Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 14, 2024

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

RE: CCN: 245164
Cycle Start Date: August 1, 2024

Dear Administrator:

On August 1, 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 immediate jeopardy (Level J).

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).

REMOVAL OF IMMEDIATE JEOPARDY

On July 27, 2024, the situation of immediate jeopardy to potential health and safety cited at **F678 - Cardio-Pulmonary Resuscitation (CPR)** was removed.

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:

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the**

following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Villas At New Brighton is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 1, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

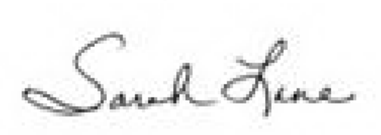
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 08/01/2024

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 7/31/24, and 8/1/24, 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 complaint was reviewed: H51646348C (MN00105270) with a deficiency cited at F678 at PAST NON-COMPLIANCE IJ. The IJ began on 7/27/24, when R1 was found unresponsive with an absence of pulse and respirations, CPR was not initiated, and R1 experienced certain death. The facility administrator and director of nursing (DON) were notified of the IJ on 8/1/24, at 5:00 p.m., which was identified at the scope and severity of an isolated IJ. The IJ was removed on 7/27/24. The facility implemented immediate corrective action on 7/27/24 to prevent recurrence, therefore, the IJ was issued at past non-compliance. Although the provider implemented corrective actions prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F 678		

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

Electronically Signed

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

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F 678	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the Provider Orders for Life Sustaining Treatment (POLST) to provide cardiopulmonary resuscitation (CPR) for 1 of 3 residents (R1), who wished to have CPR in the event of cardiopulmonary arrest (absence of pulse and respirations). This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found absent of pulse and respirations, no CPR was initiated, and R1 experienced certain death. The facility implemented corrective action, so the deficient practice was issued at past non-compliance. The IJ began on 7/27/24, when R1 was found unresponsive with an absence of pulse and respirations, CPR was not initiated, and R1 experienced certain death. The facility administrator and director of nursing (DON) were notified of the IJ on 8/1/24, at 5:00 p.m., which was identified at the scope and severity of an isolated IJ. The IJ was removed on 7/27/24 when the facility implemented immediate corrective action to prevent recurrence, therefore, the IJ was issued at past non-compliance. Findings include: A Facility Reported Incident (FRI) report was submitted to the State Agency (SA) on 7/27/24. The report identified, on 7/27/24, at 5:50 a.m., R1 was found unresponsive in her room, cool to the touch, and absent of vital signs. R1 was full code (wished CPR); however, CPR was not performed. R1's significant change Minimum Data Set (MDS), dated 7/23/24, identified R1 was	F 678	Past noncompliance: no plan of correction required.	

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F 678	Continued From page 2 cognitively intact. R1's POLST, dated 6/23/23, identified R1 wished for attempted resuscitation/CPR [Full code], if she were found with no pulse and/or active breaths. The POLST was signed by R1 and a medical provider. An IDT (interdisciplinary team) Care Conference form, locked 4/16/24, identified R1 was a Full code and wished to remain as such. A provider visit note, dated 7/19/24, identified R1 was seen by physician assistant (PA)-A. The note identified R1's Code Status as "Full Scope of Treatment." R1's Order Summary Report, active orders as of 7/22/24, identified an active CPR order. A progress note, entered on 7/27/24, at 7:23 a.m., identified the following timeline of events: -12:00 a.m., during rounds, R1 slept with no issues. -2:00 a.m., R1 was changed, repositioned, and she interacted with staff "normally." -5:40 a.m., the nurse was updated by a nursing assistant after the nursing assistant discovered R1's condition. The nurse responded and found R1 unresponsive. The nurse "grabbed the defibrator [sic] with the other nurse to start resuscitations, but it was too late, [R1] had ceased to breath, no pulse no respiration." The administrator, family, and the provider were updated. The note lacked identification R1 was provided CPR or that the AED was utilized. When interviewed on 7/31/24, at 2:44 p.m., licensed practical nurse (LPN)-A stated when a	F 678		

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F 678	Continued From page 3 resident was found unresponsive, she was expected to assess for a pulse and respirations - if absent, she was to first verify their code status. If the code status indicated Full code, she was expected to immediately initiate CPR, send others to grab the crash cart and the defibrillator (AED), page a code blue overhead, and call 911. CPR was stopped only when the paramedics gave the okay. She explained that around 2:00 a.m., R1 slept without concerns. Around 5:40 a.m., a nursing assistant called her into R1's room. Right away, LPN-A approached R1 and found her on her back in the middle of the bed. LPN-A checked R1's pulse, shook her, and called her name; however, R1 lacked a response and was without a pulse or respirations. R1 was not cold but her feet were cooler than the rest of her body. Her body was clammy, her color was "faded," and she lacked any stiffness when LPN-A shook her hand. LPN-A stated, "It was too late." LPN-A added, "I was very confused as this has never happened to me before. I was very shaken and confused. It was scary." LPN-A indicated she left R1's room and sought registered nurse (RN)-A for guidance. Once they returned to R1's room, RN-A assessed R1 and confirmed R1 lacked a pulse or respirations. LPN-A identified the AED was brought into R1's room and "opened;" however, after they verified R1 was a Full code, the AED was not used as "it was too late." LPN-A stated after, she contacted the administrator and was told, "It was okay;" however, she explained, in hindsight, she learned the administrator thought LPN-A had performed CPR and there was miscommunication during that call as she was just providing the administrator with an update on R1's passing - not looking for guidance on what to do during this situation. LPN-A denied she contacted the DON,	F 678		

