



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 15, 2025

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

RE: CCN: 245164
Cycle Start Date: February 11, 2025

Dear Administrator:

On March 3, 2025, we notified you a remedy was imposed. On April 3, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 28, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 11, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of March 3, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 11, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 3, 2025

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

RE: CCN: 245164
Cycle Start Date: February 11, 2025

Dear Administrator:

On February 11, 2025, 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 a pattern of deficiencies that constituted immediate jeopardy (Level K). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found the most serious other 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), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On January 30, 2025, the situation of immediate jeopardy to potential health and safety cited at F602 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 11, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 11, 2025. They will also notify the State Medicaid Agency that they must

also deny payment for new Medicaid admissions effective **May 11, 2025**.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Villas at New Brighton is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective **February 11, 2025**. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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) 241-7797

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 11, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must

file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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.

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT NEW BRIGHTON			STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 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
E 000	Initial Comments On 2/3/25 through 2/11/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000			
F 000	INITIAL COMMENTS On 2/3/25 through 2/11/25, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51646255C (MN108252) H51646253C (MN108280) H51646252C (MN108916) H51646254C (MN109380) H51646256C (MN109830) H51646801C (MN110389) with a deficiency cited at F602. The following complaints were reviewed. H51646257C (MN108101). Deficient practice was identified related to incidental finding. The facility's plan of correction (POC) will serve	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2025

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.

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F 000	Continued From page 1 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.	F 000			
F 550 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 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.	F 550			3/28/25

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F 550	Continued From page 2 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 ensure a resident was allowed to dress in a manner of her choosing for 1 of 1 residents (R59) reviewed for dignity. Findings Include: R59's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated R59 was severely cognitively impaired and required moderate assistance with dressing her upper body and was dependent with dressing her lower body. R59 had a diagnosis of hemiplegia (inability to move one side of her body) following a cerebral infarction (stroke) on her right dominate side. On 2/3/25 at 5:40 p.m., R59 was observed next to the nurse's station in a wheelchair with legs elevated and covered with a blanket, dressed in a hospital gown. R59's hair was brushed. On 2/4/25 at 3:17 p.m., R59 was observed sitting			F 550	1. Discussion took place with Guardian for R59 and care plan was updated to reflect that resident prefers hospital gowns and becomes agitated with attempts to encourage other clothing. 2. A Full house audit was completed regarding clothing preferences and preferences were care planned. Those that requested more clothing were assisted with that. 3. Residents will be asked their clothing preferences quarterly during care conferences, and those preferences will be reflected on the care conference form. 4. Began education with all nurses regarding documenting when a resident prefers to wear a gown throughout the day and education will be completed prior to 3/28/25.		

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F 550	Continued From page 3 in a wheelchair next to the nurse's station with her legs elevated and covered with a blanket, dressed in a green hospital gown. R59 had a food tray with a lettuce salad on a tray in front of her and was holding a salmon-colored piece of paper. R59's fingernails on right hand were visible and were painted red. On 2/5/25 at 7:16 p.m., R59 was in a wheelchair in the hallway next to the nurse's station. R59's legs were elevated and covered with a blanket. R59 was wearing a pale blue hospital gown, awake and looking around. R59 did not appear agitated. During interview on 2/4/25 at 2:16 p.m., guardian (G)-A stated she visited R59 within the last month. G-A stated she spoke with the facility about R59 wearing a hospital gown and was informed R59 had a history of ripping her clothing, so they had started to put her in a hospital gown. G-A stated she had been attempting to speak with social worker (SW)-A regarding clothing for R59, but been playing "phone tag." G-A stated she had concerns about R59 being in a public area in a hospital gown. During interview on 2/5/25 at 8:25 a.m., nurse manager (NM)-C stated R59 clothes had ripped and would fall off of her shoulders. NM-C stated R59 still wanted to wear her torn clothes. NM-C stated it was important for resident's to have their clothing preferences honored for dignity. NM-C stated staff would know a resident's preference because it would be noted on the care plan. During interview on 2/5/25 at 11:36 a.m., SW-A stated the facility would work with therapy, the family or guardian and look in the donation box if	F 550	Clinical leaders and social service employees were educated to care plan clothing preferences and also to ask about preferences during care conferences, and document that information on the care conference forms. 5. Administrator will audit 9 residents weekly x 4 weeks to ensure clothing preferences match care plan. Will audit 3 residents weekly x 4 weeks to ensure preferences were discussed at care conferences and documented on the care conference form The results of these audits will be shared by the Administrator or designee with the facility QAPI committee monthly for input on the need to increase, decrease or discontinue the audits.		

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F 550	Continued From page 4 a resident did not have enough clothing. SW-A stated he did remember R59 had two dresses she preferred to wear. SW-A stated it should be care planned if a resident was more comfortable or preferred a hospital gown. SW-A confirmed R59's care plan did not specify she preferred a hospital gown. SW-A stated it was important for a resident's preferred style of dress to be honored for dignity. SW-A was unable to locate any notes regarding attempts to contact the guardian for R59. R59's care plan review date 1/13/25, included she had a self-care deficit related to a CVA and "resident has her own style dress that is ripped on one side and don't change different style."	F 550			
F 554 SS=D	Facility policy for clothing preferences requested and not provided. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess 1 of 1 residents (R39) who wished to self-administer medications. Findings include: R39's quarterly Minimum Data Set (MDS) dated 1/15/25, included R39 was cognitively intact. R39 had diagnosis of congestive heart failure (CHF)	F 554	1. R39 had self administration form completed and this found that he is not safe to self administer as he has history of not always taking the medications. Resident was assessed and had no adverse effects from not receiving the Tamiflu. Med error form completed. Provider notified of missing doses. 2. A full house audit was completed to		3/28/25

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F 554	Continued From page 5 and diabetes. R39 received high risk medications including anticoagulants (blood thinner) and diuretics (increases urine production). R39's care plan with review date 1/15/25, failed to include R39's ability to self-administer medications. R39's Self Administration of medication evaluation dated 1/27/21, indicated R39 was unsafe to administer medications independently. On 2/3/25 at 2:44 p.m., medications were observed on R39's dresser. One medication cup contained 4 grey and yellow capsules. A second medication cup contained two white oblong pills. During interview on 2/3/25 at 2:44 p.m., R39 identified the grey and yellow capsules as Tamiflu. He stated he had a reaction to the medication and was no longer taking it. He stated the facility was aware of the reaction and that he was no longer taking the medication. R39 identified the white pills as Tylenol. He stated he keeps them on his dresser until later in the day when his pain starts. During interview on 2/4/25 at 3:42 p.m., registered nurse (RN)-C stated it would be noted on the electronic medical record if a resident was able to have medications left in their room. RN-C confirmed R39 had 4 grey and yellow capsules on his dresser. During interview on 2/4/25 at 3:52 p.m., nurse manager (NM)-C stated a resident needed a self-administration assessment prior to medication being left in their room. NM-C was unable to locate a self-administration assessment	F 554	determine which residents prefer meds left at bedside. Self administration assessments were completed with those residents. Orders were received for those appropriate and that information was care planned 3. Policy was reviewed and no changes needed 4. Began education with all nurses and TMAs explaining that they cannot leave medications at bedside without an order. Also educated regarding what to do if resident is requesting to have them left at bedside. Education will be completed before date certain. 5. DON or designee will audit 9 residents weekly x 4 weeks to ensure meds are not being left at bedside without an order. The results of these audits will be shared by the DON or designee with the facility QAPI committee monthly for input on the need to increase, decrease or discontinue the audits.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2025
FORM APPROVED
OMB NO. 0938-0391

