Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 2, 2024

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

RE: CCN: 245164
Cycle Start Date: June 26, 2024

Dear Administrator:

On July 26, 2024, 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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 2, 2024

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

Re: Reinspection Results
Event ID: NJ6F12

Dear Administrator:

On July 26, 2024 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 June 26, 2024. At this time these correction orders were found corrected.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2024

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

RE: CCN: 245164
Cycle Start Date: June 26, 2024

Dear Administrator:

On June 26, 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 September 26, 2024 (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 December 26, 2024 (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, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 06/26/2024

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 6/25/24 and 6/26/24, 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: H51644866C (MN00104226) H51644698C (MN00104244) with a deficiency issued at F755. 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 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		7/26/24

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

Electronically Signed | 07/16/2024

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.

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 06/26/2024

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 755	Continued From page 1 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures for the use of methadone hydrochloride (HCl, a synthetic medication used to treat addiction) treatment for acquisition, administration, destruction, and an appropriate taper for 1 of 1 resident (R2) reviewed for medication administration. Additionally, the facility failed to implement policies and procedures to ensure rapid detection of potential narcotic diversion for 6 of 6 medication carts reviewed. Findings include: R2's quarterly Minimum Data Set (MDS) dated	F 755	1. R2 is no longer resides at the facility 2. No other residents are receiving methadone at this time. All residents that receive narcotics have the potential to be affected. All narcotic books were reviewed for completion of narcotic indexes and page headers. 3.A methadone addendum has been developed which includes information regarding communication between facilities, information regarding what facility provider is able to do, and information regarding dispensing methadone. Also includes what to do if resident unable to go to methadone clinic, what to do if	

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 06/26/2024

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 755	Continued From page 2 5/9/24, indicated R2 was cognitively intact, and used opioids (medication used for pain relief). R2's care plan indicated a history of substance use with sobriety since 8/23, and R2 went to a methadone clinic for methadone treatment dated 11/6/23. R2's Medication Administration Record (MAR) dated May 2024, indicated R2 missed doses of methadone on 5/7/24, 5/22/24, 5/23/24, and 5/24/24. R2's progress note dated 5/7/24 at 12:43 p.m., indicated R2's methadone was on order. R2's provider orders dated 11/23/23 to 5/13/24, indicated methadone HCl methadone oral concentrate 10 milligrams (mg) /milliliter (ml) give 11.9 ml by mouth in the morning. R2's provider orders dated 5/13/24, indicated methadone HCl oral concentrate 10 milligrams (mg)/ milliliter (ml), give 10.7 ml by mouth in the morning for opioid dependence for 14 days, then give 9.6 ml by mouth for opioid dependence in the morning for 14 days. The order was discontinued on 5/31/24 by physician's assistant (PA)-A. R2's provider progress notes dated 5/8/24 at 00:00, written by PA-A indicated R2 was prescribed methadone HCl oral concentrate 10 mg/ml, give 11.9 ml by mouth in the morning for opioid dependence. The provider indicated R2 was interested in discontinuing methadone, had received her last two weeks of doses available from the methadone clinic, and PA-A was going to	F 755	methadone is not available, what to do if a dose is missed, and what to do if the dose does not match the order. The policy for controlled substance storage policy was reviewed and no changes needed. 4. Education has begun with licensed nurses to the methadone addendum and education has begun with licensed nurses and TMAs regarding the procedure for counting narcotics, narcotic book documentation, and proper medication destruction. 5. Residents that receive methadone will be audited weekly x 4 weeks, to ensure medication is being received as ordered. Methadone addendum quiz will be given; 5 quizzes weekly x 4 weeks to assess staff knowledge of process. Narcotic book audits to be completed weekly times x 4 weeks, to ensure narcotic book documentation is accurate. Narcotic counts will be observed 6x a week x 4 weeks to ensure it is being completed correctly. Medication destruction quiz will be 5 quizzes weekly x 4 weeks to assess their knowledge of destruction process. The results of these audits will be shared monthly by the DON/designee with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.	

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 06/26/2024

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 755	Continued From page 3	F 755		

consult the pain team for a plan moving forward. The progress notes further indicated R2 would not get into a wheelchair as it cut in to her sides.

