



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 17, 2026

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

RE: CCN: 245164

Cycle Start Date: July 8, 2026

Dear Administrator:

On August 4, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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July 14, 2026

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

RE: CCN:245164

Cycle Start Date: July 8, 2026

Dear Administrator:

On July 8, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
 Health Regulation Division
 Minnesota Department of Health
 625 Robert Street N
 P.O. Box 64975
 Saint Paul, Minnesota 55164-0975
 Email: annette.m.winters@state.mn.us
 Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by **October 8, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **January 8, 2027** (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



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



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July 14, 2026

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

Re: Event ID: 2373FB-H1

Dear Administrator:

The above facility survey was completed on July 8, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT NEW BRIGHTON				STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/7/26 through 7/8/26, a standard abbreviated survey was conducted at your facility. 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: H51641433C (2984542) and H51642940C (3043916) with deficiencies issued at F658, F693, F698, F761, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			07/16/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			F0761	Immediate Corrective Action: R3 eye drops and ear drops were destroyed per policy. The 3 loose pills were removed from the med cart and destroyed according to policy. Corrective Action as it applies to others: Education completed with nursing staff on the Medication Storage in the Facility policy. Full house audit of medication carts to ensure all medications are labeled with resident name and date opened. Any expired or unlabeled medications were removed from the medication carts. Recurrence will be prevented by: Audit all med carts weekly for 4 weeks to ensure		07/24/2026

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

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

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F0761 SS = E	Continued from page 1 §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 properly store and label medications for 1 of 3 residents (R3) reviewed and for medications in medication cart 1 located on the respiratory care unit (RCU) . This had the opportunity to affect all ten residents whose medications were stored in the cart. Findings include: During an observation on 7/7/26 at 2:00 p.m., registered nurse (RN)-A prepared R3's medication including artificial tears eye drops). The eye drop vial (15 milliliters) was in a box that had previously been opened. The box and the bottle lacked R3's name and lacked the date it was opened. During an observation on 7/7/26 at 2:15 p.m., of the medication cart 1 located on the RCU there were three loose white round tablets that did not contain scoring or marks were sitting in the top drawer in the right, front corner and a bottle of carbamide peroxide 6.5% ear drops that had previously been opened but lacked date opened or resident name was in the top drawer in the left front corner. R3's admission Minimum Data Set (MDS), dated 4/23/26, indicated he had diagnoses of anoxic brain injury related to ruptured cerebral aneurysm, dysphagia, persistent vegetative state, chronic respiratory failure and received nutrition and hydration via gastric tube (g-tube). R3's order summary signed by the nurse practitioner (NP), dated 6/30/26, included carboxymethylcellulose sodium ophthalmic solution (lubricant eye drops) one drop in both eyes four times daily.			F0761	Continued from page 1 that all medications are labeled and dated per policy. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Designee		07/24/2026

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F0761 SS = E	Continued from page 2 During an interview on 7/7/26 at 2:28 p.m., RN-A stated the eye drops were known to be for R3 because she “always works on this cart” but should be labeled with his name and the date they were opened. She stated eye drops were supposed to be discarded after they had been open for 30 days and she was unsure when they were opened. She stated the vials of eye drops and ear drops should only be used for one resident. The ear drops should be labeled with the resident's name and the date they were opened. She stated the three white round tablets were house stock vitamin D that was taken from another medication cart earlier in her shift. She stated the medications should not be in the drawer freely. All house stock medications should be labeled with the date they were opened. During an interview on 7/7/26, nurse manager (NM)-A stated house stock medications should be labeled with the date opened to establish the expiration date. He stated eye drops and ear drops could not be used for multiple residents due to risk of contamination and infection and should be labeled with the resident's name once they have been used to reduce the chance of being used for more than one resident. During an interview on 7/8/26 at 11:54 a.m., the director of nursing (DON) stated all house stock medications must be labeled with the date they are opened. She stated eye drops and ear drops cannot be shared among residents due to risk of cross-contamination and should have a resident's name on them. She stated there should never be loose pills in the medication cart. The facility Medication Storage in the Facility policy, dated 5/2022, directed nurses may not transfer medications from one container to another or return partially used medication to the original container. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. It directed ophthalmic medications shall be labeled with date opened and the new expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. The nurse will check the expiration date of each medication before administering it. No expired medication will be administered to a resident.			F0761			07/24/2026

