, fluid and diet restrictions. The resident's care plan would be adjusted as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R59's quarterly Minimum Data Set (MDS) dated [DATE], indicated R59 was severely cognitively impaired, required moderate assistance with dressing her upper body, was dependent with dressing her lower body, and had functional limitations in range of motion to her upper and lower extremity on one side. R59 had a diagnosis of hemiplegia (inability to move one side of her body) following a cerebral infarction (CVA) (stroke) on her right dominate side. R59's occupational therapy discharge summary dated 8/31/23, included a range of motion plan for passive range of motion (PROM) to right upper extremity (RUE) all joints and all planes of motion. R59's care plan with review date 1/13/25, included R59 had an alteration in mobility related to a CVA. Interventions included grab bars for mobility, physical therapy (PT) per doctor order, and to follow PT instructions. Care plan included she had a self-care deficit related to a CVA and resident has her own style dress that is ripped on one side and don't change different style. Care plan failed to include instruction on PROM exercise. On 2/3/25 at 5:40 p.m., R59 was observed next to the nurse's station in a wheelchair with legs elevated and covered with a blanket, dressed in a hospital gown. R59's hair was brushed. During interview on 2/5/25 at 8:20 a.m., nurse manager (NM)-C stated R59 clothes had ripped and would fall off of her shoulders. NM-C stated R59 still wanted to wear her torn clothes. NM-C stated it was important for resident's to have their clothing preferences honored for dignity. NM-C stated staff would know a resident's preference because it would be noted on the care plan. During interview on 2/5/25 at 11:36 a.m., SW-A stated the facility would work with therapy, the family or guardian and look in the donation box if a resident did not have enough clothing. SW-A stated he did remember R59 had two dresses she preferred to wear. SW-A stated it should be care planned if a resident was more comfortable or preferred a hospital gown. SW-A confirmed R59's care plan did not specify she preferred a hospital gown. SW-A stated it was important for a resident's preferred style of dress to be honored for dignity. Facility care plan policy dated 11/24, included the care plan would be modified and updated as the conditions and care of the resident changed.

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	02/11/2025

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review the facility failed ensure a resident received range of motion exercises for 1 of 1 residents (R59) reviewed for passive range of motion. Findings Include: R59's quarterly Minimum Data Set (MDS) dated [DATE], indicated R59 was severely cognitively impaired, required moderate assistance with dressing upper body and was dependent with dressing lower body. R59 had functional limitations in range of motion to her upper and lower extremity on one side. R59 had a diagnosis of hemiplegia (inability to move one side of her body) following a cerebral infarction (CVA) (stroke) on her right dominate side. On 2/3/25 at 5:40 p.m., R59 was observed next to the nurse's station in a wheelchair with legs elevated and covered with a blanket, dressed in a hospital gown. R59's occupational therapy discharge summary dated 8/31/23, included a range of motion plan for passive range of motion (PROM) to right upper extremity (RUE) all joints and all planes of motion. R59's care plan with review date 1/13/25, included R59 had an alteration in mobility related to a CVA. Interventions included grab bars for mobility, physical therapy (PT) per doctor order, and to follow PT instructions. Care plan failed to include instruction on PROM exercise. R59's medical recorded failed to include updates to either therapy or the provider regarding R59's refusal for range of motion program. During interview on 2/4/25 at 3:21 p.m., nursing assistant (NA)-A stated a resident's range of motion exercises would be on their care plan. NA-A was unsure if R59 received PROM exercises. During interview on 2/4/25 at 3:27 p.m., NA-B stated it would be on the care guide if a resident was to receive PROM exercises and it would be documented electronically. NA-B stated R59 did not like when her right arm was touched. During interview on 2/5/25 at 8:20 a.m., nursing manager (NM)-C stated R59 did have PROM exercises for a period of time. NM-C was unable to say when or why R59 stopped receiving PROM. NM-C stated therapy would send a note about restorative programs upon discharge from therapy and the provider would be updated with any refusals of the program. NM-C stated PROM is important to prevent loss of mobility and contracture. During interview on 2/6/25 at 10:48 a.m., nurse practitioner (NP)-A stated she would expect the facility to update therapy if a resident was ordered therapy and was refusing. The facility would also need to document the refusal and the communication. (continued on next page)

