DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 25, 2022

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164
Cycle Start Date: January 13, 2022

Dear Administrator:

On February 16, 2022, we notified you a remedy was imposed. On February 24, 2022 the Minnesota Department of Health 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 February 24, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 3, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 25, 2022, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 3, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 24, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
January 25, 2022

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164
Cycle Start Date: January 13, 2022

Dear Administrator:

On January 13, 2022, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

## 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 April 13, 2022 (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 July 13, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245164 | A. BUILDING _____ B. WING _____ | C 01/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW BRIGHTON A VILLA CENTER** | **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 |
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| F 000 | INITIAL COMMENTS<br><br>From 1/12/22 - 1/13/22, a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint invesitgation. New Brighton A Villa Center was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated: H5164231C (MN80010); with deficiency cited at F684.<br><br>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. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced | F 684 | | 2/9/22 |

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

Electronically Signed | 01/27/2022

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 684 | Continued From page 1<br>by:<br>Based on interview and document review, the facility failed to comprehensively assess, adequately monitor, and implement interventions to promote healing and reduce the risk of complication for a wound on 1 of 1 resident (R1) reviewed for wound care.<br><br>Findings include:<br><br>R1's hospital progress note, dated 12/8/21, indicated R1 presented to the acute care hospital with limb ischemia (decreased blood flow) and due to needing ongoing wound care to his right heel post-discharge.<br><br>R1's admission Minimum Data Set (MDS), dated 12/16/21, indicated R1 had moderate cognitive impairment, required extensive assistance with bed mobility and transfers, and had several medical complications including a lower leg ulcer, cellulitis, heart failure, diabetes and PVD (peripheral vascular disease).<br><br>R1's care plan, dated 12/29/21, indicated R1 had diabetes and instructed staff to "check all of body for breaks in skin and treat promptly ..." when assisting with activities of daily living (ADLs) as of 12/15/21. Further, the care plan outlined a skin integrity focus, added 12/23/21, which directed staff to evaluate and treat R1's bilateral heel wounds per physical orders and evaluate resident for signs and symptoms of possible infections.<br><br>R1's Order Listing Report, printed 1/13/22, included an order, dated 12/10/21, for wound care to R1's bilateral heels which directed staff to cleanse the wounds and surrounding skin with soap and water, rinse and pat surrounding skin | F 684 | 1. R1 no longer resides at facility.<br><br>2. Residents that reside and admit to New Brighton with wounds have the potential to be affected. Plans of care will be reviewed for residents with wounds including assessment completion, interventions in place and update as needed. Residents with wound care will be interviewed to ensure treatments are completed.<br><br>3. Education will be provided to Licensed Nurses and Nursing Assistant on skin care which includes assessment, monitoring and interventions to identify and/or promote wound healing and decrease risk for complications.<br><br>4. Audits will be completed weekly by DON and/or designee related to wounds and skin care process to include discussion with residents and random audits of treatments for residents who are not able to participate in an interview. DON or designee will review at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified and recommendations made for continued audits and monitoring needs. | |

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| F 684 | Continued From page 2 | F 684 | | |

dry to be completed daily during the day shift. Then, an adaptic non adherent (dressing) was to be applied to the wounds, then padded with ½ ABD pad (a thicker, larger wound dressing) and front of ankle with ½ ABD pad to prevent skin breakdown from gauze wrap, and secure with kerlix (a gauze wrap).

R1's Nursing Evaluation (Admit/Readmit, Qtly, Annual, Sig Change) - V 4, dated 12/9/21, and completed 12/23/21, indicated R1 admitted to the nursing home and had skin impairments on right and left heels. The evaluation directed staff to document initial wound measurements and general evaluation in the "description" field, and the description of both was identified as "o/a." However, the document lacked evidence of wound measurements and additional descriptors to help establish baseline characteristics of the wound.

R1's Treatment Administration Record (TAR), dated 1/13/22, indicated staff had marked the wound care and dressing changes as completed from 12/11/21 through 12/28/21, with the exception of 12/13/21. However, R1's provider note, dated 12/23/21, indicated R1 was seen by nurse practitioner (NP)-A for follow up on 12/23/21. The note specified, "R [right] heel dressing has not been changed since 12/18 [12/18/21]. Family is upset about this today." The note indicated R1's right heel wound had a large amount of slough and necrotic wound base, and tan drainage on the dressing, and R1's left heel was scabbed. The note identified NP did wound care during exam on R1's left heel and RN-A completed wound care to R1's right heel.

