Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 10, 2025

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

RE: CCN: 245164
Cycle Start Date: December 12, 2024

Dear Administrator:

On January 3, 2025, the Minnesota Department of Health, 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.

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

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December 20, 2024

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

RE: CCN: 245164
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 12, 2024, 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 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 March 12, 2025 (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 June 12, 2025 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT NEW BRIGHTON	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
F 000	INITIAL COMMENTS On 12/11/24 through 12/12/24, 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: H51642582C (MN00108989); H51642500C (MN00108905) with a deficiency issued at F684. As a result of the investigation, additional deficiency was cited at F740. 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 CFR(s): 483.25 § 483.25 Quality of care 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	F 684		12/30/24

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

Electronically Signed | 12/26/2024

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 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure professional standards of practice for medication administration were followed for 1 of 3 residents (R1) reviewed. Findings include: R1's annual Minimal Data Set (MDS) dated 11/25/24, indicated R1 had diagnoses of acute embolism and thrombosis of deep vein of left lower extremity and was cognitively intact. R1's Order Recap Report dated 12/12/24, indicated R1 had an order for Buprenorphine HCL (an opioid medication used to treat acute pain, and chronic pain) Buccal (Buccal administration involves placing a drug between your gums and cheek, where it also dissolves and is absorbed into your blood) Film 600 micograms (mcg) place and dissolve one film buccally every morning and at bedtime for pain ordered on 10/14/24, and discontinued on 11/6/24. Further, R1 had an order for Buprenorphine HCL sublingual two milligrams (mg) give one mg sublingually in the morning for pain ordered on 11/6/24, and discontinued on 11/21/24. R1's Medication Error Reconciliation Form dated 11/14/24, indicated R1 did not receive her Buprenorphine sublingual tablet on 11/9/24, and 11/10/24, and R1 was given the Buprenorphine HCL Buccal Film instead. R1 was stable however, was upset with staff over the error. Further, the form indicated an investigation completed on	F 684	1. R1 medication error had previously been identified, provider had been made aware and had no new orders. The error did not affect the resident. Follow up has now been completed with the nurse involved including receiving re-education to professional standards of practice for medication administration. 2. All medication errors from the past 2 months were reviewed to ensure follow up was completed. All residents that receive medications could be affected. 3. Medication error protocol was reviewed and no changes needed. The process to ensure all medication errors are followed up on includes a daily review of med errors with the clinical meeting to and is recorded on the meeting form. 4. Clinical leadership was educated to the medication error protocol. Education completed with nurses and TMAs in regards to professional standards of practice for medication administration including what to do if a medication is not available or not in the same form as the order. Education also provided on what to do if a medication error occurs or a medication error is found. 5. All medication errors will be reviewed over the next 6 weeks to ensure the protocol is being followed. Will audit 9 nurses weekly x 4 weeks to observe medication administration to ensure	

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F 684	Continued From page 2 12/12/24, revealed the nurse gave R1 the wrong pain medication, R1 had a recent medication change, R1 was aware of her medications and reported the nurse did not listen when she told her it was wrong. R1 did not have adverse effects and provider did not feel monitoring or change of order was necessary. Director of nursing (DON) provided education to the nurse involved. In addition, a statement was obtained from licensed practical nurse (LPN)-B by DON, and LPN-B stated she gave R1 the film because LPN-B could not find the sublingual medication. LPN-B stated she called the pharmacy and they indicated they could not send it that day and they would send it later. LPN-B confirmed she did not call the provider. LPN-B stated after R1 took the medication, R1 then informed LPN-B that was the wrong medication and then LPN-B looked. DON interviewed LPN-C as well who indicated LPN-C checked and found the sublingual tablets. The medication had been delivered a couple days prior to the medication error as they were administered on 11/7/24, and 11/8/24. On 12/12/24 at 11:01 a.m., R1 was laying in her bed in her room. R1 appeared comfortable and there were no pain indicators observed. R1 stated she was aware LPN-B gave her the film form rather that the tablet form for her pain medications. R1 stated she attempted to tell LPN-B however, LPN-B stated the tablets were discontinued and appeared to not believe R1. R1 preferred if LPN-B did not administer her medications anymore as the incident was upsetting to her. On 12/12/24 at 2:07 p.m., attempted phone interview with LPN-B was unsuccessful.	F 684	medications are administered per policy. The results of these audits will be shared by the DON with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.	

