



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 12, 2026

Administrator

The Villas at New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders

Event ID: 1F367F-H1

Dear Administrator:

The above facility survey was completed on April 23, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Regional Operations Supervisor

St. Cloud B District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 426-0175

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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May 12, 2026

Administrator

The Villas at New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164

Cycle Start Date: April 23, 2026

Dear Administrator:

On April 23, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
 St. Cloud B District Office
 Health Regulation Division
 Minnesota Department of Health
 4140 Thielman Lane
 Saint Cloud, Minnesota 56301-4557
 Email: judy.loecken@state.mn.us
 Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **July 23, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **October 23, 2026** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

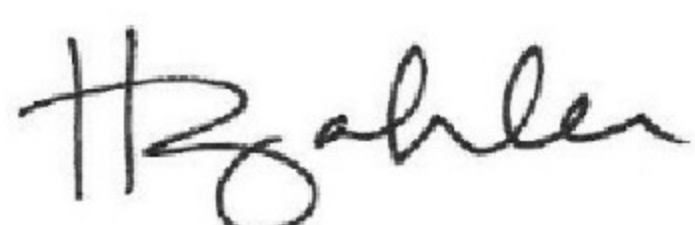
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North

P.O. Box 64975

St. Paul, MN 55164-0899

Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/23/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT NEW BRIGHTON				STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000	Initial Comments On 4/20/26 thru 4/23/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			
F0000	INITIAL COMMENTS On 4/20/26 thru 4/23/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H (iQIES #). NO deficiencies were cited. H51641393C H51641394C H51641395C H51641396C H51641396C H51641397C H51641398C H51641399C H51641400C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your			F0000			

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0000	Continued from page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.			F0000			
F0851 SS = F	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and			F0851			

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F0851 SS = F	Continued from page 2 tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: 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), Casper 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			F0851			

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F0851 SS = F	Continued from page 3 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.			F0851			
F0908 SS = F	A request for a facility policy for payroll based journal was requested and not received.						
	Essential Equipment, Safe Operating Condition			F0908			
	CFR(s): 483.90(d)(2)						
	§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.						
	This REQUIREMENT is NOT MET as evidenced by:						
	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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F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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 cart At 1:29 p.m., a housekeeper and maintenance worker walked past medication cart At 1:30 p.m., licensed practical nurse (LPN) Care Coordinator (CC)-A walked by cart to unplug a cord from a hallway outlet Between 1:33 p.m. and 1:34 p.m., four residents			F0761			

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F0761 SS = E	Continued from page 5 passed the unlocked medication cart unattended At 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.			F0761			

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F0761 SS = E	Continued from page 6 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.			F0761			
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of			F0550			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0550 SS = D	Continued from page 7 condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: 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 10/21/25, 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.			F0550			

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F0550 SS = D	Continued from page 8 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 10/21/25. 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			F0550			

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F0550 SS = D	Continued from page 9 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 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.			F0550			
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose			F0561			

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F0561 SS = D	Continued from page 10 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: 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 10/21/25, 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”.			F0561			

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F0561 SS = D	Continued from page 11 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.			F0561			
F0580 SS = D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical			F0580			

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F0580 SS = D	Continued from page 12 complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: 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:			F0580			

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F0580 SS = D	Continued from page 13 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			F0580			

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F0580 SS = D	Continued from page 14 requested but one was not received.			F0580			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: 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 10/21/25, 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,			F0677			

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F0677 SS = D	Continued from page 15 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 10/21/25. 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 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 2/9/26, 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			F0677			

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F0677 SS = D	Continued from page 16 (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 ½ 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.			F0677			

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F0677 SS = D	Continued from page 17 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 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.			F0677			
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified			F0756			

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT NEW BRIGHTON				STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112			
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F0756 SS = D	Continued from page 18 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: 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 3/9/26, 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			F0756			

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F0756 SS = D	Continued from page 19 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.	F0756			

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/20/26 thru 4/23/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H (iQIES #). NO deficiencies were cited. H51641393C			20000			

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 H51641394C H51641395C H51641396C H51641396C H51641397C H51641398C H51641399C H51641400C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			20000			
20920	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 B Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 10/21/25, indicated R71 was cognitively intact,			20920			