R1's corresponding Skin Observation - V 1 (s),

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| F 684 | Continued From page 3<br>dated 12/12/21 to 12/23/21, were reviewed and identified:<br><br>On 12/12/21, the completed Observation indicated R1 did not have any skin issues observed. There was no recorded evidence or monitoring or the wound(s) identified on R1's heels which were recorded as present on R1's TAR with associated dressing changes being recorded as completed.<br><br>On 12/19/21, the completed Observation indicated R1 had two bruises, one wound/skin tear on his right knee, and scratches on his left knee. Again, there was no recorded evidence or monitoring or the wound(s) identified on R1's heels which were recorded as present on R1's TAR with associated dressing changes being recorded as completed.<br><br>However, on 12/23/21, R1's Skin and Wound Evaluation V 5.0, was completed which indicated R1 had a wound measuring 10.8 square centimeters (cm) in area, with length of 5.0 cm and width of 2.8 cm. The evaluation lacked documentation in each the following categories: Describe, Wound Bed, Exudate, Periwound, Wound Pain, Orders, Treatment, and Progress. The completed Evaluation lacked any recorded information or wound characteristics in more than 30 documentation fields despite spacing being present and/or provided to record these items. R1's medical record lacked any evidence the facility had assessed or accurately recorded, including with any applicable characteristics, R1's bilateral heel wounds until this Evaluation was completed on 12/23/21 (nearly two weeks after R1 admitted to the nursing home) despite dressing changes being recorded as completed | F 684 | | |

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| F 684 | Continued From page 4<br>in the TAR.<br><br>During interview on 1/12/22, at 12:02 p.m. R1's family member (FM)-A stated R1's hospital discharge orders instructed staff to change the bandages on both heels daily. FM-A expressed she presented to the nursing home on 12/23/21, and NP-A was making rounds who then looked at R1's heel wound(s) and found the bandages present on them were dated 12/18/21. FM-A stated NP verbalized the date and affirmed the bandages had not been changed in five days, and went to get registered nurse (RN)-A who then helped change the dressings on R1's heels.<br><br>When interviewed on 1/12/22, at 1:20 p.m. licensed practical nurse (LPN)-A stated any dressing change orders were kept and evident in the MAR and all placed or completed dressings should have the date it was completed identified on it which, despite not being a formal facility' practice, was best practice. LPN-A stated she thought it was the standard because when she went to change a dressing, she observed different initials and dates. She stated if a dressing couldn't be completed or if a resident refused, she would document the refusal. However, LPN-A stated she was not familiar with R1.<br><br>During interview on 1/12/22, at 1:54 p.m. RN-A stated dressing changes were implemented from the physician orders and tracked when completed on the Medication Administration Record (MAR). RN-A voiced it was "nursing 101" to date and initial a dressing when it was changed, and expressed she was unable to recall and large gap of days when R1's dressing had not been changed, however, acknowledged it went two | F 684 | | |

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| F 684 | Continued From page 5 | F 684 | | |

days without being completed. When questioned on the NP note, dated 12/23/21, RN-A expressed NP brought her to R1's room and she checked his wounds and re-dressed them where she voiced being thankful it was a "dry wound and a dry dressing." RN-A stated when she went to record the dressing change in the MAR, it had already been initialed as being completed and she thought the nurse assigned to R1 had planned to do it and possibly marked it off prematurely, but RN-A could not recall who the nurse was. RN-A voiced she briefly spoke with the nurse about the importance of dressing changes, however, acknowledged R1's wound care and dressing changes had not been done daily as was ordered adding it should have been completed or a refusal should have been recorded. During subsequent interview on 1/13/22, at 11:28 a.m. RN-A explained the Nursing Evaluation, including a full body audit and wound examination, should be completed with 24 hours of their admission to the nursing home. RN-A recalled R1 admitted to the nursing home, in part, due to having wounds present on his heels. RN-A reviewed R1's medical record and verified the several completed Skin Observation(s) lacked evidence of these wounds being reviewed or monitored, and RN-A stated they should have been recorded or, at least, the presence of dressings should be indicated. RN-A explained the nurse managers completed weekly 'wound rounds' and RN-A recalled R1's first rounding had some concern as the software wasn't recording the photos for some reason. However, RN-A recalled the wound had flaps of skin which were peeling off the heels and, despite those findings, RN-A verified she did not complete any documentation of the completed wound rounding session. Further, RN-A reviewed