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F 684	Continued From page 3 On 12/12/24 at 2:54 p.m., LPN-C stated she was made aware of R1's medication error by social services. LPN-C stated R1 had been receiving Buprenorphine film prior and the order had changed to tablet instead. LPN-C indicated there was a "mix up" and R1 ended up receiving the film instead. LPN-C confirmed the facility had R1's tablets in the narcotic box and were available for administration at the time of the medication error. LPN-C stated she notified the provider at the time the error was discovered and no new orders where obtained. Further, LPN-C stated staff were expected to be completing the safety checks for the right medication, right dose, right form, and right person prior to administering the medication. On 12/12/24 at 3:26 p.m., interim director of nursing (DON) stated the medication error process was started when the medication error was identified on 11/14/24, and the provider was notified. DON indicated the previous DON had not completed the follow up and investigation portion of the medication error which was why that portion was completed on 12/12/24. DON stated the root cause of the medication error was due to LPN-B being unable to find the tablets and thought she could administer the film instead. DON stated she re-educated LPN-B on 12/12/24, regarding following orders and staff were not allowed to administer something different without the provider's permission. Further, DON stated the medication was the same however, was a different route and there was no adverse outcome noted for R1. Review of facility policy titled Preparation and General Guidelines dated 4/18, indicated staff were expected to utilize the 5 rights-right resident,	F 684		

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F 684	Continued From page 4 right drug, right dose, right route, and right time for each medication being administered. Review of facility policy titled Medication Error Procedure dated 1/20, indicated when a medication error occurred, the person responsible for the error or the person finding the error would complete the Medication Error Reconciliation Report. Further, the policy directed staff to contact the provider to inform them of the error by giving a description of the error and documenting provider comments and follow-up. The policy indicated the DON or designee would complete the Investigation Summary and meet with the person making the error and record education or follow-up action.	F 684		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a referral was made to an outside agency for psychiatric services as ordered by a physician for 1 of 1 resident (R3) reviewed.	F 740	1. ACP was notified to schedule a time to meet with R3 once she returns 2. Full house audit completed of all residents with referrals to ACP to ensure they were seen by ACP. 3. A new process was put into place	12/30/24

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F 740	Continued From page 5 Findings include: R3's quarterly Minimal Data Set (MDS) dated 11/26/24, indicated R3 had diagnoses of bipolar disorder, protein-calorie malnutrition, and adult failure to thrive. R1's physician order dated 11/29/24, indicated ACP (Associated Clinic of Psychology) referral, diagnosis concern for restrictive/avoidant eating. On 12/12/24 at 12:20 p.m., licensed practical nurse (LPN)-A confirmed R3 was not currently being seen by ACP and was last seen on 9/25/24. LPN-A was unaware if a referral had been made following the new order and stated social services (SS) submitted the ACP referrals. On 12/12/24 at 3:09 p.m., SS-A confirmed he was not aware of R3's order for an ACP referral and typically would be notified by the admissions staff or health coordinators would bring the order to SS-A to complete the referral. SS-A confirmed a referral had not been made. On 12/12/24 at 3:26 p.m., interim director of nursing (DON) stated if an order were to be received for an ACP referral, the staff would give the order to SS and to SS was aware and within a week, at least, a referral would need to be made. Requested for a policy related to physician orders however, the facility did not have a policy.	F 740	regarding nurses entering orders for referrals for ACP and for Social Services to run a report of ACP orders weekly. 4. Licensed nurses, HUC and admissions were educated regarding the process when receiving orders for ACP referrals. Education completed with Social Services regarding process of running report to view new orders for ACP and how to make ACP providers aware of new referrals. 5. Will audit all new ACP orders for the next 6 weeks to ensure that ACP was notified of the referral. Social Services to bring results of audit to QAPI for input on increase, decrease or discontinue audits.	

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Electronically delivered

December 20, 2024

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

Re: Event ID: MP5511

Dear Administrator:

The above facility survey was completed on December 12, 2024 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 12/12/2024

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

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2 000	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 12/11/24 through 12/12/24, 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:	2 000		

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2 000	Continued From page 1 H51642582C (MN00108989); H51642500C (MN00108905). 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		