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	245164	A. Building B. Wing	02/11/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/10/25 at 12:59 p.m., director of therapy (PTA)-A stated the recommendations for a resident with weakness from a CVA depend on the resident. Sometimes the focus would be on functional range of motion. PTA-A stated long term care residents are not regularly evaluated for therapy needs. Recommendations for therapy come from nursing or provider orders. PTA-A stated therapy would want to be updated if a resident was discharged from therapy with recommendations that were not able to be completed so the resident could be reevaluated or to see if anything else could be done. PTA-A stated the risk of not completing ROM exercises would be decreased rang of motion and contractures. Facility policy on range of motion requested and not provided.

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	245164	A. Building B. Wing	02/11/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review, the facility failed to provide assessment and monitoring for 1 of 1 residents (R72) reviewed for dialysis. Findings include: R72's quarterly Minimum Data Set (MDS) dated [DATE], included R72 was cognitively intact. R72 diagnoses included end stage renal disease and heart failure. R72's care plan with review date 1/2/25, included to monitor for signs of bleeding central dialysis catheter port site. Care plan failed to mention R72 received dialysis through fistula on left arm. R72's dialysis patient summary report dated 12/12/24, included both AV fistula on left forearm with placement date of 10/2/24 and central venous catheter listed under active dialysis accesses. During observation and interview on 2/5/25 at 2:00 p.m., R72 was noted to have a pressure dressing over fistula access site on left arm. R72 stated he had been receiving dialysis from the fistula on his left arm for a while. He last received dialysis the previous day. At time of interview, R72's physician orders did not indicate he had a fistula on his left arm. R72's order summary report dated 2/11/25, included the following: Dialysis T-TH-SA days of the week. Remember to send a snack or lunch with the resident, with a start date of 6/27/24 Patient has a [NAME] Right IJ Dialysis Catheter, with a start date of 6/27/24 The patient has a [NAME] catheter line, Staff is to monitor regularly for damage or leakage for accidentally pulled or bumped, with a start date of 6/27/24 Dialysis-No IV, Blood Draws, Blood pressure on left arm, with a start date of 2/5/25 Dialysis- Monitor fistula for Bruit and Thrill every sift, with a start date of 2/5/25 Dialysis - Vitals signs after dialysis, with a stat date of 6/27/24 R72's undated blood pressure summary included 246 entries between 10/3/24 and 2/5/25. 153 entries documented the blood pressure was taken on the left arm. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/5/25 at 2:03 p.m., dialysis registered nurse (DRN)-A stated R72 had his fistula placed on 10/2/24 and started to receive dialysis with his fistula on 12/23/24. DRN-A stated education was provided to R72 about making sure the pressure dressing was removed within 4 hours of it being placed because R72 had shown for his dialysis session with the pressure dressing still in place from his previous appointment. DRN-A stated a pressure dressing should not be in place longer than 4 hours after dialysis. There is risk for clotting and narrowing of the blood vessels if the dressing remains in place longer. There was also increased risk for infection if a soiled dressing remained in place longer than necessary. During interview on 2/5/25 at 2:39 p.m., nurse manager (NM)-G stated she was unsure how long R72 had a fistula or how long he was receiving dialysis with it. NM-G confirmed R72's orders were updated on 2/5/25 to monitor his fistula and to not collect blood pressure readings on his left arm. NM-G stated she was unaware of any staff noticing a pressure dressing from dialysis on R72's arm after appointments. NM-G confirmed this would have been a task nursing should have completed as part of their dialysis care. During interview on 2/5/25 at 2:49 p.m., director of nursing (DON) stated a resident who was receiving dialysis should have had daily weight and vital signs along with daily monitoring of the dialysis site. DON stated blood pressure and lab draws should not have been collected from the arm with a fistula. DON stated this would be noted on in the electronic medical record and on the care plan. There would be a risk for bleeding if this was not completed. During interview on 2/6/25 at 10:39 a.m., nurse practitioner (NP)-A stated she would expect a general assessment including vitals after dialysis. The pressure dressing should have been removed 4 hours after placement to prevent circulation issues. NP-A stated blood pressure should also not be collected on an arm with a fistula because it could lead to the fistula not working properly and circulation issues. Facility dialysis policy dated 11/22/19, included ongoing assessment and evaluation of the resident's condition would include monitoring for infection, patency by feeling the access for a thrill and listening with a stethoscope, not taking blood pressure from the access arm, and not collecting blood draws from the access arm. Documentation should have included a pre and post dialysis assessment, daily check of the access site (fistula) evaluation for signs and symptoms of an infection.