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20920	Continued from page 2 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 10/21/25. 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			20920			

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20920	Continued from page 3 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 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 2/9/26, 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			20920			

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20920	Continued from page 4 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 ½ 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 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for providing bathing and hair care as directed by the assessed needs of residents and provide education to nursing staff to			20920			

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20920	Continued from page 5 follow cares as directed by the care plan. The facility could develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.		20920				
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and		21830				

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21830	Continued from page 6 whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 10/21/25, 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,			21830			

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21830	Continued from page 7 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.			21830			

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21830	Continued from page 8 SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could develop/revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21830			
21942	Establish Resident and Family Councils CFR(s): MN St. Statute 144A.10 Subd. 8b Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During interview and document review, the facility failed to adequately offer and advertise for a family council meeting. This had the potential to affect all residents and family members. Findings include: During observation on 4/20/26 at 1:00 pm, a sign was observed in multiple places throughout the building with information regarding an upcoming family council meeting to be held on 4/22/26. During interview on 4/23/26 at 11:00 a.m., the administrator stated she was unable to find meeting minutes from previous family council meetings. The administrator stated no additional information was sent to families to alert them of the upcoming meeting and the flyer was hung up on 4/13/26. The administrator stated no family members attended the meeting on 4/22/26. Facility policy requested and not provided.			21942			

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21942	Continued from page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures related to family council and provide education. The facility could develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.			21942			

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT NEW BRIGHTON				STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 04/21/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Villas at New Brighton was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			05/27/2026

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/21/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT NEW BRIGHTON				STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112			
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: This 1 story building, built in 1963, was determined to be of Type II (222) construction. It has a partial basement, and is fully fire sprinkled throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			05/27/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction			K0372	Immediate Corrective Action: The fire wall above the fire wall doors near resident room 140 was repaired per Life Safety Code. All other smoke barriers were audited to ensure no		05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/21/2026	
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K0372 SS = E Bldg. 01	Continued from page 2 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/21/2026 at 10:35 AM, it was revealed by observation that there was a penetration in the fire wall above the fire wall doors near resident room 140 caused by piping. An interview with the Administrator, the Facility Maintenance Director and the Maintenance Operations Director verified this deficient finding at the time of discovery.			K0372	Continued from page 2 penetrations. Completed education with maintenance director on routine maintenance and after installation projects to ensure smoke barriers are maintained per Life Safety Code. Re-occurrence will be prevented by: Audit of smoke barriers to ensure no penetration is completed weekly x4 weeks. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/ Designee		05/27/2026
K0374 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.			K0374	Immediate Corrective Action: The smoke barrier door self-closure near resident room 151 was repaired per Life Safety Code. Corrective Action as it applies to others: All other smoke barrier doors were audited to ensure self-closure. Completed education with maintenance director on routine maintenance to ensure smoke barrier doors are maintained per Life Safety Code. Re-occurrence will be prevented by: Audit of smoke barrier doors to ensure doors fully close when testing the self-closing device is completed weekly x4 weeks. The results of these		05/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/21/2026	
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K0374 SS = D Bldg. 01	Continued from page 3 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/21/2026 at 10:39 AM, it was revealed by observation that the smoke barrier doors near resident room 151 did not fully close when testing the self-closing device. An interview with the Administrator, the Facility Maintenance Director and the Maintenance Operations Director verified this deficient finding at the time of discovery.			K0374	Continued from page 3 audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Maintenance Director/ Designee		05/27/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 24, 2026

Administrator
THE VILLAS AT NEW BRIGHTON
825 FIRST AVENUE NORTHWEST
NEW BRIGHTON, MN 55112

Re: Reinspection Results
Event ID: 1F367F-H2

Dear Administrator:

On June 3, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 23, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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Electronically Delivered
June 24, 2026

Administrator
THE VILLAS AT NEW BRIGHTON
825 FIRST AVENUE NORTHWEST
NEW BRIGHTON, MN 55112

RE: CCN: 245164

Cycle Start Date: April 23, 2026

Dear Administrator:

On June 3, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us