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F 554	Continued From page 6 or physician order for R39. NM-C confirmed R39 spoke with her about having an adverse reaction to the Tamiflu and that he would stop taking it. NM-C removed the medications from R39's room. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated medications could not be left in the patient's room unattended. The concern would be the patient taking them when not observed. Facility policy titled Self-Administration of Medications dated February 2024, included a comprehensive assessment from an interdisciplinary team would assess the cognitive and physical ability of a resident. The ability to safely self-administer medications would have been documented in the medical record and the care plan.	F 554			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609			3/28/25

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F 609	Continued From page 7 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to immediately report an allegation of sexual abuse to the state agency and law enforcement for 1 of 2 residents (R57) reviewed for abuse. In addition, the facility failed to immediately protect R57 from further abuse. Findings include: R57's annual Minimum Data Set (MDS) dated 11/25/24, identified cognitively intact, did not have issues with mood and did not have any behavior concerns. R57 was dependent on staff or required maximal assistance for most activities of daily living (ADL's) and did not walk. R57's diagnoses included heart failure and depression. R57's plan of care, with a last review date of 01/23/25, indicated R57 was categorically a vulnerable adult while residing in a skilled nursing facility. Staff were to be aware of statements or signs/symptoms of abuse, and if present update primary care provider, director of nursing (DON), and administrator immediately.	F 609	1. Allegation was reported, no adverse effects, resident denied incident 2. All have residents potential to be affected 3. No change to reporting process. 4. Education was completed with all staff to the abuse reporting policy. IDT educated that all allegations of abuse are to be reported per policy. 5. Weekly audits will be conducted by the Regional Director of Operations for 4 weeks to ensure that all events have been reported. The results of these audits will be shared by the Regional Director of Operations or designee with the facility QAPI committee monthly for input on the need to increase, decrease or discontinue the audits.		

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F 609	Continued From page 8 Progress noted dated 12/29/24 at 05:36 a.m., indicated family member (FM)-A reported he had seen certified nursing assistant (CNA)-A coming from R57's room. FM-A accused him of uncovering R57 and sexually abusing her. FM-A alleged CNA-A "ejaculated in R57's mouth" during the shift. The note indicated the supervisor, manager and administrator were updated on the incident. During interview on 2/4/25, at 8:30 a.m. R57 was visibly upset, her leg was shaking rapidly and was fidgeting with right hand. R57 stated there was an incident on 12/29/24. R57 deferred the story to her significant other, family member, (FM)-A. FM-A stated on the morning of 12/29/24 he left R57's room to get her a sandwich. He was directed to the kitchen by NA-A. The kitchen was locked and when he returned to her unit, he observed NA-A coming out of R57's room. FM-A confronted NA-A and asked, "What are you doing in there"? NA-A denied being in R57's room. FM-A entered R57's room and noted white substance on left outer corner of R57's mouth. Her blankets were pulled back and her brief was "pushed aside". During interview on 2/4/25, at 11:47 a.m. the administrator stated she had been notified of the allegation of abuse via text message sometime on the 28th. However, the administrator did not address this until her next business day of 12/30/24. Administrator stated she reviewed video of the hallway and observed NA-A go into the vacant room adjacent to R57's room for approximately thirty seconds. The administrator stated NA-A was not in the room long enough to have ejaculated on R57 and therefore she did not believe the allegation and as such did not report	F 609			

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F 609	Continued From page 9 the incident to the police, nor the state agency. Administrator stated all facility staff were required to report any suspected or reported allegations of abuse to the SA. She expected staff to follow facility policies and procedures for reporting any allegation of abuse. During interview on 2/4/25, at 1:40 p.m. the SW-1 stated FM-A made him aware of the allegation on 12/30/25 in the morning via text message. The SW stated FM-A was "tricky" and "not credible" and therefore, he had not reported this to law enforcement or the state agency. SW-1 stated he reported this to the administrator at approximately 9:30 a.m. on 12/30/24. SW-1 stated his understanding as a mandated reporter was to notify the SA of all abuse allegations. During interview on 2/4/25, at 2:01 p.m. R57 stated that during the night of 12/28/24 into 12/29/24, she had been awoken when NA-A was standing over her bed and reaching across her body, he was lifting her sheet between her knees and groin. She had asked NA-A what he was doing, and he stated he was checking to see if she was cold. R57 stated this made her angry and felt "weird." R57 stated she had not put on her call light to request assistance and did not know why NA-A came into her room. R57 was tearful and stated she is very uncomfortable because NA-A still, "works here," and she is fearful of him. During interview on 2/4/25, at 4:25 p.m. NA-A stated no facility staff had ever talked to him about the accusation by FM-A on 12/29/24. He continued to work with R57, and was never removed from caring for her or other residents.	F 609			

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F 609	Continued From page 10 During a telephone interview on 2/5/25, at 8:30 a.m. licensed practical nurse (LPN)-A stated on 12/29/25 at approximately 1:45 a.m., LPN-A was working when NA-A and FM-A came to the nurse's station and were arguing, FM-A said NA-A was in R57's room and had removed her covers. NA-A stated he was in the adjacent room looking at furniture (this room was empty and joined to R57's room via the bathroom). NA-A and FM-A walked away and a few minutes later NA-A returned to the desk and told LPN-A that the FM-A had accused him of ejaculating in R57's mouth. LPN-A did not immediately report to the state agency. LPN-A did not contact the police. LPN-A did not remove NA-A from providing cares. LPN-A contacted the administrator "sometime between 12:00 a.m. and 3:00 a.m." on 12/29/24 and reported the allegation of sexual abuse. LPN-A stated she had received education on mandated reporting and 'if you see something, you should report it and document it'. LPN-A stated reported incidents of physical abuse, sexual abuse, verbal abuse, and neglect were examples of a reportable incident. The facility policy titled Abuse Prohibition/Vulnerable Adult Policy with a last review date of 3/24 indicated the purpose of the policy was to protect residents against abuse by anyone, including, but not limited to facility staff, other residents; to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. The policy went on to indicate all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. The policy indicated suspected abuse shall be reported to Office of Health Facility Complaints (OHFC) not later than 2 hours after forming the suspicion of abuse.	F 609			

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to thoroughly investigate an allegation of sexual abuse for 1 of 1 residents (R57) who reported an alleged sexual assault. Findings include: R57's annual Minimum Data Set (MDS) dated 11/25/24, identified she was cognitively intact, did not have issues with mood and did not have any behavior concerns. R57 was dependent on staff or required maximal assistance for most activities of daily living (ADL's) and did not walk. R57's diagnoses included heart failure and depression. R57's plan of care, with a last review date of 01/23/25, indicated R57 was categorically a			F 610	1. Allegation was investigated and unsubstantiated 2. All residents have potential to be affected 3. There were no changes made to the investigation policy. 4. IDT was educated to abuse policy including suspending any individuals accused and completing a thorough investigation and documenting all pieces of that investigation. 5. Weekly audits will be conducted by the Regional Director of Operations for 4		3/28/25

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F 610	Continued From page 12 vulnerable adult while residing in a skilled nursing facility. Staff were to be aware of statements or signs/symptoms of abuse, and if present update primary care provider, director of nursing (DON), and administrator immediately. Additionally, under a focus area of history of refusing activities of daily living (ADL's), the care plan indicated cares in pairs at all times with an initiation date of 7/7/2023. Progress noted dated 12/29/24 at 05:36 a.m., indicated family member (FM)-A reported he had seen certified nursing assistant (CNA)-A coming from R57's room. FM-A accused him of uncovering R57 and sexually abusing her. FM-A alleged CNA-A "ejaculated in R57's mouth" during the shift. The note indicated the supervisor, manager and administrator were updated on the incident. During interview on 2/4/25 at 8:30 a.m., R57 was visibly upset, her leg was shaking rapidly and was fidgeting with right hand. R57 stated there was an incident on 12/29/24. R57 deferred the story to her significant other, FM-A. FM-A stated on the morning of 12/29/24 he left R57's room to get her a sandwich. He was directed to the kitchen by CNA-A. The kitchen was locked and when he returned to her unit, he observed CNA-A coming out of R57's room. FM-A confronted CNA-A and asked, "What are you doing in there"? CNA-A denied being in R57's room. FM-A entered R57's room and noted white substance on left outer corner of R57's mouth. Her blankets were pulled back and her brief was "pushed aside". FM-A stated he took pictures and sent them to SW-A. During interview on 2/4/25 at 11:47 a.m., and follow up interview the same date at 12:25 p.m.,	F 610	weeks to ensure that all events have been investigated. The results of these audits will be shared by the Regional Director of Operations or designee with the facility QAPI committee monthly for input on the need to increase, decrease or discontinue the audits.		