R2's progress note dated 5/8/24 at 2:38 p.m., indicated social worker (SW)-A picked up R2's methadone from the methadone clinic and was told R2 needed to be seen in the methadone clinic face-to-face, or be cut from the program.

R2's progress note dated 5/20/24 at 00:00, by PA-A indicated R2 was prescribed methadone HCl 10 mg/ml, to administer 10.7 ml by mouth in the morning for 14 days, and then 9.6 ml by mouth in the morning related to opioid dependence. R2 reported general body achiness, muscular in nature. PA-A indicated the symptoms were due to a possible pneumonia or the decreased dose of methadone. PA-A further indicated she spoke to the facility pain management team on 5/20/24, and the pain management team agreed to take over the management of R2's methadone dosing.

R2's progress note dated 5/23/24 at 4:00 p.m., indicated R2 was out of methadone, the provider was updated, R2 was experiencing pain and discomfort, and was expected to experience withdrawals. The progress note indicated the pharmacy refused to dispense it and medical doctor (MD)-A refused to prescribe it.

R2's progress note dated 5/28/24 at 2:28 p.m., indicated SW-A brought R2 a wheelchair to go to an appointment at the methadone clinic, and R2 stated she could not sit in a wheelchair that long. The progress note indicated social worker (SW)-A asked R2 what her plan was when the methadone

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 06/26/2024

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 755	Continued From page 4 clinic discontinued her from the program and R2 responded she would have to just stop using it. R2's methadone order dated 6/7/24, written by PA-A, indicated R2's methadone was prescribed for chronic pain. On 6/25/24 at 12:25 p.m., medical doctor (MD)-B stated R2 was under the care of a methadone clinic for methadone dosing for opioid addiction. R2 was admitted to the facility in October of 2023, on what was supposed to be a short-term stay. There were rules about how many take-out methadone doses a resident could have, but it was working well between the facility and the methadone clinic with the facility social worker's help. R2 was in and out of the hospital due to infections, and the methadone clinic was informed by the hospital, not the facility, that R2's dose was tapered by the facility. It was a violation of regulations for the facility to adjust the doses. The methadone clinic consulted with R2's care team and determined the methadone clinic practitioners would see R2 in the hospital and at the facility, but R2 decided she didn't want to return to the methadone program. A PA at the methadone clinic spoke with MD-A and informed MD-A anyone else changing the dose was, "Out of bounds." On 6/25/24 at 12:49 p.m., licensed practical nurse (LPN)-A stated the methadone clinic dispensed 14 methadone doses for R2 on 5/24/24, SW-A picked them up and was informed they were R2 's last doses, and the doses would last through 6/5/24. The methadone clinic dispensed 14 methadone doses to SW-A on May 8th for use May 8th through May 21st, but the facility didn't pick up the	F 755		

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 06/26/2024

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 755	Continued From page 5 doses until 5/24/24, and R2 missed doses on 5/22/24, 5/23/24, and 5/24/24. The facility started a methadone taper in May 2024, without consulting the methadone clinic, but there were rules that only the methadone clinic could perform the taper as the methadone prescriber. LPN-A further expressed concern about the facility's destruction of the remainder of each dose that was altered, if it was wasted appropriately, or if the methadone was dosed correctly. She explained the single-dose bottles were foil-sealed with the correct dose from which R2 was supposed to drink the full dose. The facility did not consult the methadone clinic for information about how to correctly administer the tapered dose from the single-dose bottle, acknowledged the facility could likely figure out how to administer the correct dose, but should have consulted the methadone clinic pharmacy or their own pharmacy first. MD-A called the methadone clinic on 6/14/24, to inquire about a dose taper but R2 was hospitalized on 6/13/24. The methadone clinic learned from the hospital the facility already started the methadone taper, so the methadone clinic could no longer follow the patient and dispense doses after the facility provider improperly adjusted the doses. LPN-A stated, "We didn't know what [the facility] was doing." The methadone clinic asked with each two-week dose pick-up, for a urine sample for urinalysis (UA) to test for R2's use of methadone, but only one was provided over the eight months. On 6/25/24 at 2:55 p.m., SW-A stated because R2 couldn't tolerate sitting in a wheelchair to transport to the methadone clinic, SW-A picked up methadone doses for R2 from the methadone clinic 14 doses at a time. The methadone program	F 755		