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	245164	A. Building B. Wing	02/11/2025

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 44645 Based on observation and document review, the facility failed to ensure the required nurse staffing information was posted daily for 3 of 6 days reviewed. This had the potential to affect all 57 residents residing in the facility and their visitors who may wish to view the information. Findings include: During observation on 2/3/25 at 2:29 p.m., the nurse staffing information was found on the outside of a nursing supply door, located in a side hallway of the facility. However, the posted nurse staffing information was dated 2/2/25. During observation on 2/5/25 at 7:17 a.m., posted nurse staffing information was dated 2/4/25. During observation on 2/11/25 at 9:52 a.m., posted nurse staffing information was dated 2/10/25. The facility's Nursing Hours Posting policy, revised 10/2/22, indicated the facility posted nursing staffing data daily, at the beginning of each shift, and the data was readily accessible to residents and visitors.

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	245164	A. Building B. Wing	02/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview, and document review, the facility failed to implement a system to secure stored narcotics for 1 of 9 residents (R35) reviewed for diversion. Further, the facility failed to ensure medications were properly labeled with name and directions for use and stored in a manner that addressed infection control concerns in 6 of 6 medication cart reviewed for medication storage. This had the potential to affect all 20 residents who used insulin. Findings include: During medication storage review on 2/10/25 and 2/11/25, several discontinued medications were noted to be in locked storage. Facility system was to count these medications. However, this process did not assure against diverted medications. R35's admission MDS, dated [DATE], indicated R35 was cognitively intact, and diagnoses included fracture of right lower leg, osteoporosis, and heart failure. R35's MAR dated 1/1/25 to 1/31/25, indicated a physician order start date 12/31/24 for oxycodone 2.5 mg po every 24 hours PRN for pain, and discontinued date 1/20/25. R35's individual narcotic record indicated 11 doses of oxycodone were signed out of the narcotic log from 1/2/25 through 1/23/25, with 2 doses signed out on 1/23/25 (2 days after medication was discontinued). However, R35's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. R35 reported they had not used any pain medications recently and had no increased pain. During interview on 2/5/25 at 2:23 p.m., RN-A stated she discussed oxycodone with R35. However, R35 did not know what oxycodone was for nor did she have any pain. RN-A stated it was suspicious and proceeded with an investigation. During review of medication cart on the transitional care unit (TCU) on 2/11/25 at 10:01 a.m., registered nurse (RN)-E showed all 12 insulin pens in the cart were stored in a cup in a drawer. The insulin pens did not have a plastic bag or other storage device to keep the insulin pens from touching each other during storage. Insulin pens did not contain a label with dosing instruction. RN-E stated only the name on the insulin pen was compared to the medication administration record (MAR) on the computer screen during administration of insulin. The dose was taken from the MAR and not compared against any other source. During review of second medication cart on the TCU on 2/11/24 at 10:14 a.m., RN-G showed all insulin pens on the cart were stored in a cup with out a bag or other separation device to keep the pens from touching each other. RN-G confirmed there was not dosing instructions on the labels of the insulin pens. RN-G stated only the medication and resident name was compared when administering insulin. The dose was only read from the MAR and not compared to another source. One insulin pen had a small piece of tan tap with a handwritten first name. RN-G stated she knew which resident that insulin pen was for because there was only one resident with that name in the building. (continued on next page)