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F 610	Continued From page 13 the administrator stated she had been notified of the allegation of abuse via text message sometime on the 28th or 29th. However, the administrator did not address this until her next business day of 12/30/24. Administrator stated she reviewed video of the hallway and observed CNA-A go into the vacant room adjacent to R57's room for approximately thirty seconds. The administrator stated CNA-A was not in the room long enough to have ejaculated on R57 and therefore she did not believe the allegation. She did not feel the need to investigate any further. Furthermore, the administrator stated she had not interviewed the resident or the reporting staff regarding the alleged incident. She did not interview any other residents or staff. Administrator stated the investigation file contained only two pieces of paper; a nursing progress note from the night of the incident and a form the SW had filled out 2/4/25 after being asked about the incident. Administrator stated everything the facility did for the investigation was in those two pieces of paper. During interviews on 2/4/25 at 12:24 p.m. and 1:40 p.m., the SW-1 stated FM-A made him aware of the allegation on 12/30/25 in the early morning via text message. SW confirmed he received pictures, however, he was not able to find them or the text message at this time. The SW stated FM-A was "tricky" and "not credible". Therefore, no report was made to the State Agency (SA) or police. SW-1 stated he reported the allegation to the administrator at approximately 9:30 a.m., on 12/30/24. SW-1 stated his understanding of the facility abuse policy was to investigate all allegations of abuse and report any reportable events to the SA. SW-1 stated his investigation included an interview with			F 610			

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F 610	Continued From page 14 R57 and review of video footage. During interview on 2/4/25 at 1:06 p.m., New Brighton police department detective (D)-A stated he was first informed of the incident on January 26th by FM-A. D-A stated he had spoke to the administrator and was told he would be sent the facilities internal investigation but had not yet received it and did not have any further information regarding an active investigation. During interview on 2/4/25 at 2:01 p.m., R57 stated that during the night of 12/28/24 into 12/29/24, she had been awoken when NA-A was standing over her bed and reaching across her body, he lifted the sheet between her knees and groin. She had asked NA-A what he was doing, and he stated he was checking to see if she was cold. R57 stated this made her angry and felt "weird." R57 stated she had not put on her call light to request assistance and did not know why NA-A came into her room. R57 was tearful and stated she was very uncomfortable because NA-A still, "works here," and she was fearful of him. During interview on 2/4/25, at 4:25 p.m. CNA-A stated no facility staff had ever talked to him about the accusation by FM-A on 12/29/24. He stated he had not been suspended after the incident nor received any education. CNA-A continued to work with R57 when FM-A was not around. During a telephone interview on 2/5/25, at 8:30 a.m. licensed practical nurse (LPN)-A stated on 12/29/25 at approximately 1:45 a.m., LPN-A was working when CNA-A and FM-A came to the nurse's station and were arguing, FM-A said	F 610			

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F 610	Continued From page 15 CNA-A was in R57's room and had removed her covers. CNA-A stated he was in the adjacent room looking at furniture (this room was empty and joined to R57's room via the bathroom). CNA-A and FM-A walked away and a few minutes later CNA-A returned to the desk and told LPN-A that FM-A had accused him of ejaculating in R57's mouth. LPN-A did not remove CNA-A from providing cares. LPN-A contacted the administrator "sometime between 12:00 a.m. and 3:00 a.m." on 12/29/24 to report the allegation of sexual abuse. LPN-A did not report the incident to the SA. LPN-A did not interview R57. LPN-A did not interview any other residents or staff. LPN-A stated she had received education on mandated reporting and 'if you see something, you should report it and document it'. LPN-A stated reported incidents of physical abuse, sexual abuse, verbal abuse, and neglect were examples of a reportable incident. The facility policy titled Abuse Prohibition/Vulnerable Adult Policy with a last review date of 3/24 indicated the purpose of the policy was to protect residents against abuse by anyone, including, but not limited to facility staff, other residents; to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. Further, the policy indicated any staff under investigation of suspected or alleged abuse will be immediately suspended until the investigation is completed and HR will be notified. The policy went on to say the following: *Investigation will begin immediately in accordance with federal law *Staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress.			F 610			

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F 610	Continued From page 16 *The facilities investigation team will review all incident reports regarding residents including those that indicate an injury of unknown origin, abuse. *The designated person will notify the designated agency in the state as soon as possible after reviewing the Vulnerable adult Report. The designated person will also complete and submit any reports required by the state agency. *All documentation will be kept in a confidential file in the facility in accordance with State Law. A summary which identifies trends or patterns will be forwarded to the QAPI committee at least quarterly. *Administration or other designated staff will report the results of all investigations to the State Survey and Certification Agency and other officials in accordance with State Law, and within five (5) working days of the incident.	F 610			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656			3/28/25

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F 656	Continued From page 17 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan that addressed resident dialysis care for 1 of 1 residents (R72). Further, the facility failed to address clothing preference and passive range of motion (PROM) for 1 of 1 resident's (R59) reviewed for care plan.	F 656	1. R72 was assessed including fistula site, and no concerns were found. Care plan was reviewed and revised to include care of the fistula. Nursing orders were entered regarding care of fistula. R59 PROM is on hold while OT reassesses. Will be added to care plan if		

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F 656	Continued From page 18 Findings include: R72's dialysis patient summary report dated 12/12/24, included both AV fistula on left forearm with placement date of 10/2/24 and central venous catheter listed under active dialysis accesses. R72's quarterly Minimum Data Set (MDS) dated 1/2/25, included R72 was cognitively intact. R72 had diagnoses included end stage renal disease and heart failure. R72's care plan with review date 1/2/25, included R72 was at risk for complications of end-stage renal disease and received dialysis at Davita Dialysis in Blaine three times a week. Interventions included to monitor for signs of bleeding central dialysis catheter port site. However, the care plan failed to mention R72 received dialysis through fistula on left arm, to avoid taking blood pressure on left arm, to avoid lab draws from left arm, and to monitor for a thrill and bruit at the fistula site. During observation and interview on 2/5/25 at 2:00 p.m., R72 was noted to have a pressure dressing over fistula access site on left arm. R72 stated he had been receiving dialysis from the fistula on his left arm for a while. He last received dialysis the previous day. At time of interview, R72's physician orders did not indicate he had a fistula on his left arm. During interview on 2/5/25 at 2:03 p.m., dialysis registered nurse (DRN)-A stated R72 had his fistula placed on 10/2/24 and started to receive dialysis with the fistula on 12/23/24.			F 656	a new PROM is ordered. R59 discussion took place with Guardian and care plan was updated to reflect that resident prefers hospital gowns and becomes agitated with attempts to encourage other clothing. 2. A full house audit was completed to identify residents that receive dialysis and there are no other residents besides the resident identified (R72) A full house audit was completed regarding residents with functional range of motion programs and these were care planned A Full house audit was completed regarding clothing preferences and preferences were care planned. 3. Dialysis policy reviewed and no changes needed OT to utilize communication forms whenever initializing or adjusting a functional range of motion program for a resident. Clinical leaders were educated to enter a progress note and add the information regarding the functional range of motion into the care plan and the care guides when the form is received. Residents will be asked their clothing preferences quarterly during care conferences, and those preferences will be reflected on the care conference form.		

