



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2026

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

RE: CCN: 245164

Cycle Start Date: July 29, 2026

Dear Administrator:

On August 7, 2026, we notified you a remedy was imposed.

On August 28, 2026, the Minnesota Departments 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 August 25, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 29, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 7, 2026, 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 October 29, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 25, 2026, 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 Therefore, the NATCEP prohibition is rescinded.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.

Your request for a 24-hour RN waiver has been approved based on the submitted documentation.

Feel free to contact me if you have questions.

Sincerely,

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

Holly Zahler, Compliance Analyst

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



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September 8, 2026

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

Re: Reinspection Results
Event ID: 2CFF09-H2

Dear Administrator:

On August 28, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 29, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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



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August 7, 2026

Administrator

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

RE: CCN: 245164

Cycle Start Date: July 29, 2026

Dear Administrator:

On July 29, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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), 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)).

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 29, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 29, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 29, 2026.

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

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 29, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Tina Larsen, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Tina.Larsen@state.mn.us
Office: (320) 223-7374 Mobile: (320) 423-0619

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 29, 2027 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



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



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August 7, 2026

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

Re: State Nursing Home Licensing Orders

Event ID: 2CFF09-H1

Dear Administrator:

The above facility survey was completed on July 29, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Tina Larsen, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

St. Cloud District Office

4140 Thielman Lane

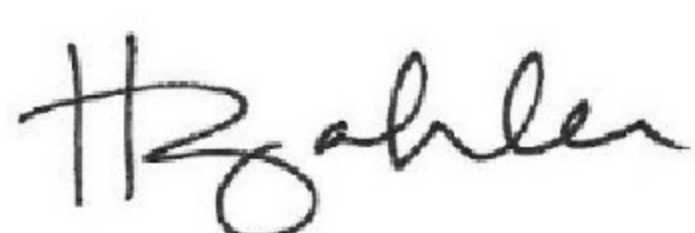
Saint Cloud, Minnesota 56301-4557

Email: Tina.Larsen@state.mn.us

Office: (320) 223-7374 Mobile: (320) 423-0619

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

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

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 07/29/2026	
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 7/29/26, an abbreviated survey was completed by a surveyor from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaint was reviewed: H51643531C (3117747); with a deficiency cited at F760 at past non-compliance. Additionally, incidental findings were discovered and cited at F609 and F761. 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			08/25/2026
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure steroid medication was given in accordance with physician orders for 1 of 3 residents (R1) reviewed. R1 had a history of long-term steroid use and multiple complex medical conditions. R1 had orders from the hospital for prednisone (a steroid medication) which were not correctly transcribed into the care center record (EMR) causing at least one missed dose. This error contributed to R1 developing an adrenal crisis and			F0760	"Past Noncompliance - no plan of correction required"		08/14/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2026	
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F0760 SS = G	Continued from page 1 being hospitalized which constitutes actual harm. However, the facility took corrective actions on 7/24/26 prior to the onsite investigation, so these findings are issued at past non-compliance (PNC). Findings include: R1's quarterly Minimum Data Set (MDS), dated 6/29/26, identified R1 had moderate cognitive impairment along with multiple medical conditions including anemia, high blood pressure, diabetes mellitus, hypothyroidism (condition where thyroid gland doesn't make enough thyroid hormone), and unspecified adrenocortical insufficiency (condition where adrenal glands do not make enough hormones, like cortisol, but the specific underlying cause had not yet been identified). R1's After Discharge Orders, dated 7/21/26, identified R1 was hospitalized on 7/10/26 and was being discharged to the care center. R1 was listed in stable condition and free of communicable disease. The orders listed R1's medications for the care center which included prednisone 5 milligrams (mg) tablets with a corresponding taper dose schedule including 17.5 mg daily for 14 days, 15 mg daily for 30 days, 12.5 mg daily for 30 days, then 10 mg daily thereafter. A start date was listed as 5/13/26, and the diagnosis attached to the prednisone was, "Sarcoidosis [inflammatory disease usually with growth of tiny clumps of immune cells called granulomas, most commonly affecting the lungs, lymph nodes, and skin] of other sites." Each page of the orders was signed by admission director (AD)-A. However, R1's Medication Administration Record (MAR), dated 7/2026, identified R1's consumed medications for the month period which lacked evidence the physician order for prednisone from the hospital (dated 7/21/26) had been provided, given, or refused. The last recorded dose of prednisone for R1 was 12.5 mg given on 7/10/26. R1's progress note, dated 7/21/26, identified R1 was readmitted to the care center from the hospital. R1 was alert and oriented X4 and had edema to both her upper and lower extremities. R1's progress note, dated 7/22/26, identified R1 was evaluated by nurse practitioner (NP)-A at the care center. R1 was hospitalized on 7/10/26 for abdominal pain, diarrhea, and elevated potassium levels. The hospitalization was complicated by urosepsis. She was discharged back to the care center on 7/21/26. On this evaluation, R1 reported			F0760			08/14/2026

