STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. Building B. Wing	04/23/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information based on payroll during 1 of 1 quarter (Quarter 1) reviewed, to the Centers for Medicare Services (CMS), according to specification established by CMS. This had the potential to affect all 83 residents at the facility. Findings include: Payroll Based Journal (PBJ), [NAME] Report 1705D indicated the facility had excessively low weekend staffing during quarter 1 of fiscal year 2026, which included dates between October 1 to December 31, 2025. The CMS payroll-based journal (PBJ) staffing data report indicated the following: Excessively Low Weekend Staffing Triggered An interview on 4/20/26 at 3:39 p.m., staffing coordinator (SC) stated she was responsible for the nurse staff schedules. SC stated there was at least one RN per shift scheduled and that the weekends are covered. SC stated if there were a call in of staff the charge nurse is responsible to find a replacement. An interview on 4/22/26 at 1:49 p.m., the administrator indicated they found the low staffing on the shift first weekend in 11/25. The administrator stated she submitted the PBJ report once corporate pulls the information and they have reviewed it. The administrator stated there was inaccurate reporting. A request for a facility policy for payroll based journal was requested and not received.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the facility's walk-in freezer was maintained to ensure water drippings and ice build-up would impact frozen food storage. This had the potential to impact all residents who ate from the kitchen.During an observation of the kitchen on 4/22/26 at 9:21 a.m., the walk-in freezer was observed. Inside the freezer, the ceiling had numerous frozen water drops out into the middle of the walk-in freezer, across from the two fans on the left side of the walk-in freezer. On the floor of the walk-in freezer were three frozen areas approximately 12 inches in diameter. An interview on 4/22/26 at 9:22 am., the culinary director (CD) stated the the walk-in freezer had been like that for a couple of weeks. The CD stated the regional person came out and de iced the walk-in freezer. The CD stated the frozen water on the floor is a safety hazard. The CD was unable to find a work order to get the walk-in freezer de iced. An interview on 4/22/26 at 9:26 a.m., the director of maintenance (DM) stated there had been a work order for the walk-in freezer ice build up 8/5/26, and was de iced. The DM stated on 10/14/25, that he had defrosted the freezer and replaced a door gasket. The DM stated he was not aware of the walk-in freezer build up. The DM stated any staff can place a work order or notify their manager and they will let me know of the issue. DM observed the walk-in freezer and indicated the ceiling was half full with frozen water drops and three frozen water areas on the floor all about 12 inches in diameter and one quarter inch thick. A policy for maintaining equipment was requested, however, was not received.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure safe storage of medication on 4 of 6 medications carts reviewed.Findings include: During observation on 4/20/26 at 1:26 p.m., a medication cart on the long term care (LTC) until was unlocked without a nurse in eye site of it.At 1:28 p.m., a nursing assistant (NA) walked by the unlocked medication cartAt 1:29 p.m., a housekeeper and maintenance worker walked past medication cartAt 1:30 p.m., licensed practical nurse (LPN) Care Coordinator (CC)-A walked by cart to unplug a cord from a hallway outletBetween 1:33 p.m. and 1:34 p.m., four residents passed the unlocked medication cart unattendedAt 1:34 p.m., CC-A locked the medication cart During interview on 4/20/26 at 1:34 p.m., CC-A confirmed she locked the unattended medication cart. CC-A confirmed the nurse who was working the medication cart was not monitoring the cart. During interview on 4/20/26 at 1:38 p.m., LPN-A confirmed he left the medication cart unlocked. LPN-A states he is unsure how long it was unlocked, but estimates it to be between 5-10 minutes. During observation on 4/21/26 at 11:53 a.m., a medication cart in the respiratory care unity (RCU) was unlocked with no nurse in eye site. A NA walked past pushing a resident in a wheelchair, a male resident passed the cart in an electric wheelchair unattended by staff, a resident pushing a wheelchair walked past unattended by staff, and two staff members walked past without locking the medication cart.At 12:00 p.m., CC-A walks past the unlocked medication cart.At 12:02 p.m., LPN-B walks up to the cart and locks it. LPN-B stated she just noticed it was unlocked and confirmed she was not in eye site