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F0658 SS = D	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 interview and document review the facility failed to include clinical indications for medication and treatments prescribed for 2 of 4 (R2,R3) residents reviewed for standards of practice. Findings include: R2's quarterly Minimum Data Set (MDS) dated 4/2/26 indicated he had end stage renal disease, heart failure, hypertension (high blood pressure), cerebrovascular disease (condition affecting the blood vessels and blood supply to the brain), history of a transient ischemic attack (a temporary blockage of blood flow to the brain), a restrictive cardiomyopathy (a heart disease where the heart becomes rigid) and was on dialysis. R2's order summary signed by the nurse practitioner (NP), dated 6/30/26, indicated he was to receive the following medication but the electronic medical record (EMR) lacked a diagnosis or clinical indication: lanthanum carbonate 500 milligrams (mg) (a medication used to lower phosphate levels in patients with end stage kidney disease) three times daily before meals on Monday, Wednesday and Friday. R3's admission Minimum Data Set (MDS), dated 4/23/26, indicated he had diagnoses of anoxic brain injury related to ruptured cerebral aneurysm, dysphagia, persistent vegetative state, chronic respiratory failure and received nutrition and hydration via gastric tube (g-tube). R3's order summary signed by the nurse practitioner (NP), dated 6/30/26, indicated he was to receive the following medications via g-tube but the electronic medical record (EMR) lacked a diagnosis or clinical indication: aspirin 81 mg every morning, baclofen 20 mg (muscle relaxant) every six hours,			F0658	Immediate Corrective Action: R2 and R3 medications were clarified with prescribing provider for indications or diagnosis. Corrective Action as it applies to others: Whole house audit of current resident's medication and treatment orders will be reviewed to ensure a diagnosis or indication is listed. Education completed with all staff who enter orders (nursing, admission coordinator, Health Information) on the Medication and Treatment Orders policy to include diagnosis/ indication for use and to clarify from the provider if there is not one listed. Recurrence will be prevented by: Audit 10 new orders weekly for 4 weeks to ensure a diagnosis or indication is listed.nThe results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Designee		07/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
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F0658 SS = D	Continued from page 4 bromocriptine mesylate 2.5 mg (a semisynthetic ergot alkaloid and dopamine D2 receptor agonist) three times daily, cyclobenzaprine 10 mg (muscle relaxant) three times daily, glycopyrrolate 1 mg (anticholinergic medication that reduces bodily secretions and regulates the nervous system) two times daily, levetiracetam 100 mg/ml (anti-seizure medication) two times daily, propranolol 30 mg (a medication for high blood pressure, migraines, and chest pain) three times daily. The orders also included the following treatments but lacked clinical indication: sodium chloride inhalation 3% (liquid medication used to treat conditions that cause thick mucus in the lungs) via nebulizer four times daily, bacitracin 500 units/gram (antibiotic ointment) every day to trach site and carboxymethylcellulose sodium ophthalmic solution (lubricant eye drops) one drop in both eyes four times daily. During an interview on 7/8/26 at 10:56 a.m., the regional nurse consultant (RNC) stated the medications should have a diagnosis or indication attached to the order. During an interview on 7/8/26 at 11:54 a.m., the director of nursing (DON) stated there must be a diagnosis for each medication ordered. She stated the admissions coordinator and health unit coordinators enter the orders into the EMR. During an interview on 7/8/26 at 1:10 p.m., the admissions coordinator stated she entered the orders for new admissions, the nurse on the unit performs a second check and a nurse manager performs a third check. She stated if the orders do not include a diagnosis, she would ask the provider to clarify why the resident is taking the medication. During an interview at 7/8/26 at 1:14 p.m., the HUC stated it was required to enter a diagnosis in the EMR for all medication orders. The facility Medication and Treatment Orders policy, dated 2/2024, directed orders for medications and treatments will be consistent with principles of safe and effective order writing. Orders for medications and treatments will be transcribed accurately and in a timely manner. Order must include clinical condition or symptoms for which the medication is prescribed.			F0658			07/24/2026