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 07/29/2026	
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
F0760 SS = G	Continued from page 2 diffuse abdominal pain that was minimal, denied chest pain and was agreeable to meet with nephrology to discuss hemodialysis. NP-A placed some lab testing orders and a taper down of her current antidepressant medication. R1's progress note, dated 7/23/26, identified R1 was evaluated by NP-A again on an urgent basis. R1 had reported low blood pressures and was lethargic with no clear cause. R1 had no increased pain, urine changes or bleeding and had completed treatment for the urosepsis identified while hospitalized prior. R1's diagnoses were reviewed and NP-A identified R1 as appearing to be volume up (fluid) and, "Adrenal insufficiency: On prednisone. Possibly contributory." A physical exam recorded R1 as lethargic, pale and mildly diaphoretic with clear lung sounds, no acute rashes on her skin, and having a regular heartrate and rhythm. R1 was sent to the ED for evaluation. R1's Emergency Department Note, dated 7/23/26, identified R1 presented to the emergency department (ED) for evaluation of general malaise. EMS reported R1's blood pressure was 70/40 at the care center and R1 had a history of hospitalization due to sepsis and adrenal crisis. A physical exam was completed which found normal heart rate and rhythm, lung sounds clear bilaterally and no evidence of trauma. The medical decision making (MDM) outlined initial concerns for possible fluid overload given R1's history of heart failure and her presentation was felt to be consistent with recurrent septic shock/sepsis. R1 was admitted to the hospital. However, R1's History & Physical, dated 7/23/26 at 3:18 p.m., identified R1 had an extensive medical history including diabetes, adrenal insufficiency, hypothyroidism, and "sarcoidosis (on prolonged steroid taper)." R1's blood pressure was low at the care center and brought to the ED. In the ED, the blood pressure was even noted to have systolic pressure in the 50's. R1 had been recently hospitalized (7/10/26 to 7/21/26) for hyperkalemia (elevated potassium) and metabolic acidosis. R1 currently endorses malaise, chills and sweats, and shortness of breath. R1's lab values were listed which included a lactate level (indicative of infection) of 1.5 which was within normal range. The physician recorded a main concern of septic shock versus adrenal crisis versus cardiogenic shock. There was no clear source of sepsis infection but was showing signs of volume overload so IV diuretics were stated. The chart then listed, "Addendum ... Med rec [reconciliation] was done[,] and it appears there are several med errors that likely contributed to the			F0760			08/14/2026

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 07/29/2026	
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F0760 SS = G	Continued from page 3 hypotension and adrenal crisis ... Prednisone was not started at the nursing home therefore she has been off steroids for 2 days likely contributing to adrenal insufficiency" R1's progress note, dated 7/24/26, identified the care center nurse contacted the hospital for an update on R1. R1 was in the intensive care unit (ICU) for an admission diagnosis of adrenal crisis. The note added, "[Name] RN updated regarding missed dose of prednisone and discussed current med orders. This nurse spoke w/ [R1], notified [patient] of missed dose of prednisone." R1's (Facility) Medication Error Reconciliation Form, dated 7/24/26, identified an error happened on 7/22/26, with handwritten description of the error. R1's prednisone taper, as transcribed from the hospital orders, had been "missed in transcription." The report listed a section labeled, "Outcome to Resident," with handwritten response, "Hospitalization." The provider was notified of the error on 7/24/26, and R1 was transferred to the hospital. The section labeled, "Investigation Summary ...," identified R1 remained in the hospital and " ... is doing well, in ICU. Drowsy but [alert and oriented] X4 and stable. Admitting DX [diagnosis] adrenal insufficiency." The report labeled a section, "Categories of Medication Errors," and marked this error as, "Category C [error occurred that resulted in hospitalization]." The facility determined this error was not reportable as an allegation of neglect to the State agency (SA) as only a single dose had been missed and listed follow-up actions which included changing the process for a triple check of admission orders. The report was signed by the director of nursing (DON), nurse manager, and administrator. R1's subsequent hospital records, dated 7/24/26 to 7/28/26, identified R1's subsequent admission and ongoing care at the hospital, with multiple physician notes recording the adrenal crisis and/or insufficiency being likely related to the omitted prednisone dosing at the care center. These included: R1's Hospitalist Progress Note, dated 7/24/26, identified R1 was evaluated by the provider. The note included, "7/24: with steroids, symptoms seem to have resolved. BP high normal." A primary diagnosis of adrenal crisis was listed which reviewed the workup and history of evaluation thus far. The note included the addendum about the missed medication but now added, "After steroids restarted, patient appears to be back to normal." The hospital continued to address R1's multiple other health			F0760			08/14/2026