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 06/26/2024

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 755	Continued From page 6 staff informed him in the early part of May [could not recall the date], R2 had to go to the methadone clinic for her doses, and R2 stated she was not going to go and was willing to just quit taking the methadone. He called the facility provider, physician's assistant (PA-A), to inform of this, and the provider stated they were unable to write the prescription for R2. He consulted with the facility pain management team who informed SW-A they could not write prescriptions for methadone for addiction, only pain management. He was unsure of the dates of any of the conversations with the providers. On 6/26/24 at 9:53 a.m., during a subsequent interview, SW-A acknowledged the nurses at the methadone clinic asked for UAs, and he told the facility nurses. He took two urine specimens to the methadone clinic during eight months he picked up methadone doses. The facility did not share with him why R2 was cut from their program, but was informed during the 5/24/24 pick-up, they were the last 14 doses the methadone clinic would provide. On 6/25/24 at 3:19 p.m., during an interview LPN-B stated on 6/13/24, when R2 went to the hospital for cellulitis, R2 was out of methadone, and the facility was unsure how to get more for the resident. R2 was required to get her methadone from a methadone clinic, and the facility providers could not prescribe it. After the taper from methadone 119 ml to 96 ml, some had to be wasted from the foil-sealed container. She put the wasted amount on a tissue in a paper cup and put it in the sharps container (needle disposal container). She looked online how to do the dose conversion but could not state how to perform the conversion.	F 755		

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 06/26/2024

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 755	Continued From page 7 On 6/25/24 at 3:38 p.m., LPN-C stated the facility PA was performing the methadone taper. She had tried to order the PA-prescribed dose from the facility pharmacy, but was told the facility pharmacy could not fill it. She reviewed the narcotic book where R2's methadone was recorded, unit RCU2, pages 81 and 86, and acknowledged nurses did not co-sign wasting the unused portion of methadone, but stated it was the facility policy for two nurses to co-sign narcotic wasting. Further, she acknowledged the narcotic signature page headers were not completed with the medication prescription information, but the facility policy indicated it should have been. She stated the signature page header should include the narcotic name, the date it was prescribed, a dose, and the name of the provider who prescribed it. She further acknowledged nursing staff was expected to administer less than was prescribed, and two nurses should have wasted the excess together, "In the chemical." Additionally, she acknowledged R2 did not receive methadone doses on 5/22/24, 5/23/24, and 5/24/24. On 6/25/24 at 4:56 p.m., pharmacist (P)-B stated the facility pharmacy was not able to prescribe methadone for anything other than pain. On 6/25/24 at 5:20 p.m., trained medication aide (TMA)-A stated when R2's methadone dose changed, she was required to waste some of the pre-filled bottle and wasted the excess by flushing it down the toilet. She acknowledged she did not always waste narcotics with a double signature, but acknowledged she did, as a TMA, perform narcotic wasting.	F 755		

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 06/26/2024

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 755	Continued From page 8 On 6/26/24 at 10:23 a.m., MD-C stated the facility should not have changed R2's methadone dose, and the hospital learned of the change from R2, not the facility. When R2 ran out of methadone on 6/13/24, the facility had no plan on how to get more, so R2 was sent to the hospital coincidentally the same day for cellulitis. MD-C stated facility staff removed the methadone with a syringe from sealed containers and, "Any pharmacist would have flagged this." MD-A planned to perform the methadone taper for R2, but then could not as it was prescribed for addiction and not pain. The taper occurred first, and then the methadone clinic discontinued R2's care due to the prescribing laws. On 6/26/24 at 10:59 a.m., R2 stated she wanted to taper off methadone, but thought the methadone clinic was going to taper it, not the facility. Her single-dose vials were brought to her open and she drank what they brought. She was concerned about what the facility was doing with her methadone dosing. On 6/26/24 at 11:06 a.m., PA-A stated she tapered R2's dose, "Very slightly." She was alerted R2 used her last dose after R2 went to the hospital on 6/13/24 for cellulitis. She talked to MD-A's associate at the pain clinic who agreed to take over the dosing, but learned later the pain clinic could not dose the methadone. "It was on [MD-A] to figure it out. There were too many cooks in the kitchen. If he was managing it, then he was managing it." On 6/26/24 at 12:02 p.m., the director of nursing	F 755		