of the cart the whole time it was unlocked.During observation on 4/22/26 at 6:55 a.m., medication cart on LTC unit was unlocked with no nurse in eye site. There was a resident sitting next to the unattended, unlocked medication cart. Staff were at nurses station speaking with backs facing medication cart. At 7:05 a.m., registered nurse (RN)-A returned to the unlocked medication cart. RN-A stated he just received the keys for the medication cart from LPN-C and she was the one who left the medication cart unlocked. RN-A confirmed he and LPN-C handed off medication cart keys at nurses station and had not completed a narcotic reconciliation at time of handing off the medication keys. RN-A walked away from unlocked medication cart to find LPN-C to complete narcotic reconciliation and alert her to leaving the medication cart unlocked. RN-A confirmed he knowingly walked away from the unlocked medication cart so he could show LPN-C. During observation on 4/22/26 at 1:14 p.m., medication cart on RCU was unlocked with no nurse in eye site. Two NA's were next to cart preparing to enter a resident room, RN-A walked past unlocked medication cart pushing a resident, a housekeeping staff walks past the cart, and a resident passes the cart in a wheelchair. At 1:19 p.m., LPN-D returned to the cart and locked it. LPN-D confirmed she left the cart unattended and stated she was only on day 2 of her training and forgot to lock the medication cart. LPN-D stated the nurse training her was currently on break. During interview on 4/22/26 at 1:44 p.m., direct of nursing (DON) confirmed medications carts should be locked any time a nurse is outside of arm's length away. DON stated she has not done any audits of medication carts being locked and was unaware this was an issue. DON confirmed keys to the medication cart should have been handed off at the medication cart and a narcotic reconciliation should be completed at that time. DON confirmed she was aware of the concerns found with the last recertification survey regarding medication storage but had not implemented any monitoring. DON stated locking medication carts was important for safety.A policy regarding medication was requested but was not provided.

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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** Based on observation, interview, and document review, the facility failed to ensure resident rights were maintained for 1 of 2 residents (R71) reviewed for dignity. Findings include: R71's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R71 was cognitively intact, and diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, and quadriplegia. R71 communicated clearly and understood others and was dependent on staff for activities of daily living (ADLs). R71's care plan last reviewed 2/11/26, indicated R71 had an alteration in elimination and required staff assistance with incontinent cares upon rising, before or after meals, at bedtime, and two times overnight. R71 had a self-care deficit and required staff assistance with dressing, personal hygiene, and bathing. R71 preferred showers. R71's care plan further indicated staff were not to get R71 up and into her wheelchair until after 11:00 a.m. per patient preference. During interview on 4/20/26 at 2:50 p.m., R71 stated she had requested several times to get up after 11:00 a.m. but staff consistently get her dressed and transferred to her wheelchair earlier in the mornings. R71 became tearful and stated, makes me feel I'm in the land of misfit toys. During interview on 4/20/26 at 3:03 p.m., R71 stated she remains in the same brief all day from the time staff get her up into her wheelchair in the morning until late afternoon, and when staff change her in the afternoon, urine has soaked through her clothing onto her wheelchair. R71 stated that because her wheelchair was soiled, staff changed her into a hospital gown and placed her into bed until the next morning. R71 stated staff typically changed her again at 8:00 p.m. and 5:00 a.m. R71 stated when she asked the staff for help, they told her they were too busy, so I just stopped asking; I gave up the beginning of this year. R71 started to cry and stated she smelled from urine and felt humiliated. During observation and interview on 4/20/26 at 5:21 p.m., R71 was observed in her bed with a hospital gown on. R71 stated this is what they do; I'll be in here for the rest of the day. R71 stated her clothing and wheelchair were saturated because her brief had not been changed since she got up that morning. R71's wheelchair cushion appeared damp and smelled of urine. During observation on 4/22/26 at 1:24 p.m., R71's hair was oily, clumped together at the roots, stringy, heavy and limp. R71 had a significant amount