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 07/29/2026	
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
F0760 SS = G	Continued from page 4 conditions including edema and poor kidney function. R1's Nephrology Progress Note, dated 7/27/26, identified R1 was evaluated for her chronic kidney disease while hospitalized. R1 admitted to the hospital with "significant hypotension in the setting of septic shock/adrenal crisis after stopping home dose of prednisone." R1 also had acute kidney injury and volume overload. The note recorded an impression which included, "5. Shock at admission likely from adrenal crisis from mixed [sic] doses of prednisone." R1's Hospitalist Progress Note, dated 7/28/26, identified R1 remained in the hospital after presenting to the ED from the care center with profound hypotension (low blood pressure) which "improved rapidly" after IV steroid infusion adding, "... her presentation was felt to be most consistent with adrenal crisis related to inadequate outpatient steroid dosing rather than sepsis." R1's infection work-up in the hospital remained "unrevealing" and IV antibiotics had been discontinued. R1 was also found to have anemia and continued to have work-up completed on other medication conditions including diffuse anasarca (extreme, generalized fluid swelling across body). R1 remained hospitalized at the time of the onsite investigation (exited 7/29/26) and was unable to be interviewed. When interviewed on 7/29/26 at 9:11 a.m., registered nurse (RN)-A explained all medication administrations are completed using the "five rights" to ensure the correct dose, patient and route. When a patient returns from the hospital, the orders are entered into the EMR by AD-A or a nurse. The orders were then double checked by another nurse for accuracy before being listed as 'active.' RN-A stated they recalled having some education on this process just recently but were unable to recall the exact date of that. If a medication error was discovered, then a form was completed with the error information and the physician was updated. RN-A stated they had not had to fill-out one of those forms for a long time and were unsure where they were located. When interviewed on 7/29/26 at 10:11 a.m., AD-A verified their signature at the bottom of R1's After Discharge Orders (dated 7/21/26) and stated they often entered orders into the care center record before they were double-checked by the nurses. AD-A used the start date listed on the prednisone			F0760			08/14/2026

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F0760 SS = G	Continued from page 5 (5/13/26) to initially enter the prednisone into the facility EMR, however, they forgot to add a field of information which caused the screen to place a red-font warning at the top until it was correct. AD-A then went to the provider to confirm the prednisone dose for R1 and returned to the computer but did not see the red-colored warning. They clicked to save the order; however, it did not save due to the warning which needed to be addressed. The order packet was then placed on the desk for the nurse, who was RN-B, to double check and verify them. AD-A stated they were aware an error had occurred with R1's prednisone as the hospital called the care center when they discovered it had happened and told them. As a result, education had been provided and AD-A stated they were “paying more attention” to orders and to ensure no warnings were displayed with the saved orders in the EMR. On 7/29/26 at 10:29 a.m., NP-A was interviewed and recalled sending R1 to the ED on 7/23/26. R1 had developed low blood pressure and almost appeared septic aside from the abnormal low heartrate. She had been “deep lethargy” and appeared “really sick.” NP-A stated they had seen R1 on 7/22/26 for an examination and she “looked fine” then. NP-A stated they had received a notification after R1 was admitted to the hospital about the medication error and explained when prednisone was abruptly stopped after being taken, that it could cause a reduction in cardiac output and lead to low blood pressure and low heart rates. Those symptoms were also possible in sepsis but usually only in “severe cases.” NP-A stated it was hard to imagine a single missed dose of prednisone could cause the rapid change R1 had on 7/23/26, but if it were two or three missed doses, then a change like she demonstrated would be more likely. NP-A then reviewed the hospital H&P (dated 7/23/26) which included the addendum of the missed medication. NP-A stated dictation using words like contributing was the hospital's way of saying the missed medication was “the most likely contributor” to the event. NP-A stated upon review of that documentation, the missed medication was possibly a “pretty significant reason she was hospitalized.” NP-A added, “It fits the picture.” When interviewed on 7/29/26 at 11:05 a.m., RN-B verified they were assigned to R1 on 7/21/26 when she returned from the hospital. RN-B stated R1 arrived back to the care center in the evening hours on 7/21/26 and recalled going through the orders left on the desk by AD-A. RN-B stated they did not recall ever seeing the order for prednisone but had			F0760			08/14/2026