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 06/26/2024

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 755	Continued From page 9 (DON) stated she was not aware the methadone clinic required monthly urine testing, the nurses should not have punctured the seal on the foil-sealed doses from the methadone clinic, and should not have drawn the dose into a syringe. The facility providers did not know they could not adjust the methadone doses. The MAR was not correct to indicate methadone was used for pain. The DON acknowledged R2 missed doses of methadone when the facility ran out and didn't pick it up timely, and acknowledged the facility did not have a policy or procedures in place to manage methadone for addiction. On 6/26/24 at 12:18 p.m., P-D stated methadone prescriptions from the facility contracted pharmacy could only be for pain, the dosing for pain was typically 5-30 mg, and for opioid dependence was between 60-120 mg. PH-D stated, "The dose [R2] was prescribed told us it was not used for pain." If the facility providers wanted to decrease the dose, it was recommended the facility providers collaborated with the methadone clinic provides, and the medical record lacked indication that occurred. On 6/26/24 at 1:06 p.m., MD-A stated he was unsure why the methadone clinic quit following R2 as a patient but knew he could not write a prescription for R2's methadone for addiction. He learned after the patient went to the hospital the methadone clinic thought he was tapering the dose, but upon review of the order, PA-A from the facility tapered the dose. Only one provider could write a prescription for methadone addiction. He was not consulted when PA-A changed the dose.	F 755		

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 06/26/2024

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 755	Continued From page 10 On 6/27/24 at 10:47 a.m., P-C stated if the methadone was dispensed from a methadone clinic, the facility contracted pharmacy could not also dispense it, and the methadone clinic would manage dose adjustments and tapers. She did not know the facility staff withdrew methadone from the doses provided by the methadone clinic to adjust the doses. After 6/13/24, the facility plan to ensure R2 received prescribed methadone was unknown and, "That is part of the problem. I guess she would have had to quit cold turkey," because of the prescribing rules, and it appeared there was a lack of communication between the facility and the methadone clinic. The proper way to dispose of liquid methadone was in the medication safe. On 6/26/24 at 9:15 a.m., during document review of the narcotic books on each unit the following was identified: Unit RCU2's narcotic book lacked 19 of 152 narcotic count signatures from 6/1/24 a.m. shift to 6/26/24 a.m. shift. Unit RCU1's narcotic book lacked 20 of 152 narcotic count signatures from 6/1/24 a.m. shift to 6/26/24 a.m. shift. Unit LTC2's narcotic book lacked 22 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night. shift. Unit LTC1's narcotic book lacked 56 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Unit TCU1a's narcotic book lacked 52 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Unit TCU2 a' s' narcotic book lacked 69 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift.	F 755		

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 06/26/2024

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 755	Continued From page 11 Additionally, R2's methadone records in the narcotic book, page 10, was not indexed in the narcotic book, and the information on the narcotic record / count sheet lacked information about the prescribing provider, the pharmacy, the directions, the dose, the prescription number, or prescription date. R2's methadone record in the narcotic book page 86 was not indexed in the narcotic book, and lacked information about prescribing provider, the pharmacy, the directions, the prescription number, and the prescription date. On 6/26/24 at 1:18 p.m., during a follow-up interview the DON stated the nursing staff and TMAs count narcotics together at the end of each shift, unless the nurse was working a double shift. The nurse who received a narcotic delivery would index the medication in the narcotic book, and complete a medication count sheet head fully with the name of the medication, prescribing provider, dosage, pharmacy name, prescription number, prescription date, and the transfer page number if the medication was transferred from another unit. The DON acknowledged medication indexed were not complete, shift count signatures were not completed at the end of each shift, and the medication information was not present on the signature pages. Medications should not run out, should be ordered ahead of time to ensure they did not. The facility did not have a policy about resident use of methadone clinics for addiction but should. Pre-filled doses should be dispensed as labeled or the medication administration staff should clarify the order and instructions with the pharmacy or provider. Additionally, she expected nurses to dispose of narcotics per recommended guidelines for the medication and the policy or ask	F 755		