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	245164	A. Building B. Wing	02/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During review off the first medication cart on respiratory care unit (RCU) on 2/11/25 at 10:27 a.m., RN-H showed the insulin pens for the cart were all stored together without a plastic bag or other separation device. RN-H showed a few bags with pharmacy labels on the in the cart in the same drawer as the insulin pens. RN-H stated she was not sure why the pens were not stored in the bags from pharmacy with the medication labels on them. RN-H confirmed one insulin pen in the drawer had only a piece of tape with a handwritten name on it. RN-H stated the label fell off so the handwritten name was placed for identification. During review of the first medication cart on the long term care (LTC) unit on 2/11/25 at 10:41 a.m., licensed practical nurse (LPN)-B showed all the insulin pens on the cart were stored in a box without plastic bags or any other separation device. LPN-B confirmed some of the pens were missing open dates and proper labeling. The first cart on LTC also contained a clear plastic cup with a piece of white tape and the words Vit C 500 mg written on it. LPN-B confirmed the cup contained unknown pills and was labeled Vitamin C. During review of the second medication cart on LTC on 2/11/25 at 11:01 a.m., LPN-C showed all of the insulin pens were stored in a box without plastic pharmacy bags with labels on them or any other separation device. LPN-C confirmed one Humulin KwikPen was unlabeled. LPN-C stated it may have come from the emergency kit and therefore was not labeled. LPN-C stated only one resident took that specific kind of insulin which is how he knew who it belonged to. LPN-C confirmed the pen was also missing an open date. During interview on 2/11/25 at 10:45 a.m., care coordinator (CC)-C confirmed the insulin pens on the first LTC medication carts were not stored or labeled correctly. CC-C confirmed the medications should have been stored in a plastic bag from pharmacy. CC-C confirmed not all of the pens have open or expiration dates on them. CC-C confirmed the insulin pens are brought into precautions rooms and the replaced into the cart where they touch other insulin pens which could lead to contamination. CC-C confirmed there was a clear plastic cup with unknown pills it and a handwritten label. CC-C stated the medication carts should be During interview on 2/11/25 at 11:50 a.m., CC-C confirmed 4 insulin pens on the second LTC medication cart were not labeled correctly. Open dates were missing and an identification label was missing from one pen. During interview on 2/11/25 at 1:15 p.m., RN-A confirmed all pens were stored in a plastic cup and were not in plastic pharmacy bags. RN-A stated the pens were stored and labeled incorrectly and were undated and some were missing names. RN-A stated she was unable to state how the floor nurses would be completing the proper checks prior to giving the medication without the proper labels. RN-A stated it was important to label all insulin pens with open dates because there was a certain amount of time an insulin pen could be used before it needed to be disposed of. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated education for proper checks during administration of medication was an ongoing process. The DON stated the label on the medication should be compared against the EMAR to verify the patient, route, time, dose, and medication all match. DON confirmed the insulin pens were not stored properly and that the dosing should be on the insulin pen to compare it against the EMAR. (continued on next page)

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	245164	A. Building B. Wing	02/11/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy for pharmacy services and medication administration dated January 2018, included medications should have been checked for the five rights (right resident, right drug, right dose, right route, and right time) three times by comparing the medication administration record with the medication label.