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F0760 SS = G	Continued from page 6 since been told they missed it. RN-B stated they should have used the hospital orders to match against the EMR orders once they had been entered. RN-B acknowledged the medication error and explained, "I think it was just an oversight on my part too." RN-B verified they had been provided re-education on the expectations for order checking and expressed aloud, "I can't have that happen [again]." On 7/29/26 at 11:19 a.m., the director of nursing (DON) was interviewed. DON verified hospital return orders should be entered and then double checked by a nurse in the EMR. They should then be checked on the night shift as a "triple check." DON stated R1's orders on 7/21/26 should have passed through three different people at the care center to help catch the error that happened. DON stated R1 remained hospitalized and, to their knowledge, the final diagnosis was adrenal insufficient and adrenal crisis. The hospital contacted the care center about the discovered medication error on 7/24/26. DON stated R1 would have had the 7/21/26 dose from the hospital, and the only dose they could confirm she missed as the 7/22/26 dose. R1 had the change of condition so early on 7/23/26, that she had not yet had her morning medications which is when the prednisone would have been given (if it were transcribed). DON stated they then investigated the situation and verified the medication error had happened but questioned if R1 was ever truly stable when she returned from the hospital on 7/21/26. DON acknowledged the lack of any charting in the progress notes to show R1 as lethargic or unwell until the 7/23/26 change of condition. DON stated they knew prednisone was a medication which was "important to take on time" as it could cause side effects if abruptly stopped. DON explained that since this incident happened, they had completed several steps to help prevent reoccurrence including education to the nurses and auditing other recent readmissions to ensure their orders were correctly entered and transcribed. They had found no further errors. When interviewed on 7/29/26 at 11:50 a.m., the consulting pharmacist (CP) stated prednisone was an intermediate acting steroid medication but was hard to say from "a pharmacist's standpoint" if a single missed dose could cause that rapid of decline or not. CP stated they didn't feel missing just a single dose could cause a major clinical change, however, CP added they were unsure of R1's exact clinical background or other medical conditions. Prednisone had a biological half-life (duration of action and tissue effect) of 12 to 36 hours so there would likely			F0760			08/14/2026

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F0760 SS = G	Continued from page 7 still be some, although reduced, medication in the body with just one missed dose. A National Library of Medicine article, titled "Prednisone," dated 4/2025, identified the elimination half-life of prednisone was 3 to 4 hours in an adult. The facility Medication and Treatment Orders policy, dated 2/2024, identified orders would be consistent with principles of safe and effective order writing. Medications would be administered only by people licensed and authorized to do so. The policy identified orders for medications would be "...transcribed accurately and in a timely manner." However, the policy lacked specific information on how orders would be double-checked or audited. The PNC harm-level finding was corrected on 7/24/26 prior to the onsite investigation exited on 7/29/26. The facility took multiple actions to correct the non-compliance including education to direct care staff, auditing other residents for medication errors, and reviewing their systems to reduce the risk of repeated incidence. A sample of other residents was reviewed as part of the investigation, and no additional errors were identified.			F0760			08/14/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations			F0609	Immediate Corrective Action: Administrator and Director of Nursing were educated on significant medication errors, Abuse Prohibition/Vulnerable Adult policy, specifically to reporting events. Corrective Action as it applies to others: Education was completed with IDT leadership on significant medication errors, medication error procedure, Abuse Prohibition/Vulnerable Adult policy. Full house audit of medication errors within the last 30 days to ensure any allegations of potential neglect were reported per policy. Recurrence will be prevented by: Audit medication errors weekly for 4 weeks to ensure any significant medication errors were		08/25/2026