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F 678	Continued From page 4 the on-call nurse, nor the provider for guidance. She stated she should have contacted the DON as the DON "is clinical," whereas the administrator was not. LPN-A stated she failed to follow the facility's policy for timely code status verification and CPR initiation. LPN-A identified she was suspended right away and was since provided education that included paper education, conversations with management, and mock drill participation's in which she "has to be the champion." On 7/31/24 and 8/1/24, interviews were attempted with NA-D, the nursing assistant who updated LPN-A on R1's unresponsive status; however, these were unsuccessful. During a telephone interview on 8/1/24, at 9:38 a.m., physician assistant (PA)-A stated the facility updated her that R1 was found unresponsive, and the attempted CPR was unsuccessful. If a Full code resident was found unresponsive, with no pulse or respirations, she identified she expected staff to initiate chest compressions and AED use if the AED advised a shock. In addition, she expected 911 to be called. When she was updated that R1 was not provided with CPR, she wished to reserve any comments related to the lack of CPR, as she was unaware of the event details, especially considering not being initially provided all the facts. She indicated she was present at the facility and observed at least two mock CPR drills. On 8/1/24, between 10:22 a.m. and 11:35 a.m., the following staff were interviewed respectively: LPN-B at 10:22 a.m., nursing assistant (NA)-A at 10:30 a.m., NA-B at 10:39 a.m., RN-B at 10:49 a.m., NA-C at 10:56 a.m., LPN -C at 11:06 a.m.,	F 678		

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F 678	Continued From page 5 and LPN-E at 11:35 a.m. The nurses stated if a resident was found unresponsive, they were to assess for a pulse and respirations. If none found, they were to verify the code status and if full code, CPR was to be initiated right away. The nurses were able to identify where the code status identification was located. In addition, all the nurses indicated there were no reasons why CPR would not be initiated if a resident were Full code. All nurses acknowledged they were up to date on their CPR certifications. All the NAs identified if they found a resident unresponsive, they were to update a nurse immediately. All the NAs identified they were not allowed to perform CPR, only to assist in the accompanying code processes such as getting the crash cart and AED. All staff explained they were to use the overhead paging system for a code blue call, the crash cart and AED were to be obtained, and call 911 when a resident's code status warranted Full code action. All staff were able to direct where the crash cart and the AED were located. All staff explained the education they had received, and the mock CPR drills they had participated in. All acknowledged the education and drills were very helpful. When interviewed on 8/1/24, at 11:18 a.m., LPN-D, identified herself as the long-term care (LTC) coordinator. She explained if a resident were found unresponsive, assessed to be free of pulse or respirations, and identified to be a Full code, she expected staff to yell for help, call a "code" and initiate CPR. LPN-D identified nurses were responsible for CPR, and she confirmed all nurses were CPR certified. She indicated there were no reasons why CPR would not be initiated for a Full code resident, and the paramedics were the only ones who could stop CPR once initiated.	F 678		

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F 678	Continued From page 6 LPN-D confirmed R1 was a Full code. She was aware of CPR not being initiated and she identified she was confused by the whole episode as performing CPR on a Full code resident was "nursing 101." She explained, it was her understanding there was a "communication breakdown" as LPN-A contacted the administrator versus the DON or the on-call nurse, along with confusion as to when LPN-A contacted the administrator. In response to the failed systems, education was provided to all staff and mock CPR drills were initiated daily for each shift. These drills continued and would continue until all nurses participated and demonstrated competency. During an interview on 8/1/24, at 11:47 a.m., the DON stated if a resident was found unresponsive, and CPR was assessed to be indicated based on a verified Full code status, the licensed staff were to initiate CPR "no matter what." The DON explained she was contacted by the administrator on the morning of 7/27/24. The administrator informed her that after a phone call with LPN-A, and the administrator had additional time to process the call, the administrator was concerned staff did not perform CPR on R1, despite the administrator's knowledge R1 was Full code. Both she and the administrator presented to the facility on 7/27/24 and initiated a plan to educate all staff going forward. This included paper education with an associated quiz and mock CPR drills. This education would continue until all the staff were educated and all the nurses demonstrated participation. She stated additional follow ups included LPN-A's suspension, review of licensed staff CPR certification statuses and a whole house review of residents' code status with verification to ensure the POLST, orders, and	F 678		