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 06/26/2024

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 755	Continued From page 12 for help. The Medication Storage in the Facility: Controlled Substance Storage policy dated August 2019, directed a controlled substance accountability record was prepared by the pharmacy/ facility and the following information was completed on the accountability form [narcotic book] upon dispensing or receipt of a controlled substance: Name of the resident, Prescription number, Name, strength, and dosage form of the medication, date received, quantity received, and the name of the person receiving the medication. The policy further indicated at each shift, or when keys were transferred, a physical inventory of all controlled substances was conducted by two licensed nurses and was documented. The Specific Medication Administration Procedures Policy dated April 2018, directed immediately after administration of a controlled substance the nurse would document administration immediately in the controlled substance sign out record [narcotic book]. Once removed from the package or container, unused or partial doses should be disposed of in accordance to the medication destruction policy.	F 755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: NJ6F11

Dear Administrator:

The above facility was surveyed on June 25, 2024 through June 26, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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
	00114	A. BUILDING: _____ B. WING _____	06/26/2024

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) COMPLETE DATE
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 6/25/24 and 6/26/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was	2 000		

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 _____	06/26/2024

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) COMPLETE DATE
2 000	Continued From page 1 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 complaints were reviewed: H51644866C (MN00104226) H51644698C (MN00104244) with a licensing order issued at 4658.1350 Subp 3 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 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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 _____	06/26/2024

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) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures for the use of methadone hydrochloride (HCl, a synthetic medication used to treat addiction) treatment for acquisition, administration, destruction, and an appropriate taper for 1 of 1 resident (R2) reviewed for medication administration. Additionally, the facility failed to implement policies and procedures to ensure rapid detection of potential narcotic diversion for 6 of 6 medication carts reviewed. Findings include:	21550	Corrected	7/26/24