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F0609 SS = D	Continued from page 8 to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential neglect of healthcare was reported to the State agency (SA) for 1 of 1 resident (R1) reviewed who had a significant medication error resulting in an adrenal crisis and hospitalization. Findings include: R1's After Discharge Orders, dated 7/21/26, identified R1 was hospitalized on 7/10/26 and was being discharged to the care center. R1 was listed in stable condition and free of communicable disease. The orders listed R1's medications for the care center which included prednisone 5 milligrams (mg) tablets with a corresponding taper dose schedule including 17.5 mg daily for 14 days, 15 mg daily for 30 days, 12.5 mg daily for 30 days, then 10 mg daily thereafter. A start date was listed as 5/13/26, and the diagnosis attached to the prednisone was, "Sarcoidosis [inflammatory disease usually with growth of tiny clumps of immune cells called granulomas, most commonly affecting the lungs, lymph nodes, and skin] of other sites." However, R1's Medication Administration Record (MAR), dated 7/2026, identified R1's consumed medications for the month period and lacked evidence the physician order for prednisone from the hospital (dated 7/21/26) had been provided, given, or refused. The last recorded dose of prednisone for R1 was 12.5 mg given on 7/10/26. R1's progress note, dated 7/23/26, identified R1 was evaluated by nurse practitioner (NP)-A on an urgent basis. R1 had reported low blood pressures and was lethargic with no clear cause. R1's diagnoses were reviewed and NP-A identified R1 as appearing to be volume up (fluid) and, "Adrenal insufficiency: On prednisone. Possibly contributory." A physical exam recorded R1 as lethargic, pale and mildly diaphoretic with clear lung sounds, no acute rashes on her skin, and having a regular heartrate and rhythm. R1 was sent to the ED for evaluation. R1's (Hospital) History & Physical, dated 7/23/26 at 3:18 p.m., identified R1 had an extensive medical			F0609	Continued from page 8 reported to the State Agency 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		08/25/2026

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F0609 SS = D	Continued from page 9 history including diabetes, adrenal insufficiency, hypothyroidism, and “sarcoidosis (on prolonged steroid taper).” R1’s blood pressure was low at the care center and brought to the ED. In the ED, the blood pressure was even noted to have systolic pressure in the 50’s. The physician recorded a main concern of septic shock versus adrenal crisis versus cardiogenic shock. There was no clear source of sepsis infection but was showing signs of volume overload so IV diuretics were started. The chart then listed, “Addendum ... Med rec [reconciliation] was done[,] and it appears there are several med errors that likely contributed to the hypotension and adrenal crisis ... Prednisone was not started at the nursing home therefore she has been off steroids for 2 days likely contributing to adrenal insufficiency” SEE F760 FOR ADDITIONAL INFORMATION. R1’s (Facility) Medication Error Reconciliation Form, dated 7/24/26, identified an error happened on 7/22/26, with handwritten description of the error. R1’s prednisone taper, as transcribed from the hospital orders, had been “missed in transcription.” The report listed a section labeled, “Outcome to Resident,” with handwritten response, “Hospitalization.” The provider was notified of the error on 7/24/26, and R1 was transferred to the hospital. The section labeled, “Investigation Summary ...,” identified R1 remained in the hospital and “ ... is doing well, in ICU. Drowsy but [alert and oriented] X4 and stable. Admitting DX [diagnosis] adrenal insufficiency.” The report labeled a section, “Categories of Medication Errors,” and marked this error as, “Category C [error occurred that resulted in hospitalization].” The facility determined this error was not reportable as an allegation of neglect to the State agency (SA) as only a single dose had been missed and listed follow-up actions which included changing the process for a triple check of admission orders. The report was signed by the director of nursing (DON), nurse manager, and administrator. The Centers for Medicare and Medicaid (CMS) Internet Quality Improvement and Evaluation System (iQIES) database was reviewed. There was no evidence that the missed medication had been reported to the SA as an allegation of neglect despite the error causing an adrenal crisis and contributing to her hospitalization. When interviewed on 7/29/26 at 11:19 a.m., the director of nursing (DON) verified R1 sustained a medication error due to her prednisone not being transcribed into the record system (EMR). They had since adjusted their process and reeducated staff on			F0609			08/25/2026