of large, thick, and oily yellow-white flakes that clung to R71's scalp and hair. A layer of yellow-white flakes were noted on R71's shoulders and the back edges of R71's electric wheelchair. Additionally, R71's hair had a greasy, musky odor. During interview on 4/22/26 at 1:24 p.m., R71 stated staff have used a shampoo shower cap on her hair, but staff had not washed her hair since she moved into the facility on [DATE]. R71 stated she could feel the buildup and was aware of the excessive flaking. R71 stated it's demeaning, and very much a dignity issue; dignity left when I came in here. R71 stated the lack of adequate brief care and showers made it worse and caused her to isolate because I don't want anyone to smell it. R71 stated staff had not followed the care plan for brief changes, and it's done when they care and when they want. R71 further stated, I'm marginalized because I'm in a lower income bracket and so you realize that means a lower standard of care. During observation and interview on 4/23/26 at 10:16 a.m., R71 was dressed and seated in an electric wheelchair, and R71's bed was made. R71 stated two aides got her up at 9:30 a.m., and basically said it's now or never. During interview on 4/23/26 at 11:12 a.m., nursing assistant (NA)-A stated the NAR care guides indicated resident preferences and care needs. NA-A stated R71 needed two staff to assist because R71 required a Hoyer lift, and NA-A and another NA got R71 up between 9:00 a.m. and 10:00 a.m. today. NA-A stated she did not usually work with R71 and did not reference the care guide to see the instructions regarding R71's preferred time request. NA-A further stated she had not noticed that R71's hair was oily. During interview on 4/23/26 at 11:53 a.m., director of nursing (DON) stated staff were expected to provide incontinence care every 2 to 3 hours and as needed, and it was important for residents to be kept clean and dry to prevent skin breakdown and infection, and for resident (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignity. DON stated staff were expected to follow the care plan, honor resident preferences, and regular showers was important for the dignity and health of the residents. The facility's Resident Rights Policy, revised 11/2025, indicated it is the practice of this facility to uphold the rights of all residents.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to honor a resident's right to make choices about aspects of care for 1 of 2 residents (R71) reviewed for self-determination. Findings include: R71's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R71 was cognitively intact, and had clear speech, the ability to make self understood, and the ability to understand others. R71's diagnoses included multiple sclerosis, neuromuscular dysfunction of bladder, and quadriplegia, and R71 was dependent on staff for activities of daily living (ADLs). R71's care plan last reviewed 2/11/26, indicated R71 required assist of two with Hoyer transfer, required assist of one with ADLs, and don't get up pt [patient] into her w/c [wheelchair] until after 11AM per pt preference. During interview on 4/20/26 at 2:50 p.m., R71 stated she had requested several times to get up after 11:00 a.m. but staff consistently get her dressed and transferred to her wheelchair earlier in the mornings. R71 became tearful and stated, makes me feel I'm in the land of misfit toys. During observation and interview on 4/23/26 at 10:16 a.m., R71 was dressed and seated in an electric wheelchair, and R71's bed was made. R71 stated two aides got her up at 9:30 a.m., and basically said it's now or never. During interview on 4/23/26 at 11:12 a.m., nursing assistant (NA)-A stated the NAR care guides indicated resident preferences and care needs. NA-A stated R71 needed two staff to assist because R71 required a Hoyer lift, and NA-A and another NA got R71 up between 9:00 a.m. and 10:00 a.m. today. NA-A stated she did not usually work with R71 and did not reference the care guide to see the instructions regarding R71's preferred time request. During interview on 4/23/26 at 11:53 a.m., director of nursing (DON) stated R71's care plan indicated it was R71's preference to not get up and put into her wheelchair until 11:00 a.m., and DON expected staff to honor the resident's preference. DON stated R71's preference should have been listed on the daily nursing assistant (NAR) guide. R71's section of the NAR guide, dated 4/23/26, indicated Don't get up the pt before 11 AM. The facility's Resident Rights Policy, revised 11/2025, indicated it is the practice of this facility to uphold the rights of all residents.