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 3 R2's quarterly Minimum Data Set (MDS) dated 5/9/24, indicated R2 was cognitively intact, and used opioids (medication used for pain relief). R2's care plan indicated a history of substance use with sobriety since 8/23, and R2 went to a methadone clinic for methadone treatment dated 11/6/23. R2's Medication Administration Record (MAR) dated May 2024, indicated R2 missed doses of methadone on 5/7/24, 5/22/24, 5/23/24, and 5/24/24. R2's progress note dated 5/7/24 at 12:43 p.m., indicated R2's methadone was on order. R2's provider orders dated 11/23/23 to 5/13/24, indicated methadone HCl methadone oral concentrate 10 milligrams (mg) /milliliter (ml) give 11.9 ml by mouth in the morning. R2's provider orders dated 5/13/24, indicated methadone HCl oral concentrate 10 milligrams (mg)/ milliliter (ml), give 10.7 ml by mouth in the morning for opioid dependence for 14 days, then give 9.6 ml by mouth for opioid dependence in the morning for 14 days. The order was discontinued on 5/31/24 by physician's assistant (PA)-A. R2's provider progress notes dated 5/8/24 at 00:00, written by PA-A indicated R2 was prescribed methadone HCl oral concentrate 10 mg/ml, give 11.9 ml by mouth in the morning for opioid dependence. The provider indicated R2 was interested in discontinuing methadone, had received her last two weeks of doses available from the methadone clinic, and PA-A was going to	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 4 consult the pain team for a plan moving forward. The progress notes further indicated R2 would not get into a wheelchair as it cut in to her sides. R2's progress note dated 5/8/24 at 2:38 p.m., indicated social worker (SW)-A picked up R2's methadone from the methadone clinic and was told R2 needed to be seen in the methadone clinic face-to-face, or be cut from the program. R2's progress note dated 5/20/24 at 00:00, by PA-A indicated R2 was prescribed methadone HCl 10 mg/ml, to administer 10.7 ml by mouth in the morning for 14 days, and then 9.6 ml by mouth in the morning related to opioid dependence. R2 reported general body achiness, muscular in nature. PA-A indicated the symptoms were due to a possible pneumonia or the decreased dose of methadone. PA-A further indicated she spoke to the facility pain management team on 5/20/24, and the pain management team agreed to take over the management of R2's methadone dosing. R2's progress note dated 5/23/24 at 4:00 p.m., indicated R2 was out of methadone, the provider was updated, R2 was experiencing pain and discomfort, and was expected to experience withdrawals. The progress note indicated the pharmacy refused to dispense it and medical doctor (MD)-A refused to prescribe it. R2's progress note dated 5/28/24 at 2:28 p.m., indicated SW-A brought R2 a wheelchair to go to an appointment at the methadone clinic, and R2 stated she could not sit in a wheelchair that long. The progress note indicated social worker (SW)-A asked R2 what her plan was when the methadone clinic discontinued her from the program and R2	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 5 responded she would have to just stop using it. R2's methadone order dated 6/7/24, written by PA-A, indicated R2's methadone was prescribed for chronic pain. On 6/25/24 at 12:25 p.m., medical doctor (MD)-B stated R2 was under the care of a methadone clinic for methadone dosing for opioid addiction. R2 was admitted to the facility in October of 2023, on what was supposed to be a short-term stay. There were rules about how many take-out methadone doses a resident could have, but it was working well between the facility and the methadone clinic with the facility social worker's help. R2 was in and out of the hospital due to infections, and the methadone clinic was informed by the hospital, not the facility, that R2's dose was tapered by the facility. It was a violation of regulations for the facility to adjust the doses. The methadone clinic consulted with R2's care team and determined the methadone clinic practitioners would see R2 in the hospital and at the facility, but R2 decided she didn't want to return to the methadone program. A PA at the methadone clinic spoke with MD-A and informed MD-A anyone else changing the dose was, "Out of bounds." On 6/25/24 at 12:49 p.m., licensed practical nurse (LPN)-A stated the methadone clinic dispensed 14 methadone doses for R2 on 5/24/24, SW-A picked them up and was informed they were R2 's last doses, and the doses would last through 6/5/24. The methadone clinic dispensed 14 methadone doses to SW-A on May 8th for use May 8th through May 21st, but the facility didn't pick up the doses until 5/24/24, and R2 missed doses on 5/22/24, 5/23/24, and 5/24/24. The facility started	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 6 a methadone taper in May 2024, without consulting the methadone clinic, but there were rules that only the methadone clinic could perform the taper as the methadone prescriber. LPN-A further expressed concern about the facility's destruction of the remainder of each dose that was altered, if it was wasted appropriately, or if the methadone was dosed correctly. She explained the single-dose bottles were foil-sealed with the correct dose from which R2 was supposed to drink the full dose. The facility did not consult the methadone clinic for information about how to correctly administer the tapered dose from the single-dose bottle, acknowledged the facility could likely figure out how to administer the correct dose, but should have consulted the methadone clinic pharmacy or their own pharmacy first. MD-A called the methadone clinic on 6/14/24, to inquire about a dose taper but R2 was hospitalized on 6/13/24. The methadone clinic learned from the hospital the facility already started the methadone taper, so the methadone clinic could no longer follow the patient and dispense doses after the facility provider improperly adjusted the doses. LPN-A stated, "We didn't know what [the facility] was doing." The methadone clinic asked with each two-week dose pick-up, for a urine sample for urinalysis (UA) to