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	245164	A. Building B. Wing	02/11/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review, the facility failed to ensure they were free of medication error rate of five percent or greater. The facility had a mediation error rate of 8% with 2 errors out of 25 opportunities for errors involving 2 of 6 residents (R2, R240) observed during medication passes. Findings include: R2 quarterly Minimum Data Set (MDS) dated [DATE], included R2 was severely impaired cognitively. R2 had diagnoses of coronary artery disease (common form of heart disease where blood flow to the heart is limited), hypertension (high blood pressure) and dementia. R2's order summary report dated 2/10/25, included an order for metoprolol tartrate (a medication that affects the flow of blood to the arteries and veins) Tablet 25 MG Give 12.5 mg by mouth two times a day for hypertension with parameters to hold for apical pulse less than 60 beats per minute. During observation on 2/5/25 at 7:25 a.m., licensed practical nurse (LPN)-C obtained R2's blood pressure and pulse with an automatic blood pressure cuff after setting up medication in medication cup. Blood pressure reading was 150/89 with a pulse of 55. LPN-C gave R2 all medications including metoprolol tartrate. During interview on 2/5/25 at 7:25 a.m., LPN-C confirmed the pulse was below the parameter for giving the metoprolol tartrate and it should not have been given. During interview on 2/5/25 at 8:17 a.m., nursing manager (NM)-C stated she expected nurses to collect the pulse and confirm it was within the parameters prior to giving medication. During interview on 2/6/25 at 10:39 a.m., nurse practitioner (NP)-A stated the risk for giving metoprolol tartrate outside of the parameters is worsening bradycardia (slow heart rate) and in severe cases could lead to death. R240 admission record dated 2/10/25, included diagnoses of unspecified psychosis and dementia with behavioral disturbance. R240 order summary report dated 2/10/25, included an order for Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 12.5 mg by mouth in the afternoon for hospice care and seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth every 4 hours as needed for agitation and hallucinations for 14 Days. During observation on 2/6/25 at 12:52 p.m., LPN-D was passing scheduled medication for R240. LPN-D prepared quetiapine fumarate 25 mg tablet with other scheduled medication and brought all medications into R240 to administer. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/6/25 at 1:05 p.m., LPN-D compared medications in medication cup to blister pack cards. LPN-D confirmed she prepared and was going to give the incorrect dose of quetiapine fumarate. LPN-D confirmed she was going to give the unscheduled higher dose. During interview on 2/10/25 at 10:10 a.m., consultant pharmacist (CP) stated the risk of giving an incorrect dose would have been increased risk of side effects for the resident and the error could have been avoided by completing the proper checks prior to administering. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated all medication needed to be administered according to provider orders. The risk of the incorrect medication dose or timing of medication could lead to side effects, such as a low pulse rate. He stated staff should have verified the label of the medication against the electronic medication administration record (EMAR) prior to preparing and giving any medication. DON stated education was recently provided on the rights of medication administration. Facility medication administration policy dated January 2018, included a triple check of the five rights (right resident, right drug, right dose, right route and right time) was recommended when medication was prepared for administration.

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	245164	A. Building B. Wing	02/11/2025

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49035 Based on observation and interview, the facility failed to maintain safe storage of medications when medication carts were left unlocked and unattended in 2 of 6 medication carts and one instance of medications left unattended in a resident room. Findings include: On 2/3/25 at 2:05 p.m., a medication cart on the long term care (LTC) unit of the facility was observed being unlocked and unattended. No staff was within direct eye site. At 2:09 p.m., a staff person was observed walking past the medication cart without locking it. At 2:13 p.m., care coordinator (CC)-C was observed locking the medication cart. During interview on 2/3/25 at 2:13 p.m., CC-C confirmed she locked the mediation cart after observing it unlocked and unattended. She stated the nurse was at the nurse's station and out of eye site. During observation of medication pass on 2/4/25 at 8:49 a.m., registered nurse (RN)-D brought R9's morning medications to his room. RN-D left medications in the room on a countertop next to R9's TV to return to the medication cart to collect some alcohol wipes. R9's door was approximately 1/4 of the way open and residents were walking past doorway after leaving the dining room. Medications were left unattended for approximately 2 minutes. During interview on 2/4/25 at 8:56 a.m., RN-D confirmed she left the medications in R9's room to go back to her medication cart. RN-D stated she knew she was supposed to take the medications with her when she left the room and was not to leave them unattended. On 2/11/25 at 10:14 a.m., a medication cart was observed on the transitional care unit (TCU) being unlocked and unattended. Residents were observed in the hallway near the cart. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated it was his expectation to have medication carts locked anytime a nurse steps away from the cart, even if it is only 10 seconds. The only time a cart should have only been unlocked was when the nurse was removing medication from it. He stated 10 seconds could have easily turned into 10 minutes if the nurse were to be asked to assist with another task. DON stated a medication can never been left in a patient's room unattended. The nurse would be responsible for keeping the medication with them after it was dished up until it was given. He stated this was important to ensure residents were taking the correct medications. Facility policy for medication administration dated April 2018, included the medication art was to be kept closed and locked when out of sight of the nurse.