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F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interviews, the facility failed to verify placement of a gastric tube (g-tube) prior to medication administration for 1 of 2 residents (R3) reviewed for medication administration via feeding tube. Findings include: During an observation on 7/7/26 at 2:00 p.m., registered nurse (RN)-A paused R3's tube feeding and used a syringe to flush the g-tube with 30 milliliters (ml) water. She then administered the following medications, mixed with 15 ml water each, via gravity: cyclobenzaprine 10 milligrams (mg), gabapentin 100 mg and propranolol 30 mg. RN-A failed to verify placement of the g-tube prior to procedure. R3's admission Minimum Data Set (MDS), dated 4/23/26, indicated he had diagnoses of anoxic brain injury related to ruptured cerebral aneurysm dysphagia, persistent vegetative state, chronic respiratory failure and received nutrition and hydration via g-tube.			F0693	Immediate Corrective Action: RN-A was re-educated on the Enteral Tube Feeding Competency, including the Administering Medications through an Enteral Tube policy and Confirming Placement of Feeding Tube. Corrective Action as it applies to others: Education completed with all nurses related to Administering Medications through an Enteral Tube policy and Confirming Placement of Feeding Tube. Recurrence will be prevented by: Audit 3 medication administration via enteral tube weekly for 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Designee		07/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2026	
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F0693 SS = D	Continued from page 6 R3's care plan, dated 4/24/26, directed tube feeding per order and nothing by mouth (NPO). R3's signed NP orders, dated 6/30/26, indicated to check g-tube to ensure tube is in correct location prior to administering medications/feeding by aspirating small amount of stomach contents. During an interview on 7/7/26 at 2:15 p.m., RN-A stated it was not necessary to verify placement of R3's g-tube as long as R3 was not vomiting and there was no resistance when she flushed it. She stated it was not necessary to visualize the g-tube site as she assessed it earlier in the morning. During an interview on 7/7/26 at 3:37 p.m., nurse manager (NM)-A stated g-tube medication administration procedure should include checking for residue and checking for the resident's orders. During an interview on 7/8/26 at 10:14 a.m., the nurse practitioner (NP) stated verifying placement of the g-tube prior to medication administration was "usually the standard" to ensure medications were injected into the stomach. During an interview on 7/8/26 at 11:54 a.m., the director of nursing (DON) stated it was necessary to verify g-tube placement required verification of placement and she expected the nurses to follow care plans and orders to reduce the of the tube clogging and/or not working properly. The facility Administering Medications through an Enteral Tube policy, dated 3/2023, directed to verify placement of feeding tube. When correct tube placement has been verified, flush tubing with at least 30 ml of lukewarm tap water. The facility Confirming Placement of Feeding Tube policy, dated 7/2025, directed check to see if there is a specific provider order to check placement. To confirm placement of an existing feeding tube at the bedside: The exit site of the feeding tube should be marked at the time of initial placement.			F0693			07/24/2026

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F0693 SS = D	Continued from page 7 Use additional methods to test whether the tube is properly positioned: For g-tubes: attach syringe to connector and pull back gently to aspirate a small amount of stomach contents. If above suggests improper tube positioning, do not administer the feeding or the medication.			F0693			07/24/2026
F0698 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 interview and document review the facility failed to coordinate care with the dialysis center for 1 of 2 residents (R4) reviewed for dialysis. This had the opportunity to affect two of the residents at the facility. Findings include: R4's care plan, dated 8/28/25, directed communication folder to be sent to dialysis with each run. R4's quarterly Minimum Data Set (MDS) dated 6/5/26, indicated she had diagnoses of end stage renal failure (ESRD), dependent on renal dialysis and diabetes mellitus. R4's signed physician orders, dated 6/30/26, directed to complete dialysis form and send with resident to dialysis with dialysis scheduled for every Tuesday, Thursday, and Saturday. During an interview on 7/7/26 at 1:15 p.m., R4 stated she had just returned from dialysis and was not sent to dialysis with paperwork that morning. She stated the facility did not consistently send her to dialysis with paperwork.			F0698	Immediate Corrective Action: R4 dialysis communication form sent with resident to dialysis effective immediately. Corrective Action as it applies to others: Education completed with nursing and health information regarding the importance of using the dialysis communication form each time a resident goes to dialysis which includes vital signs, weight, changes in their health status and any refusals of care. Batch order in place for dialysis residents on dialysis communication form process. Recurrence will be prevented by: Audit 2 dialysis patients 3x weekly for 4 weeks to ensure that dialysis communication form is being utilized per policy. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Designee		07/24/2026

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F0698 SS = D	Continued from page 8 During an interview on 7/7/26 at 3:45 p.m., registered nurse (RN)-B stated the facility did not get R4's vital signs prior to her leaving for dialysis on 7/7/26 and did not send her with paperwork. A phone call was not made to the dialysis center. During an interview on 7/7/26 at 4:11 p.m., the health unit coordinator (HUC) stated it was her responsibility to set up appointments and transportation. She also sets up the paperwork for each appointment. She stated R4 did not require paperwork for her dialysis treatments. During an interview on 7/7/26 at 4:24 p.m., nurse manager (NM)-B stated the facility's standard practice was to send paperwork with every resident to all appointments, including dialysis. During an interview on 7/8/26 at 11:13 a.m., the dialysis center RN stated R4 did not usually arrive for her dialysis appointments with paperwork from the facility but should arrive with paperwork, including medication list, weight, vital signs, and any changes to her medical condition. During an interview on 7/8/26 at 11:54 a.m., the director of nursing (DON) stated it was not necessary for the facility to send paperwork to all dialysis appointments. The facility should call the dialysis center if the resident has any issues. She stated she was unsure what the facility policy directed them to do as she had not read it. She stated, "That's how it's been everywhere I have worked." During an interview on 7/8/26 at 1:29 p.m., the regional nurse consultant (RNC) stated the facility used a dialysis communication form each time a resident went to dialysis which included their vital signs, weight, changes to their health status and any refusals of care. During an interview 7/8/26 at 1:37 p.m., the administrator stated communication with the dialysis center should occur using the dialysis communication form. The facility Dialysis Center Communication Record			F0698			07/24/2026