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and document review, the facility failed to notify a resident/resident representative Medicare part A coverage would end prior to going on a leave of absence (LOA) for one of one residents (R11) reviewed for therapy services. Findings include: R11's admission Minimum Data Set R11 admitted to the facility 1/12/26, was cognitively intact and had the following diagnoses: coronary artery disease (narrowing of arteries), diabetes mellitus, morbid obesity and debility (a state of physical weakness). During interview on 4/20/26 at 6:36 p.m. R11 stated he had gone home for the Easter holiday on 4/5/26, and returned on 4/7/26. R11 stated he had notified facility staff he was planning to leave on 4/5/26, and would need his medication for two days. R11 stated on 4/5/26, the nurse reviewed his medication instructions and then gave him medications through the morning of 4/7/26. Upon his return he was notified by the Minimum Data Set (MDS) nurse (MDS-A) his leave violated his ability to continue receiving Medicare part A covered services and he was given a Notice of Medicare Non-Coverage (NOMNC) with a therapy services end date of 4/10/26. R11 stated he was not informed prior to leaving his leave of absence (LOA) would result in termination of his Medicare part A covered services. During interview on 4/22/26 at 10:53 a.m., Director of Rehab Services (DRS) stated R11 was discharged from physical therapy (PT) and occupational therapy (OT) services on 4/10/26 after a LOA. DRS stated he was first made aware R11 was to be discharged on 4/8/26, during facility staff morning meeting when he was informed R11 had to discharge from therapy because he had taken a LOA and no longer qualified for Medicare part A coverage. During interview on 4/22/26 at 12:20 p.m., MDS nurse stated she issued R11 the NOMNC notice on 4/8/26 after she learned he had been on LOA 4/5/26 through 4/7/26. MDS-A stated due to taking a LOA R11 no longer meet the criteria for a skilled Medicare stay and therefore needed to be discharged from physical and occupational therapy. MDS-A stated she had been previously instructed if a resident was on skilled services they were not allowed to take a LOA.Review of R11's progress note dated 4/5/26 indicated R11 had requested a LOA from facility staff on 4/4/26, was provided with his medications and was instructed on medication administration. The progress note further indicated the on-call nurse and provider were updated at time of LOA per facility protocol.A policy on denial of medicare coverage was requested but one was not received.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide activities of daily living (ADLs) for 2 of 2 resident (R62 and R71) who were dependent on staff for assistance with ADLs. Findings include: R71's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R71 was cognitively intact, diagnoses included multiple sclerosis and quadriplegia, and R71 required total assistance with bathing. R71's care plan, last reviewed 2/11/26, indicated R71 had a self-care deficit and patient bathing preference was assist of one staff with showers. R71's Weekly Skin Inspection forms dated 11/14/25 through 4/8/26, indicated R71 received weekly bathing assistance as follows: Bed Baths - 4/8, 4/1, 3/25, 3/19, 3/11, 3/4, 2/25, 2/19, 2/11, 2/4, 1/28, 1/21, 1/14, 1/12, 1/2, 12/26, 12/19, 12/12, 11/28, 11/21 Shower - 11/14, 12/5 Refused - 3/17 During observation on 4/22/26 at 1:24 p.m., R71's hair was oily, clumped together at the roots, stringy, heavy and limp. R71 had a significant amount of large, thick, and oily yellow-white flakes that clung to R71's scalp and hair. A layer of yellow-white flakes was noted on R71's shoulders and the back edges of R71's electric wheelchair. Additionally, R71's hair had a greasy, musky odor. During interview on 4/22/26 at 1:24 p.m., R71 stated she preferred showers but has received weekly bed baths instead, and staff told her that she could not have showers because she was not able to hold herself upright in the shower chair. R71 stated that staff have used a shampoo shower cap on her hair, but staff had not washed her hair since she moved into the facility on [DATE]. R71 stated she could feel the buildup and was aware of the excessive flaking. R71 stated it's demeaning. During interview on 4/23/26 at 11:12 a.m., nursing assistant (NA)-A stated the facility had shower chairs with straps to keep residents upright during showers. During interview on 4/23/26 at 11:53 a.m., director of nursing (DON) stated resident care plans were developed based on orders, assessments, and resident preferences, and staff were expected to honor R71's preference for a shower and use the shower chairs that were available in the facility to help R71 remain seated upright. DON stated R71 should have been given showers with hair-washing as per R71's preference. DON stated