test for R2's use of methadone, but only one was provided over the eight months. On 6/25/24 at 2:55 p.m., SW-A stated because R2 couldn't tolerate sitting in a wheelchair to transport to the methadone clinic, SW-A picked up methadone doses for R2 from the methadone clinic 14 doses at a time. The methadone program staff informed him in the early part of May [could not recall the date], R2 had to go to the methadone clinic for her doses, and R2 stated she	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 7 was not going to go and was willing to just quit taking the methadone. He called the facility provider, physician's assistant (PA-A), to inform of this, and the provider stated they were unable to write the prescription for R2. He consulted with the facility pain management team who informed SW-A they could not write prescriptions for methadone for addiction, only pain management. He was unsure of the dates of any of the conversations with the providers. On 6/26/24 at 9:53 a.m., during a subsequent interview, SW-A acknowledged the nurses at the methadone clinic asked for UAs, and he told the facility nurses. He took two urine specimens to the methadone clinic during eight months he picked up methadone doses. The facility did not share with him why R2 was cut from their program, but was informed during the 5/24/24 pick-up, they were the last 14 doses the methadone clinic would provide. On 6/25/24 at 3:19 p.m., during an interview LPN-B stated on 6/13/24, when R2 went to the hospital for cellulitis, R2 was out of methadone, and the facility was unsure how to get more for the resident. R2 was required to get her methadone from a methadone clinic, and the facility providers could not prescribe it. After the taper from methadone 119 ml to 96 ml, some had to be wasted from the foil-sealed container. She put the wasted amount on a tissue in a paper cup and put it in the sharps container (needle disposal container). She looked online how to do the dose conversion but could not state how to perform the conversion. On 6/25/24 at 3:38 p.m., LPN-C stated the facility PA was performing the methadone taper. She had tried to order the PA-prescribed dose from the	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 8 facility pharmacy, but was told the facility pharmacy could not fill it. She reviewed the narcotic book where R2's methadone was recorded, unit RCU2, pages 81 and 86, and acknowledged nurses did not co-sign wasting the unused portion of methadone, but stated it was the facility policy for two nurses to co-sign narcotic wasting. Further, she acknowledged the narcotic signature page headers were not completed with the medication prescription information, but the facility policy indicated it should have been. She stated the signature page header should include the narcotic name, the date it was prescribed, a dose, and the name of the provider who prescribed it. She further acknowledged nursing staff was expected to administer less than was prescribed, and two nurses should have wasted the excess together, "In the chemical." Additionally, she acknowledged R2 did not receive methadone doses on 5/22/24, 5/23/24, and 5/24/24. On 6/25/24 at 4:56 p.m., pharmacist (P)-B stated the facility pharmacy was not able to prescribe methadone for anything other than pain. On 6/25/24 at 5:20 p.m., trained medication aide (TMA)-A stated when R2's methadone dose changed, she was required to waste some of the pre-filled bottle and wasted the excess by flushing it down the toilet. She acknowledged she did not always waste narcotics with a double signature, but acknowledged she did, as a TMA, perform narcotic wasting. On 6/26/24 at 10:23 a.m., MD-C stated the facility should not have changed R2's methadone dose, and the hospital learned of the change from R2, not the facility. When R2 ran out of methadone on	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 9 6/13/24, the facility had no plan on how to get more, so R2 was sent to the hospital coincidentally the same day for cellulitis. MD-C stated facility staff removed the methadone with a syringe from sealed containers and, "Any pharmacist would have flagged this." MD-A planned to perform the methadone taper for R2, but then could not as it was prescribed for addiction and not pain. The taper occurred first, and then the methadone clinic discontinued R2's care due to the prescribing laws. On 6/26/24 at 10:59 a.m., R2 stated she wanted to taper off methadone, but thought the methadone clinic was going to taper it, not the facility. Her single-dose vials were brought to her open and she drank what they brought. She was concerned about what the facility was doing with her methadone dosing. On 6/26/24 at 11:06 a.m., PA-A stated she tapered R2's dose, "Very slightly." She was alerted R2 used her last dose after R2 went to the hospital on 6/13/24 for cellulitis. She talked to MD-A's associate at the pain clinic who agreed to take over the dosing, but learned later the pain clinic could not dose the methadone. "It was on [MD-A] to figure it out. There were too many cooks in the kitchen. If he was managing it, then he was managing it." On 6/26/24 at 12:02 p.m., the director of nursing (DON) stated she was not aware the methadone clinic required monthly urine testing, the nurses should not have punctured the seal on the foil-sealed doses from the methadone clinic, and should not have drawn the dose into a syringe. The facility providers did not know they could not	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 10 adjust the methadone doses. The MAR was not correct to indicate methadone was used for pain. The DON acknowledged R2 missed doses of methadone when the facility ran out and didn't pick it up timely, and acknowledged the facility did not have a policy or procedures in place to manage methadone for addiction. On 6/26/24 at 12:18 p.m., P-D stated methadone prescriptions from the facility contracted pharmacy could only be for pain, the dosing for pain was typically 5-30 mg, and for opioid dependence was between 60-120 mg. PH-D stated, "The dose [R2] was prescribed told us it was not used