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F0698 SS = D	Continued from page 9 form included resident name, pre-treatment vital signs, weight, transfer needs/mobility, injection site, precautions needed, as needed/pain medications administered prior to dialysis and additional information. The document included a section for the dialysis nurse to complete upon return to the facility. The facility Hemodialysis policy, dated 11/22/19, directed residents who require dialysis will receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The facility staff and dialysis center will have ongoing communication and collaboration regarding dialysis care and services. Documentation should include, but is not limited to, pre and post dialysis assessment/observation, daily check of the access site, evaluation for signs and symptoms of infection and fluid intake amounts for each shift with a 24-hour total if fluid restriction is in place.			F0698			07/24/2026
F0880 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 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			F0880	Immediate Corrective Action: R3 tube feeding was discarded and provided with new tube feed for infection control. Monitored R3 for signs & symptoms of infection. Corrective Action as it applies to others: Education with nurses on the proper infection control procedure on where to place the open tubing when disconnected, including the placement on tube feed pump and utilizing a cap. Audit all other enteral tube feed residents to ensure cap is placed on enteral feeding unit to be utilized for infection control. Recurrence will be prevented by: Audit 5 enteral tube feed residents once weekly for 4 weeks to ensure the cap is in proper placement in the enteral feeding unit or currently being utilized on the tube. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: DON/Designee		07/24/2026

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F0880 SS = D	Continued from page 10 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. §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 and interviews, the facility failed to maintain clean technique with the gastric feeding tubing for 1 of 2 residents (R3) reviewed for medication administration via enteral feeding. Findings include:			F0880			07/24/2026

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F0880 SS = D	Continued from page 11 During an observation on 7/7/26 at 2:00 p.m., registered nurse (RN)-A paused R3's tube feeding and placed the open end of the tube in a glove, wrapped the glove around the tubing and pressed into the handle of the feeding pump which was attached to a pole, while she administered R3's medications via a syringe. During an observation on 7/7/26 at 3:40 p.m., R3 was in his reclining wheelchair. The tubing was hanging on the pump connected to the pole and the tubing was open to air. R3's admission Minimum Data Set (MDS), dated 4/23/26, indicated he had diagnoses of anoxic brain injury related to ruptured cerebral aneurysm dysphagia, persistent vegetative state, chronic respiratory failure and received nutrition and hydration via g-tube. R3's care plan, dated 4/24/26, directed tube feeding per order and nothing by mouth (NPO). During an interview on 7/7/26 at 2:25 p.m., RN-A stated she covered the tubing with a glove to keep it clean, and she did not have a cap for it. During an interview on 7/7/26 at 3:37 p.m., nurse manager (NM)-A stated he would not recommend using a glove to cover the end of the tubing or leaving the tubing open to air for enteral feeding as it could pose a risk for contamination. During an interview on 7/8/26 at 10:14 a.m., nurse practitioner (NP)-A stated the enteral feeding tubing was not a sterile process but should be a clean process. He stated, "I would not recommend" leaving the tubing open to air or covering with a glove and would prefer to have the tubing covered with the cap. During an interview on 7/8/26 at 11:54 a.m., the director of nursing (DON)/infection preventionist stated placing a glove on the end of the tubing or leaving it open to air for the enteral tubing because germs could get into the tubing and there was a potential harm of infection. She stated this was not			F0880			07/24/2026

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F0880 SS = D	Continued from page 12 the practice she would expect. The facility Administering Medications through an Enteral Tube policy, dated 3/23/23, directed to stop the feeding and flush the tubing with 15-30 ml of lukewarm tap water then remove the syringe and clamp the tubing. Place the end of the tubing on a clean gauze pad positioned on the abdomen or chest of the resident.			F0880			07/24/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/7/26 through 7/8/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H51641433C (2984542) and H51642940C (3043916). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.			20000			07/16/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			07/16/2026