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	02/11/2025

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** 27955 Based on observation, interview and record review, the facility failed to conduct appropriate hand hygiene during tracheostomy cares for 1 of 1 resident (R8) observed for tracheostomy cares. Further, the facility failed to ensure proper catheter drainage bag care and catheter drainage bag laying on the floor for 1 of 1 resident (R12) observed for cares. Findings include: R8's admission Minimum Data Set (MDS) dated [DATE], indicated R8 was severely cognitively impaired, dependent for all cares and transfers, required the use of oxygen, suctioning, and tracheostomy care, and had the following diagnoses: non-traumatic brain dysfunction, heart failure (heart beats ineffectively), renal insufficiency (failure of the kidneys to pump efficiently), asthma, and respiratory failure. On 2/5/25 at 7:44 a.m., tracheostomy cares were observed for R8. Licensed practical nurse (LPN)-B began to remove the soiled gauze pad from between the resident's skin and tracheostomy tube, and used a Q-Tip with gauze to clean around the opening. After finishing cleaning, LPN-B removed her gloves and did not perform hand hygiene and put on a new pair of gloves. Registered Nurse (RN)-D was in the room assisting, and after LPN-B had finish cleaning, RN-D cleaned off the dirty items used for cleaning on the bedside table and removed her gloves, did not perform hand hygiene, put on new gloves and assisted in preparing the bed side table with the suctioning supplies. LPN-B then put on her sterile gloves to perform suctioning, completed it and removed her gloves and did not perform hand hygiene, then put on another pair of gloves. RN-D cleaned off the table of suctioning supplies, removed her gloves and did not perform hand hygiene, then put on a new pair of gloves. LPN-B then got a new gauze to place back under the tracheostomy tube, and then clean the residents face, neck and chest then removed her gloves and did complete hand hygiene once all cares had been completed. On 2/5/25 at approximately 8:00 a.m., LPN-B and RN-D stated they were expected to perform hand hygiene if their hands become soiled or contaminated, and any time they remove gloves and put on a new pair during cares. LPN-B and RN-D confirmed they did not wash their hands in between changing gloves, stated they thought they had but were nervous and hand hygiene should have been completed each time they removed their gloves because it was important to prevent any infections. On 2/6/25 at 2:03 p.m., the director of nursing (DON) stated they expected their staff to perform hand hygiene when entering/exiting a room, and when they change gloves between cares. The DON stated the importance of completing hand hygiene to prevent the spread of infection, and to ensure they were not carrying bacteria from one resident to the next. R12's admission Minimum Data Set, dated dated dated [DATE], indicated R12 was cognitively intact. R12's care plan indicated he had alteration in elimination related to a foley catheter (indwelling urinary catheter). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's provider progress note dated 1/29/25 indicated diagnosis of seizures, chronic obstructive pulmonary disease, cerebral vascular accident, and benign prostate hyperplasia with lower urinary tract symptoms (prostate gland enlarges putting pressure on the urethra and causing urinary problems). R12 interview on 2/03/25 at 5:19 p.m., revealed he had problems urinating and he had the catheter for about eight months. R12 stated the staff empty the urinary catheter drainage bad about two times a day. An observation on 2/5/25 at 7:38 a.m., the urinary catheter drainage bag was lying on the floor. Nursing assistant (NA)-D stated the urinary catheter drainage bag did not belong on the floor. NA-D hung the urinary catheter drainage bag on the bed. An observation on 2/6/25 at 2:42 p.m., the urinary catheter bag was lying on the floor. Licensed practical nurse (LPN)-D stated the urinary catheter drainage bag did not belong on the floor because it was a dignity issue, and it was not respectful for the resident and it was a cleanliness issue. An observation on 2/6/25 at 2:48 p.m., LPN-D put gloves on hung up the urinary catheter bag on the bed. LPN-D got a urinal and emptied the catheter drainage bag into the urinal with 300 milliliters (ml). LPN-D put the spout in the holder on the catheter drainage bag. Then rinsed out the urinal and let air dry. LPN-D took her gloves off and washed her hands. LPN-D went to the medication cart out in the hallway. LPN-D stated she should have wiped the spout off prior to securing it back it the holder with an alcohol wipe. LPN-D took several alcohol wipes out of her pocket and stated she had them the whole time in her pocket. The facility's Handwashing policy last revised 2/2024, indicated when conducting a procedure requiring the use of gloves, proper hand hygiene shall be completed before donning gloves and removing gloves. A facility policy Indwelling Catheter Care Procedure dated 7/21/23, revealed 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 the outlet. Measure urine and dispose of it in the toilet. Remove gloves and wash hands. 49657