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F 656	Continued From page 19 During interview on 2/5/25 at 2:39 p.m., nurse manager (NM)-G stated she was unsure how long R72 had a fistula or how long he was receiving dialysis with it. NM-G stated she was unaware of any staff noticing a pressure dressing from dialysis on R72's arm after appointments. She confirmed there were no orders or nursing tasks to remove pressure dressing. During interview on 2/5/25 at 2:49 p.m., director of nursing (DON) stated a resident who was receiving dialysis should have had daily weight and vital signs along with daily monitoring of the dialysis site. DON stated blood pressure and lab draws should not have been collected from the arm with a fistula. DON stated this would be communicated with staff through the care plan. Facility dialysis policy dated 11/22/19, included information included on the care plan would include but was not limited to, the location and frequency of dialysis treatments, the type and location of the dialysis access site, medications, fluid and diet restrictions. The resident's care plan would be adjusted as needed. R59's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated R59 was severely cognitively impaired, required moderate assistance with dressing her upper body, was dependent with dressing her lower body, and had functional limitations in range of motion to her upper and lower extremity on one side. R59 had a diagnosis of hemiplegia (inability to move one side of her body) following a cerebral infarction (CVA) (stroke) on her right dominate side. R59's occupational therapy discharge summary	F 656	4. Began education with all nurses to document all dialysis sites when completing any skin checks. Also to notify a clinical leader if the site and type of dialysis access site does not match the orders. Also to document any changes that occur to access such as returning to facility after port is changed to a fistula. Clinical nurse leaders were educated to review and revise the dialysis care plan quarterly and any time there are changes in regards to dialysis cares or site. Began education with OT to utilize communication forms whenever initializing or adjusting a functional range of motion program for a resident. Clinical leaders were educated to enter a progress note and add the information regarding the functional range of motion into the care plan and the care guides. Began education with all nurses regarding documenting when a resident prefers to wear a gown throughout the day. Clinical leaders and social service employees were educated to care plan clothing preferences and also to ask about preferences during care conferences, and document that information on the care conference forms. Education will be completed by date certain. 5. DON or designee will Audit all dialysis residents weekly x 4 weeks to ensure dialysis cares and site are accurate in the		

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F 656	Continued From page 20 dated 8/31/23, included a range of motion plan for passive range of motion (PROM) to right upper extremity (RUE) all joints and all planes of motion. R59's care plan with review date 1/13/25, included R59 had an alteration in mobility related to a CVA. Interventions included grab bars for mobility, physical therapy (PT) per doctor order, and to follow PT instructions. Care plan included she had a self-care deficit related to a CVA and "resident has her own style dress that is ripped on one side and don't change different style." Care plan failed to include instruction on PROM exercise. On 2/3/25 at 5:40 p.m., R59 was observed next to the nurse's station in a wheelchair with legs elevated and covered with a blanket, dressed in a hospital gown. R59's hair was brushed. During interview on 2/5/25 at 8:20 a.m., nurse manager (NM)-C stated R59 clothes had ripped and would fall off of her shoulders. NM-C stated R59 still wanted to wear her torn clothes. NM-C stated it was important for resident's to have their clothing preferences honored for dignity. NM-C stated staff would know a resident's preference because it would be noted on the care plan. During interview on 2/5/25 at 11:36 a.m., SW-A stated the facility would work with therapy, the family or guardian and look in the donation box if a resident did not have enough clothing. SW-A stated he did remember R59 had two dresses she preferred to wear. SW-A stated it should be care planned if a resident was more comfortable or preferred a hospital gown. SW-A confirmed R59's care plan did not specify she preferred a	F 656	orders and the care plan DON or designee will audit 3 residents weekly to ensure their functional range of motion programs are in the care guide and care plan and is being followed. DON or designee will audit 9 residents weekly to ensure clothing preferences match care plan The results of these audits will be shared by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 656	Continued From page 21 hospital gown. SW-A stated it was important for a resident's preferred style of dress to be honored for dignity.	F 656			
F 658 SS=D	Facility care plan policy dated 11/24, included the care plan would be modified and updated as the conditions and care of the resident changed. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered according to provider order and within professional standards for 1 of 1 residents (R2) observed during medication passes with parameters. Findings include: R2 quarterly Minimum Data Set (MDS) dated 11/12/24, included R2 was severely impaired cognitively. R2 had diagnoses of coronary artery disease (common form of heart disease where blood flow to the heart is limited), hypertension (high blood pressure) and dementia. R2's order summary report dated 2/10/25, included an order for metoprolol tartrate (a medication that affects the flow of blood to the arteries and veins) Tablet 25 MG Give 12.5 mg by mouth two times a day for hypertension with	F 658	1. R2 was assessed and had no adverse effects related to the medication error. Provider, resident and poa notified, med error form and follow up was completed. 2. Full house audit was completed to identify all residents that have parameters included in their medication orders. MAR report was reviewed for the past month to ensure they had not received any medications outside of the parameters 3. Medication administration policy was reviewed and no changes needed 4. Began education with nurses and TMAs in regards to what parameters are and why they are ordered and what may happen if not followed. Also educated to PCC including where to locate who requires vital signs prior to med		3/28/25

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F 658	Continued From page 22 parameters to hold for apical pulse less than 60 beats per minute. During observation on 2/5/25 at 7:25 a.m., licensed practical nurse (LPN)-C obtained R2's blood pressure and pulse with an automatic blood pressure cuff after setting up medication in medication cup. Blood pressure reading was 150/89 with a pulse of 55. LPN-C gave R2 all medications including metoprolol tartrate. During interview on 2/5/25 at 7:25 a.m., LPN-C confirmed the pulse was below the parameter for giving the metoprolol tartrate and it should not have been given. R2's medication administration record dated 11/1/24 - 11/30/24, included an order for metoprolol tartrate 12.5 mg twice a day with 59 administrations recorded. Seven of the 59 administrations noted a pulse below the 60 beats per minute parameter. However, lacked indication the medication was held as ordered. R2's medication administration record dated 12/1/24 - 12/31/24, included an order for metoprolol tartrate 12.5 mg twice a day with 61 administrations recorded. Each administration included a recording for pulse, with 10 records with a pulse below 60 beats per minute. However, lacked indication the medication was held as ordered. R2's medication administration record dated 1/1/25 - 1/31/25, included an order for metoprolol tartrate 12.5 mg twice a day with 62 administrations recorded. Each administration included a recorded pulse, with 14 records with a pulse below the 60 beats per minute parameters.	F 658	administration, where to see instructions for medications including parameters and not prepping the medications until the parameter is checked first. Education will be completed before date certain 5. DON or designee will audit 3 residents with parameters weekly x 4 weeks to ensure they are being followed. The results of these audits will be shared by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 658	Continued From page 23 However, lacked indication the medication was held as ordered. During interview on 2/5/25 at 8:17 a.m., nursing manager (NM)-C stated she expected nurses to collect the pulse and confirm it is within the parameters prior to giving medication. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated all medication needed to be administered according to provider orders. The risk of the incorrect medication dose or timing of medication could lead to side effects, such as a low pulse rate. He stated staff should have verified the label of the medication against the electronic medication administration record (EMAR) prior to preparing and giving any medication. DON stated education was recently provided on the rights of medication administration. Facility medication administration policy dated January 2018, included a triple check of the five rights (right resident, right drug, right dose, right route and right time) was recommended when medication was prepared for administration. Medication was to be administered in accordance with written orders.	F 658			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688			3/28/25

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F 688	Continued From page 24 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed ensure a resident received range of motion exercises for 1 of 1 residents (R59) reviewed for passive range of motion. Findings Include: R59's quarterly Minimum Data Set (MDS) dated 1/23/25, indicated R59 was severely cognitively impaired, required moderate assistance with dressing upper body and was dependent with dressing lower body. R59 had functional limitations in range of motion to her upper and lower extremity on one side. R59 had a diagnosis of hemiplegia (inability to move one side of her body) following a cerebral infarction (CVA) (stroke) on her right dominate side. On 2/3/25 at 5:40 p.m., R59 was observed next to the nurse's station in a wheelchair with legs elevated and covered with a blanket, dressed in a hospital gown. R59's occupational therapy discharge summary dated 8/31/23, included a range of motion plan for			F 688	1. R59 PROM is on hold while OT reassesses. Will be added to care plan if a new PROM is ordered. 2. A full house audit was completed regarding residents with functional range of motion programs and these were care planned 3. OT to utilize communication forms whenever initializing or adjusting a functional range of motion program for a resident. Clinical leaders will enter a progress note and add the information regarding the functional range of motion into the care plan and the care guides. 4. Education began with OT staff to utilize communication forms whenever initializing or adjusting a functional range of motion program for a resident. Clinical leaders were educated to enter a progress note and add the information regarding the functional range of motion into the care plan and the care guides. Education will be completed by date certain.		