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F0609 SS = D	Continued from page 10 expectations for order entry. DON stated that, for certain, only a single dose had been missed prior to R1 being sent back to the hospital on 7/23/26. DON stated they did elevate this incident to corporate oversight who then determined it was not reportable as it was only a single dose missed and they felt that couldn't have caused the clinical change R1 demonstrated on 7/23/26. As a result, it was not reported to the SA. When interviewed on 7/29/26 at 2:28 p.m., the administrator stated they were out of the office when the incident happened, so questions on reporting it would have gone to the corporate regional consultant. The administrator verified it was not reported to the SA but was unsure of the rationale or insight into the decision-making on how that decision was reached. The administrator stated they believed R1 had been transferred due to a change of condition and not the medication error itself. The facility Abuse Prohibition/Vulnerable Adult Policy, dated 11/2025, identified the definition of neglect as, " ... the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." The policy directed allegations or suspicions of neglect which cause serious bodily injury would be reported to the SA within 2 hours of learning of the allegation, or within 24 hours if the allegation did not result in serious bodily injury.			F0609			08/25/2026
F0761 SS = D	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: R2 medication label was corrected with directional stickers to ensure accurate administration instructions. Corrective Action as it applies to others: A full house audit of all med carts was completed to ensure all medications were labeled with current and accurate administration instructions. Education was completed with all nurses regarding using the five rights of medication administration, specifically comparing the medication on the packaging to the orders in PCC for current and accurate administration instructions, and what to do when there is a discrepancy.		08/25/2026

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F0761 SS = D	Continued from page 11 §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, interview, and document review, the facility failed to ensure medications were labeled with current and accurate administration instructions to reduce the risk of medication error for 1 of 1 resident (R2) whose medication administration was observed. Findings include: R2's Order Summary Report, signed 6/30/26, identified R2's current physician ordered medications and treatments. This included an order for Propranolol HCL (medication used to treat high blood pressure, chest pain, and tremors) 30 milligrams (mg) orally three times daily. The order had a start date recorded as 2/4/2026. On 7/29/26 at 8:53 a.m., R2's medication administration was observed by registered nurse (RN)-A who prepared the medications from a mobile cart. RN-A handed each medication blister pack to the surveyor for review. The medications included one labeled Propranolol 10 mg tablets with label directions reading, "Give three tablets (30 mg) per g-tube four times daily before meals and at bedtime." The label had a dispense date recorded as 12/30/2025 and multiple doses had already been removed from the blister pack prior to this observation. RN-A compared the labeled medication to the Medication Administration Record (MAR) which directed 30 mg three times daily (TID) by mouth. RN-A stated the label was wrong and listed the incorrect route for the medication and incorrect frequency of administration. RN-A verified the dose just removed by them was not the first one taken from the blister pack and stated incorrect labels should be addressed with the pharmacy so a new, accurate one can be applied. RN-A stated an incorrect label could cause a medication error. RN-A then continued to prepare R2's medications and gave them to R2 who was seated outside in her wheelchair. R2 took the cup of prepared medications whole with water.			F0761	Continued from page 11 Recurrence will be prevented by: Audit 10 medications in each med cart weekly for four weeks to ensure all medication labels match the orders entered in PCC. 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		08/25/2026

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F0761 SS = D	Continued from page 12 Following, at 9:05 a.m., R2 was interviewed and stated she had never even had a gastronomy tube so was unsure where that direction on the label had come from. R2 stated she'd always taken her medications orally. When interviewed on 7/29/26 at 11:19 a.m., the director of nursing (DON) stated if a label is identified as wrong during the medication pass, the nurse should contact pharmacy and verify the actual provider order in the chart. The pharmacy should then send a new label so the order and label match. DON reiterated, "Everything should match." DON verified R2 never had a g-tube and stated she was unsure where that direction on the labeled came from. DON stated the label and order should match to ensure correct instructions are followed and having an incorrect label could cause a medication error. When interviewed on 7/29/26 at 11:50 a.m., the consulting pharmacist (CP) stated if nurses find a label that is inaccurate, they should place a sticker over it that indicates referring to the actual order. CP stated the facility should have those on hand to use. In the meantime, the nurse should follow the actual order in the MAR as that is likely the correct one. CP stated the label and order should match to help reduce discrepancy and the risk of medication error adding that a resident getting an extra dose of Propranolol could cause their heart rate or blood pressure to drop. The facility Medication Administration – General Guidelines policy, dated 5/2022, identified medications would be checked using the “five rights” method before each administration. This included checking the label and package and comparing them to the MAR. If the MAR and label are different, then the container should be flagged right away and the order changes communicated to the pharmacy so the next supply of medication can be labeled with current instructions. However, the policy did not identify how or what to flag the label with to meet this step.			F0761			08/25/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2026	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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 7/29/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H51643531C (3117747); order issued at 01610.			20000			08/10/2026