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| F 684 | Continued From page 6 | F 684 | | |

R1's completed Skin and Wound Evaluation V5.0, dated 12/23/21, and verified it lacked several fields of information to record the wound characteristics; however, RN-A expressed since it was an unstageable wound, she did not need to complete any of those other fields, including those pertaining to drainage, dressings, and progress. RN-A acknowledged developed wounds should be monitored, as depending on the severity of the wound, it could worsen and lead to hospitalization.

During interview on 1/13/22, at 9:46 a.m. NP-A stated she saw R1 for a routine visit on 12/23/21, and wanted to see the wound on his heel and FM-A was present at the bedside. NP-A voiced she went to take off the dressing and noted the date, 12/18/21, was written on the dressing indicating it had not been changed which was "unfortunate" as there was heavy discharge present on it. NP-A then went and retrieved RN-A and reminded her the dressing was to be changed on a daily basis, then had her follow into the room and help with the dressing change and wound evaluation. NP-A stated RN-A was going to do the wound care and dressing change and was signing into the wound phone to take pictures and measurements when NP-A left the room. NP-A stated she did not know why the dressing was not changed, but expressed it should have been done before that and she documented such in her completed note. NP-A explained she relied on the nursing staff to update her between provider visits if the wound had been worsening or the dressing changes weren't being completed as ordered for various reasons.

On 1/13/22, at 1:59 p.m. the director of nursing

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| F 684 | Continued From page 7 | F 684 | | |

(DON) was interviewed, and she explained a comprehensive resident skin assessment should be completed as soon as possible after admission with subsequent observations completed on a weekly basis thereafter, usually on bath days. DON verified nurses should be recording all skin issues, including heel wounds, on those weekly evaluations and if a resident admitted with a previously identified wound, the first wound assessment should take place within 24-48 hours of admission and, again, weekly afterward. DON reviewed R1's medical record and verified the completed Skin Observations lacked record or evidence of the heel wounds being present along with any documentation measuring or assessing the wound until 12/23/21, which was weeks after R1 admitted to the nursing home. DON expressed R1's completed Skin and Wound Evaluation, dated 12/23/21, should have included a description of the wound in addition to the measurements, and identified the electronic form was still "in progress" and was never closed, which prevented it from appearing on the monitoring dashboard. DON added R1 had, "Clearly fell through the cracks." DON stated wound dressing changes were tracked in the TAR and she expected orders for daily dressing changes to be completed but there was no requirement to date each applied dressing adding it was rather a standard many nurses used and had. Further, DON stated wound dressing orders and monitoring should be completed and record to help prevent complications such as worsening of the wound and promote continuity of care.

The facility Skin Protection Guideline dated 7/7/21, indicated residents' skin should be examined as soon as possible upon admission, and staff should prioritize completion of the skin

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| F 684 | Continued From page 8<br>evaluation within the first two hours where possible. Further, the policy identified skin will be observed daily during care by the nursing assistants, and the nurse will be notified of any change in skin integrity and continue observation.<br><br>The facility Quick Reference Guide for Topical Wound Management (n.d.) indicated wound assessment should be conducted every 7-14 days and contain location and dimension and include assessment of periwound skin for changes in temperature and firmness. | F 684 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 25, 2022

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

Re: Event ID: WQJP11

Dear Administrator:

The above facility survey was completed on January 13, 2022 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00114 | A. BUILDING: _____ B. WING _____ | C 01/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW BRIGHTON A VILLA CENTER** | **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) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>From 1/12/22 to 1/13/22, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. New Brighton A Villa Center was found in compliance with the Minnesota (MN) State Licensure requirements. | 2 000 | | |

Minnesota Department of Health

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 01/27/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00114 | A. BUILDING: _____ B. WING _____ | C 01/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **NEW BRIGHTON A VILLA CENTER** | **825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112** |

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|---|---|---|---|---|
| 2 000 | Continued From page 1<br>The following complaint was found to be substantiated: H5164231C (MN80010), however, no licensing orders were issued.<br><br>The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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. | 2 000 | | |