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F 688	Continued From page 25 passive range of motion (PROM) to right upper extremity (RUE) all joints and all planes of motion. R59's care plan with review date 1/13/25, included R59 had an alteration in mobility related to a CVA. Interventions included grab bars for mobility, physical therapy (PT) per doctor order, and to follow PT instructions. Care plan failed to include instruction on PROM exercise. R59's medical recorded failed to include updates to either therapy or the provider regarding R59's refusal for range of motion program. During interview on 2/4/25 at 3:21 p.m., nursing assistant (NA)-A stated a resident's range of motion exercises would be on their care plan. NA-A was unsure if R59 received PROM exercises. During interview on 2/4/25 at 3:27 p.m., NA-B stated it would be on the care guide if a resident was to receive PROM exercises and it would be documented electronically. NA-B stated R59 did not like when her right arm was touched. During interview on 2/5/25 at 8:20 a.m., nursing manager (NM)-C stated R59 did have PROM exercises for a period of time. NM-C was unable to say when or why R59 stopped receiving PROM. NM-C stated therapy would send a note about restorative programs upon discharge from therapy and the provider would be updated with any refusals of the program. NM-C stated PROM is important to prevent loss of mobility and contracture. During interview on 2/6/25 at 10:48 a.m., nurse	F 688	5. DON or designee will audit 3 residents weekly x 4 weeks to ensure their functional range of motion programs are in the care guide and care plan and is being followed. The results of these audits will be shared by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 688	Continued From page 26 practitioner (NP)-A stated she would expect the facility to update therapy if a resident was ordered therapy and was refusing. The facility would also need to document the refusal and the communication. During interview on 2/10/25 at 12:59 p.m., director of therapy (PTA)-A stated the recommendations for a resident with weakness from a CVA depend on the resident. Sometimes the focus would be on functional range of motion. PTA-A stated long term care residents are not regularly evaluated for therapy needs. Recommendations for therapy come from nursing or provider orders. PTA-A stated therapy would want to be updated if a resident was discharged from therapy with recommendations that were not able to be completed so the resident could be reevaluated or to see if anything else could be done. PTA-A stated the risk of not completing ROM exercises would be decreased rang of motion and contractures.	F 688			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assessment	F 698	1. R72 was assessed including fistula site, and no concerns were found. Care		3/28/25

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F 698	Continued From page 27 and monitoring for 1 of 1 residents (R72) reviewed for dialysis. Findings include: R72's quarterly Minimum Data Set (MDS) dated 1/2/25, included R72 was cognitively intact. R72 diagnoses included end stage renal disease and heart failure. R72's care plan with review date 1/2/25, included to monitor for signs of bleeding central dialysis catheter port site. Care plan failed to mention R72 received dialysis through fistula on left arm. R72's dialysis patient summary report dated 12/12/24, included both AV fistula on left forearm with placement date of 10/2/24 and central venous catheter listed under active dialysis accesses. During observation and interview on 2/5/25 at 2:00 p.m., R72 was noted to have a pressure dressing over fistula access site on left arm. R72 stated he had been receiving dialysis from the fistula on his left arm for a while. He last received dialysis the previous day. At time of interview, R72's physician orders did not indicate he had a fistula on his left arm. R72's order summary report dated 2/11/25, included the following: Dialysis T-TH-SA days of the week. Remember to send a snack or lunch with the resident, with a start date of 6/27/24 Patient has a Hickman Right IJ Dialysis Catheter, with a start date of 6/27/24 The patient has a Hickman catheter line, Staff is to monitor regularly for damage or leakage for	F 698	plan was reviewed and revised to include care of the fistula. Nursing orders were entered regarding care of fistula. 2. A full house audit was completed to identify residents that receive dialysis and there are no other residents besides the resident identified (R72) 3. Dialysis policy reviewed and no changes needed 4. Began education with all nurses to document all dialysis sites when completing any skin checks. Also to notify a clinical leader if the site and type of dialysis access site does not match the orders. Also to document any changes that occur to access such as returning to facility after port is changed to a fistula. Clinical nurse leaders were educated to review and revise the dialysis care plan quarterly and any time there are changes in regards to dialysis cares or site. Education will be completed by date certain 5. DON or designee ill Audit all dialysis residents weekly x 4 weeks to ensure dialysis cares and site are accurate in the orders and the care plan The results of these audits will be shared by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 698	Continued From page 28 accidentally pulled or bumped, with a start date of 6/27/24 Dialysis-No IV, Blood Draws, Blood pressure on left arm, with a start date of 2/5/25 Dialysis- Monitor fistula for Bruit and Thrill every sift, with a start date of 2/5/25 Dialysis - Vitals signs after dialysis, with a stat date of 6/27/24 R72's undated blood pressure summary included 246 entries between 10/3/24 and 2/5/25. 153 entries documented the blood pressure was taken on the left arm. During interview on 2/5/25 at 2:03 p.m., dialysis registered nurse (DRN)-A stated R72 had his fistula placed on 10/2/24 and started to receive dialysis with his fistula on 12/23/24. DRN-A stated education was provided to R72 about making sure the pressure dressing was removed within 4 hours of it being placed because R72 had shown for his dialysis session with the pressure dressing still in place from his previous appointment. DRN-A stated a pressure dressing should not be in place longer than 4 hours after dialysis. There is risk for clotting and narrowing of the blood vessels if the dressing remains in place longer. There was also increased risk for infection if a soiled dressing remained in place longer than necessary. During interview on 2/5/25 at 2:39 p.m., nurse manager (NM)-G stated she was unsure how long R72 had a fistula or how long he was receiving dialysis with it. NM-G confirmed R72's orders were updated on 2/5/25 to monitor his fistula and to not collect blood pressure readings on his left arm. NM-G stated she was unaware of any staff noticing a pressure dressing from			F 698			

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F 698	Continued From page 29 dialysis on R72's arm after appointments. NM-G confirmed this would have been a task nursing should have completed as part of their dialysis care. During interview on 2/5/25 at 2:49 p.m., director of nursing (DON) stated a resident who was receiving dialysis should have had daily weight and vital signs along with daily monitoring of the dialysis site. DON stated blood pressure and lab draws should not have been collected from the arm with a fistula. DON stated this would be noted on in the electronic medical record and on the care plan. There would be a risk for bleeding if this was not completed. During interview on 2/6/25 at 10:39 a.m., nurse practitioner (NP)-A stated she would expect a general assessment including vitals after dialysis. The pressure dressing should have been removed 4 hours after placement to prevent circulation issues. NP-A stated blood pressure should also not be collected on an arm with a fistula because it could lead to the fistula not working properly and circulation issues. Facility dialysis policy dated 11/22/19, included ongoing assessment and evaluation of the resident's condition would include monitoring for infection, patency by feeling the access for a thrill and listening with a stethoscope, not taking blood pressure from the access arm, and not collecting blood draws from the access arm. Documentation should have included a pre and post dialysis assessment, daily check of the access site (fistula) evaluation for signs and symptoms of an infection.	F 698			
F 732 SS=E	Posted Nurse Staffing Information	F 732			3/28/25