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 Minnesota Department of Health (MDH) documents the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.		20000			08/10/2026	
21620	Labeling of Drugs CFR(s): MN Rule 4658.1345 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were labeled with current and accurate administration instructions to reduce the risk of medication error for 1 of 1 resident (R2) whose medication administration was observed.		21620	Immediate Corrective Action: R2 medication label was corrected with directional stickers to ensure accurate administration instructions. Corrective Action as it applies to others: A full house audit of all med carts was completed to ensure all medications were labeled with current and accurate administration instructions.		08/25/2026	

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21620	Continued from page 2 Findings include: R2's Order Summary Report, signed 6/30/26, identified R2's current physician ordered medications and treatments. This included an order for Propranolol HCL (medication used to treat high blood pressure, chest pain, and tremors) 30 milligrams (mg) orally three times daily. The order had a start date recorded as 2/4/2026. On 7/29/26 at 8:53 a.m., R2's medication administration was observed by registered nurse (RN)-A who prepared the medications from a mobile cart. RN-A handed each medication blister pack to the surveyor for review. The medications included one labeled Propranolol 10 mg tablets with label directions reading, "Give three tablets (30 mg) per g-tube four times daily before meals and at bedtime." The label had a dispense date recorded as 12/30/2025 and multiple doses had already been removed from the blister pack prior to this observation. RN-A compared the labeled medication to the Medication Administration Record (MAR) which directed 30 mg three times daily (TID) by mouth. RN-A stated the label was wrong and listed the incorrect route for the medication and incorrect frequency of administration. RN-A verified the dose just removed by them was not the first one taken from the blister pack and stated incorrect labels should be addressed with the pharmacy so a new, accurate one can be applied. RN-A stated an incorrect label could cause a medication error. RN-A then continued to prepare R2's medications and gave them to R2 who was seated outside in her wheelchair. R2 took the cup of prepared medications whole with water. Following, at 9:05 a.m., R2 was interviewed and stated she had never even had a gastronomy tube so was unsure where that direction on the label had come from. R2 stated she'd always taken her medications orally. When interviewed on 7/29/26 at 11:19 a.m., the director of nursing (DON) stated if a label is identified as wrong during the medication pass, the nurse should contact pharmacy and verify the actual provider order in the chart. The pharmacy should then send a new label so the order and label match. DON reiterated, "Everything should match." DON verified R2 never had a g-tube and stated she was unsure where that direction on the labeled came from. DON stated the label and order should match to ensure correct instructions are followed and			21620	Continued from page 2 Education was completed with all nurses regarding using the five rights of medication administration, specifically comparing the medication on the packaging to the orders in PCC for current and accurate administration instructions, and what to do when there is a discrepancy. Recurrence will be prevented by: Audit 10 medications in each med cart weekly for four weeks to ensure all medication labels match the orders entered in PCC. 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		08/25/2026

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21620	Continued from page 3 having an incorrect label could cause a medication error. When interviewed on 7/29/26 at 11:50 a.m., the consulting pharmacist (CP) stated if nurses find a label that is inaccurate, they should place a sticker over it that indicates referring to the actual order. CP stated the facility should have those on hand to use. In the meantime, the nurse should follow the actual order in the MAR as that is likely the correct one. CP stated the label and order should match to help reduce discrepancy and the risk of medication error adding that a resident getting an extra dose of Propranolol could cause their heart rate or blood pressure to drop. The facility Medication Administration – General Guidelines policy, dated 5/2022, identified medications would be checked using the “five rights” method before each administration. This included checking the label and package and comparing them to the MAR. If the MAR and label are different, then the container should be flagged right away and the order changes communicated to the pharmacy so the next supply of medication can be labeled with current instructions. However, the policy did not identify how or what to flag the label with to meet this step. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on medication labeling to determine education needs to be provided to direct care staff. Then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days			21620			08/25/2026