regular bathing was important for the dignity and health of the residents. The facility's Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, indicated it is the policy of the facility to specify the responsibility to create and sustain an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment that humanizes and individualizes each resident's quality of life by ensuring all staff understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. Findings include: R62's significant change minimum data set (MDS) dated [DATE], included R62 had severe cognitive impairment. R62's diagnoses included heart failure, bipolar disorder (a mental health condition with intense, fluctuating mood shifts), and schizophrenia (a severe brain disorder which includes delusions, hallucinations, and lack of motivation). During interview and observation on 4/20/26 at 3:57 p.m., R62 stated she really wanted her toenails cut. R62 stated she needed help with this and needed to see a podiatrist. R62's toenails were growing past the end of her toe, some had some thickening. Facility assessment for weekly skin assessment included an observation for fingernails and toenails. Assessments included the following: 3/10/26: refused assessment 3/27/26: Fingernails and toenails not necessary to be trimmed 4/6/26: Fingernails and toenails not necessary to be trimmed 4/10/26: Fingernails and toenails not necessary to be trimmed 4/17/26: Fingernails and toenails not necessary to be trimmed During interview on 4/22/26 at 7:24 a.m., licensed practical nurse (LPN)-A stated skin and nails are assessed once a week after a resident's bath. Fingernails could be trimmed by a nurse if they are long or the patient is diabetic. LPN-A stated the resident would be referred to podiatry if the toenails were long, thick or otherwise unable to be cared for in house. During interview and observation on 4/22/26 at 9:33 a.m., LPN Care Coordinator (CC)-A stated staff do monitor nails weekly during bath time. CC-A stated she does know that R63 sometimes refuses nail care, but staff should be documenting that she refused on the weekly assessments or in a progress note. CC-A confirmed there were no recent notes about R63 refusing nail care. During observation of R63's toenails, CC-A confirmed the toenails were long and some were thickening. CC-A stated R63's toenail on her big toe was grown at least 1/2 inch past the toenail and others were similar lengths. CC-A stated R63 should have been put on the podiatry rounds list but does not believe she was. During interview on 4/22/26 at 9:42 a.m., health information manager (HIM) stated she was the one who coordinates the residents who see podiatry. HIM confirmed R63 was not on the list to see podiatry. During interview on 4/22/26 at 1:44 p.m., director of nursing (DON) confirmed nails should be assessed on bath days and nail care should be completed as needed. DON stated those who needed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be put on a list to see podiatry. DON stated if proper toenail care was not completed, the resident was at risk for skin damage, ingrown toenails and other health hazards. Facility policy for ADLs dated 3/31/23, included residents who were unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed follow up on pharmacist recommendations for 1 of 5 residents (R23) reviewed for monthly pharmacist reviews.Findings include: R23's quarterly minimum data set (MDS) dated [DATE], included R23 was cognitively intact. R23 had diagnoses of heart failure, diabetes mellitus (high blood sugars), depression, respiratory failure, and anemia (deficiency of healthy red blood cells reducing oxygen to the body tissues. Review of R23's electronic medical record (EMR) included progress note from the consultant pharmacist indicating recommendations for the facility on 10/21/25, 11/18/25, 12/15/25, 1/23/26, 2/11/26, 3/19/26, 4/15/26. R23's pharmacy recommendation dated 12/15/25, included a recommendation to review the use of both Omeprazole 40 mg (a proton-pump inhibitor used to treat gastroesophageal reflux disease) and Sucralfate 1 mg (a mucosal protectant used to treat and prevent active duodenal ulcers) in an effort to avoid potentially unnecessary medications. During interview on 4/22/26 at 1:44 p.m., director of nursing (DON) stated she gets the monthly pharmacy recommendations emailed to her and she distributes them appropriately to be addressed. DON confirmed the December pharmacy recommendation for R23 was not addressed. The DON stated it was important to follow up on pharmacy recommendations timely for the resident's health. Facility policy for consultant pharmacist reports dated January 2026, included all recommendations are acted upon and documented by the facility staff and/or the prescriber.