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F 732	Continued From page 30 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732			

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F 732	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to ensure the required nurse staffing information was posted daily for 3 of 6 days reviewed. This had the potential to affect all 57 residents residing in the facility and their visitors who may wish to view the information. Findings include: During observation on 2/3/25 at 2:29 p.m., the nurse staffing information was found on the outside of a "nursing supply" door, located in a side hallway of the facility. However, the posted nurse staffing information was dated 2/2/25. During observation on 2/5/25 at 7:17 a.m., posted nurse staffing information was dated 2/4/25. During observation on 2/11/25 at 9:52 a.m., posted nurse staffing information was dated 2/10/25. The facility's Nursing Hours Posting policy, revised 10/2/22, indicated the facility posted nursing staffing data daily, at the beginning of each shift, and the data was readily accessible to residents and visitors.	F 732	1. The missing nurse staffing was completed for days not posted. 2. All missing nurse staffing were completed for the past 6 months. 3. The form will be completed the day before and hung for the next day. The postings are hung on Friday for the weekends. The posting is adjusted as changes occur during the day by the staffing coordinator and the manager on duty. 4. Staffing coordinator and IDT were educated regarding the process of nursing staff postings and their responsibilities for adjusting this when they are the manager on duty. 5. The Administrator will audit 3x a week x 4 weeks to ensure the posting is hung and being updated. The results of these audits will be shared by the Administrator or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755			3/28/25

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F 755	Continued From page 32 §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a system to secure stored narcotics for 1 of 9 residents (R35) reviewed for diversion. Further, the facility failed to ensure medications were properly labeled with name and directions for use and stored in a manner that addressed infection control concerns in 6 of 6 medication cart reviewed for medication storage. This had the potential to affect all 20 residents who used insulin.			F 755	1. R35 Oxycodone was destroyed 2. Full house audit was completed to identify all residents that use insulin. Each Insulin pen was checked to ensure it is in a bag and that the bag has a label from pharmacy with dosing instructions 3. Med carts were reviewed and all narcotics were destroyed for those that		

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F 755	Continued From page 33 Findings include: During medication storage review on 2/10/25 and 2/11/25, several discontinued medications were noted to be in locked storage. Facility system was to count these medications. However, this process did not assure against diverted medications. R35's admission MDS, dated 12/24/24, indicated R35 was cognitively intact, and diagnoses included fracture of right lower leg, osteoporosis, and heart failure. R35's MAR dated 1/1/25 to 1/31/25, indicated a physician order start date 12/31/24 for oxycodone 2.5 mg po every 24 hours PRN for pain, and discontinued date 1/20/25. R35's individual narcotic record indicated 11 doses of oxycodone were signed out of the narcotic log from 1/2/25 through 1/23/25, with 2 doses signed out on 1/23/25 (2 days after medication was discontinued). However, R35's MAR dated 1/1/25 to 1/31/25, indicated 2 doses of oxycodone were administered. R35 reported they had not used any pain medications recently and had no increased pain. During interview on 2/5/25 at 2:23 p.m., RN-A stated she discussed oxycodone with R35. However, R35 did not know what oxycodone was for nor did she have any pain. RN-A stated it was suspicious and proceeded with an investigation. During review of medication cart on the transitional care unit (TCU) on 2/11/25 at 10:01 a.m., registered nurse (RN)-E showed all 12	F 755	had orders DC or residents discharged. Full house audit was completed to identify all residents that use insulin. Each Insulin pen was checked to ensure it is in a bag and that the bag has a label from pharmacy with dosing instructions Clinical leaders will review carts and destroy narcotics for those that had orders DC or residents discharged weekly. 4. Nurse managers were educated regarding destroying narcotics weekly including why this is to be done. All nurses were educated that all insulin pens must remain in the bag they arrived with that includes the pharmacy label with dosing instructions for infection control purposes and to complete rights of medication administration when administering insulin. Also educated in regards to what to do if an insulin bag is missing. 5. The DON or designee will audit all medication carts weekly x 4 weeks to ensure all narcotics were destroyed for those that had orders DC or residents discharged in that past week. The DON or designee will audit all medication carts weekly x 4 weeks to ensure that all insulin pens are in separate bags with the pharmacy label with dosing instructions. The results of these audits will be shared		

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F 755	Continued From page 34 insulin pens in the cart were stored in a cup in a drawer. The insulin pens did not have a plastic bag or other storage device to keep the insulin pens from touching each other during storage. Insulin pens did not contain a label with dosing instruction. RN-E stated only the name on the insulin pen was compared to the medication administration record (MAR) on the computer screen during administration of insulin. The dose was taken from the MAR and not compared against any other source. During review of second medication cart on the TCU on 2/11/24 at 10:14 a.m., RN-G showed all insulin pens on the cart were stored in a cup with out a bag or other separation device to keep the pens from touching each other. RN-G confirmed there was not dosing instructions on the labels of the insulin pens. RN-G stated only the medication and resident name was compared when administering insulin. The dose was only read from the MAR and not compared to another source. One insulin pen had a small piece of tan tap with a handwritten first name. RN-G stated she knew which resident that insulin pen was for because there was only one resident with that name in the building. During review off the first medication cart on respiratory care unit (RCU) on 2/11/25 at 10:27 a.m., RN-H showed the insulin pens for the cart were all stored together without a plastic bag or other separation device. RN-H showed a few bags with pharmacy labels on the in the cart in the same drawer as the insulin pens. RN-H stated she was not sure why the pens were not stored in the bags from pharmacy with the medication labels on them. RN-H confirmed one insulin pen in the drawer had only a piece of tape	F 755	by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 755	Continued From page 35 with a handwritten name on it. RN-H stated the label fell off so the handwritten name was placed for identification. During review of the first medication cart on the long term care (LTC) unit on 2/11/25 at 10:41 a.m., licensed practical nurse (LPN)-B showed all the insulin pens on the cart were stored in a box without plastic bags or any other separation device. LPN-B confirmed some of the pens were missing open dates and proper labeling. The first cart on LTC also contained a clear plastic cup with a piece of white tape and the words "Vit C 500 mg" written on it. LPN-B confirmed the cup contained unknown pills and was labeled Vitamin C. During review of the second medication cart on LTC on 2/11/25 at 11:01 a.m., LPN-C showed all of the insulin pens were stored in a box without plastic pharmacy bags with labels on them or any other separation device. LPN-C confirmed one Humulin KwikPen was unlabeled. LPN-C stated it may have come from the emergency kit and therefore was not labeled. LPN-C stated only one resident took that specific kind of insulin which is how he knew who it belonged to. LPN-C confirmed the pen was also missing an open date. During interview on 2/11/25 at 10:45 a.m., care coordinator (CC)-C confirmed the insulin pens on the first LTC medication carts were not stored or labeled correctly. CC-C confirmed the medications should have been stored in a plastic bag from pharmacy. CC-C confirmed not all of the pens have open or expiration dates on them. CC-C confirmed the insulin pens are brought into precautions rooms and the replaced into the cart	F 755			