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F 678	Continued From page 7 care plan reflected each other. No concerns were identified with the review and verifications. When interviewed on 8/1/24, at 12:34 p.m., RN-A explained if a resident were found unresponsive, without a pulse and respirations, he was to check the code status. If the resident were a Full code, he was then to initiate CPR right away. He denied there were any reasons why CPR would be withheld if the resident were Full code. RN-A acknowledged he worked the morning of 7/27/24 and was approached by LPN-A around 5:40 a.m. He stated LPN-A informed him that R1 was unresponsive and asked him to come and see R1. He denied knowledge R1 had passed until he arrived at her room and assessed her. RN-A explained R1 was absent of a pulse and respirations. This prompted him to direct LPN-A to verify R1's code status and to grab the crash cart. In response, LPN-A informed him she contacted the administrator and the administrator told LPN-A not to do CPR. RN-A confirmed he, nor LPN-A, initiated CPR, or used the AED on R1. After he exited R1's room, he consulted another nurse related to his concerns that R1 was a full code and CPR was not initiated, especially as CPR should have been performed. RN-A and the nurse conferred and felt maybe there were a change in the policy, and they had just not yet been updated. RN-A identified education since this incident which included his participation in three mock CPR drills so far. During a telephone interview on 8/1/24, at 1:24 p.m., R1's family member (FM)-A identified he never personally reviewed R1's POLST; however, "[R1] always said she wanted to be Full code." Based on this, he expected they would have attempted resuscitations when they found her on	F 678		

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F 678	Continued From page 8 7/27/24. Further, he expected, after they initiated CPR, they would have transferred her to the hospital so hospital staff could have taken over. During an interview on 8/1/24, at 1:32 p.m., the administrator confirmed LPN-A contacted her on 7/27/24 at approximately 5:50 a.m., and told her "It was too late, it was too late," related to R1: LPN-A stated this matter of fact and did not sound panicked. The administrator initially understood during this first call that CPR was attempted on R1 and it was unsuccessful; however, during the investigation, it was discovered there were communication failures that started with that first call and continued through a third call. After the administrator was able to process the initial phone call once she woke up more, as the phone call woke her up, she called back to the facility and spoke again to LPN-A. She questioned LPN-A if the AED instructed them not to perform a shock. LPN-A responded to her, "Yes, [RN-A] took the AED." After the administrator contacted R1's family, she again called back to the facility and spoke a third time to LPN-A. She questioned LPN-A if they took the AED into R1's room: LPN-A confirmed this. As the administrator continued to feel something was off with the events that occurred, she contacted the DON and instructed the DON they needed to investigate further. She arrived at the facility between 8:00 a.m. and 8:30 a.m. During staff interviews, the administrator discovered LPN-A informed RN-A the administrator directed LPN-A to not perform CPR. After this, the DON took over the remainder of the investigation. The administrator acknowledged an action plan was put into place on 7/27/24 to mitigate repeat episodes once it was confirmed R1 was not provided with CPR. She expected if CPR was	F 678		

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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 678	Continued From page 9 indicated, staff were to perform it. Steps in the correction plan included LPN-A's suspension, prepped, and provided staff education which included paper education and mock CPR drills, along with audits. The administrator confirmed there were no concerns identified with the audits and the drills continued. The IJ that began on 7/27/24 was removed the same day, when it was verified through staff interviews and document review, the facility performed the following corrective actions all on 7/27/24: -The facility implemented a full-on investigation that included staff interviews along with family, provider, coroner, and medical director notifications. -LPN-A was suspended. -A FRI was submitted to the SA. -A full house CPR/POLST audit was conducted that verified POLSTs, orders, and care plans all reflected each other. -All licensed staff CPR certifications were verified and reflected all were current. -The CPR policy was reviewed, and no changes were needed. -All staff training on the Code Blue policy, which included a quiz, was initiated. - All staff participation in mock Code Blue drills were initiated. Drills have continued and will continue until each nurse has been deemed competent in the policy processes. -Audits related to CPR protocols would continue to be completed with five staff weekly for four weeks. A Cardiopulmonary Resuscitation policy, dated 2/2024, directed care would be provided according to the resident and/or the resident's	F 678		

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 08/01/2024

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F 678	Continued From page 10 representative identified preferences indicated by the physician orders and within the plan of care. CPR was to be initiated, by certified staff, for a resident who experienced a cardiac or respiratory arrest after code status was verified and an assessment revealed no signs of irreversible death were present. If irreversible signs of death were present, CPR was not to be initiated. The policy defined irreversible signs of death based on the American Heart Association which included rigor mortis (body limb stiffening) and dependent lividity (purplish red discoloration to the skin).	F 678		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2024

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

Re: Event ID: IGLL11

Dear Administrator:

The above facility survey was completed on August 1, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00114	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/31/24, and 8/1/24, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaint was reviewed: H51646348C (MN00105270). No licensing orders	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		