for pain." If the facility providers wanted to decrease the dose, it was recommended the facility providers collaborated with the methadone clinic provides, and the medical record lacked indication that occurred. On 6/26/24 at 1:06 p.m., MD-A stated he was unsure why the methadone clinic quit following R2 as a patient but knew he could not write a prescription for R2's methadone for addiction. He learned after the patient went to the hospital the methadone clinic thought he was tapering the dose, but upon review of the order, PA-A from the facility tapered the dose. Only one provider could write a prescription for methadone addiction. He was not consulted when PA-A changed the dose. On 6/27/24 at 10:47 a.m., P-C stated if the methadone was dispensed from a methadone clinic, the facility contracted pharmacy could not also dispense it, and the methadone clinic would manage dose adjustments and tapers. She did not know the facility staff withdrew methadone from the doses provided by the methadone clinic to	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 11 adjust the doses. After 6/13/24, the facility plan to ensure R2 received prescribed methadone was unknown and, "That is part of the problem. I guess she would have had to quit cold turkey," because of the prescribing rules, and it appeared there was a lack of communication between the facility and the methadone clinic. The proper way to dispose of liquid methadone was in the medication safe. On 6/26/24 at 9:15 a.m., during document review of the narcotic books on each unit the following was identified: Unit RCU2's narcotic book lacked 19 of 152 narcotic count signatures from 6/1/24 a.m. shift to 6/26/24 a.m. shift. Unit RCU1's narcotic book lacked 20 of 152 narcotic count signatures from 6/1/24 a.m. shift to 6/26/24 a.m. shift. Unit LTC2's narcotic book lacked 22 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night. shift. Unit LTC1's narcotic book lacked 56 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Unit TCU1a's narcotic book lacked 52 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Unit TCU2 a' s' narcotic book lacked 69 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Additionally, R2's methadone records in the narcotic book, page 10, was not indexed in the narcotic book, and the information on the narcotic record / count sheet lacked information about the prescribing provider, the pharmacy, the directions, the dose, the prescription number, or prescription date. R2's methadone record in the narcotic book page 86 was not indexed in the narcotic book, and	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 12 lacked information about prescribing provider, the pharmacy, the directions, the prescription number, and the prescription date. On 6/26/24 at 1:18 p.m., during a follow-up interview the DON stated the nursing staff and TMAs count narcotics together at the end of each shift, unless the nurse was working a double shift. The nurse who received a narcotic delivery would index the medication in the narcotic book, and complete a medication count sheet head fully with the name of the medication, prescribing provider, dosage, pharmacy name, prescription number, prescription date, and the transfer page number if the medication was transferred from another unit. The DON acknowledged medication indexed were not complete, shift count signatures were not completed at the end of each shift, and the medication information was not present on the signature pages. Medications should not run out, should be ordered ahead of time to ensure they did not. The facility did not have a policy about resident use of methadone clinics for addiction but should. Pre-filled doses should be dispensed as labeled or the medication administration staff should clarify the order and instructions with the pharmacy or provider. Additionally, she expected nurses to dispose of narcotics per recommended guidelines for the medication and the policy or ask for help. The Medication Storage in the Facility: Controlled Substance Storage policy dated August 2019, directed a controlled substance accountability record was prepared by the pharmacy/ facility and the following information was completed on the accountability form [narcotic book] upon dispensing or receipt of a controlled substance:	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 13 Name of the resident, Prescription number, Name, strength, and dosage form of the medication, date received, quantity received, and the name of the person receiving the medication. The policy further indicated at each shift, or when keys were transferred, a physical inventory of all controlled substances was conducted by two licensed nurses and was documented. The Specific Medication Administration Procedures Policy dated April 2018, directed immediately after administration of a controlled substance the nurse would document administration immediately in the controlled substance sign out record [narcotic book]. Once removed from the package or container, unused or partial doses should be disposed of in accordance to the medication destruction policy. SUGGESTED METHOD OF CORRECTION: The consultant pharmacist, director of nursing (DON) or designee could develop, review, and/or revise policies and procedures regarding the usage and ordering of methadone from a methadone clinic. The consultant pharmacist, DON or designee could develop, review, and/or revise policies and procdures regarding recording new medications in the unit narcotic books, regarding co-signatures for wasting narcotics. The consultant pharmacist, DON or designee could develop, review, or revise policies and procedures for a record-keeping system that ensures an accurate inventory of narcotics. The consultant pharmacist, DON or designee could educate all appropriate staff on the policies and procedures. The consultant pharmacist, DON or designee	21550		

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 _____	06/26/2024

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) COMPLETE DATE
21550	Continued From page 14 could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		