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F 755	Continued From page 36 where they touch other insulin pens which could lead to contamination. CC-C confirmed there was a clear plastic cup with unknown pills it and a handwritten label. CC-C stated the medication carts should be During interview on 2/11/25 at 11:50 a.m., CC-C confirmed 4 insulin pens on the second LTC medication cart were not labeled correctly. Open dates were missing and an identification label was missing from one pen. During interview on 2/11/25 at 1:15 p.m., RN-A confirmed all pens were stored in a plastic cup and were not in plastic pharmacy bags. RN-A stated the pens were stored and labeled incorrectly and were undated and some were missing names. RN-A stated she was unable to state how the floor nurses would be completing the proper checks prior to giving the medication without the proper labels. RN-A stated it was important to label all insulin pens with open dates because there was a certain amount of time an insulin pen could be used before it needed to be disposed of. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated education for proper checks during administration of medication was an ongoing process. The DON stated the label on the medication should be compared against the EMAR to verify the patient, route, time, dose, and medication all match. DON confirmed the insulin pens were not stored properly and that the dosing should be on the insulin pen to compare it against the EMAR. Facility policy for pharmacy services and medication administration dated January 2018,			F 755			

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F 755	Continued From page 37	F 755			
F 759 SS=D	included medications should have been checked for the five rights (right resident, right drug, right dose, right route, and right time) three times by comparing the medication administration record with the medication label. Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free of medication error rate of five percent or greater. The facility had a mediation error rate of 8% with 2 errors out of 25 opportunities for errors involving 2 of 6 residents (R2, R240) observed during medication passes. Findings include: R2 quarterly Minimum Data Set (MDS) dated 11/12/24, included R2 was severely impaired cognitively. R2 had diagnoses of coronary artery disease (common form of heart disease where blood flow to the heart is limited), hypertension (high blood pressure) and dementia. R2's order summary report dated 2/10/25, included an order for metoprolol tartrate (a medication that affects the flow of blood to the arteries and veins) Tablet 25 MG Give 12.5 mg by mouth two times a day for hypertension with parameters to hold for apical pulse less than 60	F 759			3/28/25
			1. R2 was assessed and had no adverse effects related to the medication error. Provider, resident and poa notified, med error form and follow up was completed. R240 has discharged from the facility 2. Full house audit was completed to identify all residents that have parameters included in their medication orders. MAR report was reviewed for the past month to ensure they had not received any medications outside of the parameters All residents may be affected by medication errors 3. Medication administration policy was reviewed and no changes needed 4. Began education with nurses and TMAs in regards to what parameters are and why they are ordered and what may		

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F 759	Continued From page 38 beats per minute. During observation on 2/5/25 at 7:25 a.m., licensed practical nurse (LPN)-C obtained R2's blood pressure and pulse with an automatic blood pressure cuff after setting up medication in medication cup. Blood pressure reading was 150/89 with a pulse of 55. LPN-C gave R2 all medications including metoprolol tartrate. During interview on 2/5/25 at 7:25 a.m., LPN-C confirmed the pulse was below the parameter for giving the metoprolol tartrate and it should not have been given. During interview on 2/5/25 at 8:17 a.m., nursing manager (NM)-C stated she expected nurses to collect the pulse and confirm it was within the parameters prior to giving medication. During interview on 2/6/25 at 10:39 a.m., nurse practitioner (NP)-A stated the risk for giving metoprolol tartrate outside of the parameters is worsening bradycardia (slow heart rate) and in severe cases could lead to death. R240 admission record dated 2/10/25, included diagnoses of unspecified psychosis and dementia with behavioral disturbance. R240 order summary report dated 2/10/25, included an order for Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 12.5 mg by mouth in the afternoon for hospice care and seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth every 4 hours as needed for agitation and hallucinations for 14 Days. During observation on 2/6/25 at 12:52 p.m.,			F 759	happen if not followed. Also educated to PCC including where to locate who requires vital signs prior to med administration, where to see instructions for medications including parameters and not prepping the medications until the parameter is checked first. Began reeducation with nurses and TMAs in regards to the 7 rights of medication administration. Education will be completed by date certain. 5. DON or designee will audit 3 residents with parameters weekly x 4weeks to ensure they are being followed. DON or designee will audit med pass 9 times a week x 4 weeks to ensure residents are receiving medications per orders. The results of these audits will be shared by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 759	Continued From page 39 LPN-D was passing scheduled medication for R240. LPN-D prepared quetiapine fumarate 25 mg tablet with other scheduled medication and brought all medications into R240 to administer. During interview on 2/6/25 at 1:05 p.m., LPN-D compared medications in medication cup to blister pack cards. LPN-D confirmed she prepared and was going to give the incorrect dose of quetiapine fumarate. LPN-D confirmed she was going to give the unscheduled higher dose. During interview on 2/10/25 at 10:10 a.m., consultant pharmacist (CP) stated the risk of giving an incorrect dose would have been increased risk of side effects for the resident and the error could have been avoided by completing the proper checks prior to administering. During interview on 2/11/25 at 2:20 p.m., director of nursing (DON) stated all medication needed to be administered according to provider orders. The risk of the incorrect medication dose or timing of medication could lead to side effects, such as a low pulse rate. He stated staff should have verified the label of the medication against the electronic medication administration record (EMAR) prior to preparing and giving any medication. DON stated education was recently provided on the rights of medication administration. Facility medication administration policy dated January 2018, included a triple check of the five rights (right resident, right drug, right dose, right route and right time) was recommended when medication was prepared for administration.	F 759			

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F 761 F 761 SS=D	Continued From page 40 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 maintain safe storage of medications when medication carts were left unlocked and unattended in 2 of 6 medication carts and one instance of medications left unattended in a resident room. Findings include:			F 761 F 761	1. The medication carts were locked when observed to have been unlocked The nurse returned to R9 room and R9 received their medications 2. All residents that receive medications may be affected		3/28/25

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F 761	Continued From page 41 On 2/3/25 at 2:05 p.m., a medication cart on the long term care (LTC) unit of the facility was observed being unlocked and unattended. No staff was within direct eye site. At 2:09 p.m., a staff person was observed walking past the medication cart without locking it. At 2:13 p.m., care coordinator (CC)-C was observed locking the medication cart. During interview on 2/3/25 at 2:13 p.m., CC-C confirmed she locked the mediation cart after observing it unlocked and unattended. She stated the nurse was at the nurse's station and out of eye site. During observation of medication pass on 2/4/25 at 8:49 a.m., registered nurse (RN)-D brought R9's morning medications to his room. RN-D left medications in the room on a countertop next to R9's TV to return to the medication cart to collect some alcohol wipes. R9's door was approximately ¼ of the way open and residents were walking past doorway after leaving the dining room. Medications were left unattended for approximately 2 minutes. During interview on 2/4/25 at 8:56 a.m., RN-D confirmed she left the medications in R9's room to go back to her medication cart. RN-D stated she knew she was supposed to take the medications with her when she left the room and was not to leave them unattended. On 2/11/25 at 10:14 a.m., a medication cart was observed on the transitional care unit (TCU) being unlocked and unattended. Residents were observed in the hallway near the cart. During interview on 2/11/25 at 2:20 p.m., director	F 761	3. No change to processes 4. Began education with all nurses and TMAs regarding locking medication carts prior to walking away. Began education with all nurses and TMAs that they can not leave medications in a room (even for a moment) Education will be completed by date certain. 5. DON or designee will audit 3 medication carts 3x a week x 4 weeks to ensure the medication carts were locked when left unattended. DON or designee will audit med pass 9 times a week x 4 weeks to ensure medications are not being left in resident room without an order The results of these audits will be shared by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 761	Continued From page 42 of nursing (DON) stated it was his expectation to have medication carts locked anytime a nurse steps away from the cart, even if it is only 10 seconds. The only time a cart should have only been unlocked was when the nurse was removing medication from it. He stated 10 seconds could have easily turned into 10 minutes if the nurse were to be asked to assist with another task. DON stated a medication can never been left in a patient's room unattended. The nurse would be responsible for keeping the medication with them after it was dished up until it was given. He stated this was important to ensure residents were taking the correct medications. Facility policy for medication administration dated April 2018, included the medication art was to be kept closed and locked when out of sight of the nurse.	F 761			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880			3/28/25

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F 880	Continued From page 43 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880			

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F 880	Continued From page 44 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct appropriate hand hygiene during tracheostomy cares for 1 of 1 resident (R8) observed for tracheostomy cares. Further, the facility failed to ensure proper catheter drainage bag care and catheter drainage bag laying on the floor for 1 of 1 resident (R12) observed for cares. Findings include: R8's admission Minimum Data Set (MDS) dated 11/3/2024, indicated R8 was severely cognitively impaired, dependent for all cares and transfers, required the use of oxygen, suctioning, and tracheostomy care, and had the following diagnoses: non-traumatic brain dysfunction, heart failure (heart beats ineffectively), renal insufficiency (failure of the kidneys to pump efficiently), asthma, and respiratory failure. On 2/5/25 at 7:44 a.m., tracheostomy cares were observed for R8. Licensed practical nurse (LPN)-B began to remove the soiled gauze pad from between the resident's skin and tracheostomy tube, and used a Q-Tip with gauze to clean around the opening. After finishing cleaning, LPN-B removed her gloves and did not	F 880	1. R8 was assessed and had no adverse effects after hand sanitization was not completed R12 was assessed and had no adverse effects after catheter care was touching floor and was not completed per protocol. Care plan was reviewed and revised that he occasionally self transfers into bed and leaves catheter bag laying on floor. Risk and benefit completed regarding leaving bag on floor and nursing order was entered to check to ensure bag is not on the floor. 2. Full house audit completed to identify residents with trach Full house audit completed to identify residents with catheters 3. Handwashing policy was reviewed and no changes needed 4. Began education with all staff regarding hand hygiene Began education with nurses regarding		

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F 880	Continued From page 45 perform hand hygiene and put on a new pair of gloves. Registered Nurse (RN)-D was in the room assisting, and after LPN-B had finish cleaning, RN-D cleaned off the dirty items used for cleaning on the bedside table and removed her gloves, did not perform hand hygiene, put on new gloves and assisted in preparing the bed side table with the suctioning supplies. LPN-B then put on her sterile gloves to perform suctioning, completed it and removed her gloves and did not perform hand hygiene, then put on another pair of gloves. RN-D cleaned off the table of suctioning supplies, removed her gloves and did not perform hand hygiene, then put on a new pair of gloves. LPN-B then got a new gauze to place back under the tracheostomy tube, and then clean the residents face, neck and chest then removed her gloves and did complete hand hygiene once all cares had been completed. On 2/5/25 at approximately 8:00 a.m., LPN-B and RN-D stated they were expected to perform hand hygiene if their hands become soiled or contaminated, and any time they remove gloves and put on a new pair during cares. LPN-B and RN-D confirmed they did not wash their hands in between changing gloves, stated they thought they had but were nervous and hand hygiene should have been completed each time they removed their gloves because it was important to prevent any infections. On 2/6/25 at 2:03 p.m., the director of nursing (DON) stated they expected their staff to perform hand hygiene when entering/exiting a room, and when they change gloves between cares. The DON stated the importance of completing hand hygiene to prevent the spread of infection, and to ensure they were not carrying bacteria from one	F 880	hand hygiene specific to trach care. Began education with nursing department staff regarding infection control with catheter bag location and emptying including cleaning of spout. Education will be completed by date certain 5. DON or designee will audit trach care 3 times a week x 4 weeks to ensure hand hygiene was completed per policy DON or designee will audit 4 residents with catheters weekly x 4 weeks to ensure they are not touching the floor and that infection control practices were being followed during emptying. The results of these audits will be shared by the DON or designee monthly with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.		

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F 880	Continued From page 46 resident to the next. R12's admission Minimum Data Set dated 1/13/25, indicated R12 was cognitively intact. R12's care plan indicated he had alteration in elimination related to a foley catheter (indwelling urinary catheter). R12's provider progress note dated 1/29/25 indicated diagnosis of seizures, chronic obstructive pulmonary disease, cerebral vascular accident, and benign prostate hyperplasia with lower urinary tract symptoms (prostate gland enlarges putting pressure on the urethra and causing urinary problems). R12 interview on 2/03/25 at 5:19 p.m., revealed he had problems urinating and he had the catheter for about eight months. R12 stated the staff empty the urinary catheter drainage bad about two times a day. An observation on 2/5/25 at 7:38 a.m., the urinary catheter drainage bag was lying on the floor. Nursing assistant (NA)-D stated the urinary catheter drainage bag did not belong on the floor. NA-D hung the urinary catheter drainage bag on the bed. An observation on 2/6/25 at 2:42 p.m., the urinary catheter bag was lying on the floor. Licensed practical nurse (LPN)-D stated the urinary catheter drainage bag did not belong on the floor because it was a dignity issue, and it was not respectful for the resident and it was a cleanliness issue. An observation on 2/6/25 at 2:48 p.m., LPN-D put	F 880			

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F 880	Continued From page 47 gloves on hung up the urinary catheter bag on the bed. LPN-D got a urinal and emptied the catheter drainage bag into the urinal with 300 milliliters (ml). LPN-D put the spout in the holder on the catheter drainage bag. Then rinsed out the urinal and let air dry. LPN-D took her gloves off and washed her hands. LPN-D went to the medication cart out in the hallway. LPN-D stated she should have wiped the spout off prior to securing it back it the holder with an alcohol wipe. LPN-D took several alcohol wipes out of her pocket and stated she had them the whole time in her pocket. The facility's Handwashing policy last revised 2/2024, indicated when conducting a procedure requiring the use of gloves, proper hand hygiene shall be completed before donning gloves and removing gloves. A facility policy Indwelling Catheter Care Procedure dated 7/21/23, revealed when emptying the catheter bag, don new gloves, uncap bottom outlet of bag, drain urine into measuring container, cleanse outlet with alcohol swab and recap the outlet. Measure urine and dispose of it in the toilet. Remove gloves and wash hands.	F 880			

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted on 02/04/2025, 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			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2025

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.

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K 000	Continued From page 1 445 Minnesota St., Suite 145 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 80 at the time of the survey.	K 000			

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K 000	Continued From page 2			K 000			
K 362 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/04/2025 between 9:30 AM and 11:30			K 362			3/28/25
					1. The penetration above the crash cart and area next to office that had missing drywall have been repaired 2. All corridor walls were audited to determine if there are other penetrations, and these areas will be repaired. 3. When contractors do work in the building, maintenance will follow to ensure		

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K 362	Continued From page 3 AM, it was revealed by observation that there was a conduit penetrating the deck that had not been sealed in the crash cart room. 2. On 02/04/2025 between 9:30 AM and 11:30 AM it was revealed by observation that a section of drywall next to the office had not been replaced when an electronic tablet had been installed. An interview with the Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 362	that penetrations have been sealed. 4. A monthly audit will be completed by the Administrator for 3 months to ensure that contract work has been reviewed by the Maintenance Director. 5.The administrator or designee will bring results of audits to the facility QAPI committee monthly for input on the need to increase, decrease or discontinue the audit.		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363			3/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT NEW BRIGHTON				STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 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
K 363	Continued From page 4 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/04/2025, between 9:30 AM and 11:30AM it was revealed by observation that the kick plate to resident room 166 was damaged causing the door to not fully close and latch. An interview with the Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.			K 363	1. The door to room 166 was repaired to ensure the door properly closed. 2. All doors in the facility will be audited to determine if there are issues with closing and latching. Doors identified will be repaired. 3. Nursing, Housekeeping and Maintenance were educated on the process to report doors that do not latch or close properly. 4. A monthly audit will be completed by the Administrator for 3 months to ensure that ten (10) random doors close and latch properly. 5. The administrator or designee will bring results of audits to the facility QAPI committee monthly for input on the need		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2025
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K 363	Continued From page 5	K 363	to increase, decrease or discontinue the audit.		