Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2026

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

RE: CCN: 245164
Cycle Start Date: February 23, 2026

Dear Administrator:

On March 31, 2026, we notified you a remedy was imposed.

On April 14, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 6, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 15, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of March 31, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 15, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 6, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst

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

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March 6, 2026

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

RE: CCN:245164
Cycle Start Date: February 23, 2026

Dear Administrator:

On Cycle February 23, 2026, a survey was completed at your facility by the Minnesota Departments 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 May 23, 2026 (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 August 23, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

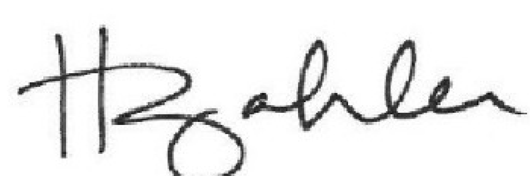
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245164**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/23/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 2/20/26 and 2/23/26, 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: H51646602C (2745813), H51646540C (2745270), and H51646920 (2747738) with deficiencies issued at F656. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		03/11/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F0656	Immediate Corrective Action: R2 – Risk and Benefits completed. Refusals of bathing care planned. Care plan was reviewed and revised to reflect resident's preferences and interventions. Bath day changed to resident's preference. R3 - Risk and Benefits completed. Refusals of bathing care planned. Care plan was reviewed and revised to reflect resident's preferences and interventions. Reviewed and revised amount of assistance needed. Corrective Action as it applies to others: Full house audit completed to review bathing care plan and ensure the information is accurate to that resident and their needs and preferences.	03/13/2026

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

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

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F0656 SS = D	Continued from page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to develop care plans for 2 of 3 residents (R2, R3) reviewed for baths/ showers. R2 and R3 refused baths/showers and their care plans did not include interventions for refusals. Findings include: R2's quarterly MDS dated 1/7/26 indicated intact cognition, paralysis on one side of the body related to stroke, was fully dependent upon staff assistance for bathing, and identified no refusals of bathing/showering. R2's care plan dated 7/7/23 indicated a self-care	F0656	Continued from page 1 If resident has been refusing bathing, the care plan was reviewed to ensure that information is included including interventions to follow when refusing. Care plan policy was reviewed and no revision needed. Education with the clinical leadership to assessing and care planning bathing accurately including refusals and interventions for staff to follow if resident is refusing. Education with clinical staff on how to approach for bathing, what to do if refusing, where to find the bathing information for each resident, and interventions for refusals. Education with all nurses regarding how to chart bathing in weekly skin checks for residents, how to chart refusals and what to do if a resident is refusing. Date of Compliance: 3/13/26 Recurrence will be prevented by: Audit 10 residents weekly x 4 weeks to ensure their bathing care plan is accurate in regards to assist needed for bathing, refusals in regards to bathing if applicable, bathing preferences and interventions if applicable. The results of these audits will be reviewed at the facility QAPI meeting for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/designee	

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F0656 SS = D	Continued from page 2 deficit related to stroke and left-sided weakness, had a history of refusing ADLs, and starting 7/12/23 required assistance of one staff for bathing/showers. The care plan lacked interventions for refusal of bathing and/or showers. R2's Weekly Skin Assessments dated 1/26/26, 2/2/26, 2/9/26, indicated R2 refused showers. During an interview on 2/20/26 at 3:55 p.m., NA-A stated R2 refused showers frequently, but did not know why. NA-A stated staff should offer another shower time when R2 refused but did not know if alternate times were offered. Further, NA-A stated if residents refused showers, the nurse managers should be notified. During an interview on 2/20/26 at 4:03 p.m., during an interview NA-B stated R2 only allowed certain staff to assist with showers and the care plan should indicate that preference. During an interview on 2/23/26 at 1:56 p.m., LPN-A acknowledged R2 missed baths, had a history of refusing baths, and should have a risk/benefit form in place for refusals of showers, but did not. LPN-A stated when residents refused showers, staff should continue to offer showers at another time or day, but acknowledged the medical record lacked indication staff offered other times. LPN-A stated the care plan lacked interventions for staff to follow for R2's bath refusals but acknowledged care plans should have interventions for staff to try when residents refused baths. R3's quarterly MDS dated 12/22/25 indicated intact cognition, and diagnoses that included traumatic brain injury, a seizure disorder, heart disease, and lung disease. R3 required supervision or touch assistance with bathing and identified no refusals of bathing/showering. R3's care plan dated 6/4/25, indicated R3 had a self-care deficit related to weakness but was independent with bathing, but lacked indication R3 required supervision or touch assistance with bathing. Weekly Skin Inspections dated 1/13/26, 1/20/26,	F0656		

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F0656 SS = D	Continued from page 3 1/27/26, and 2/3/26 indicated R3 refused showers. During an interview and observations on 2/20/26 at 5:18 p.m., R3 appeared disheveled, and had body odor. R3 stated he did not bathe weekly because he did not feel physically strong enough some weeks, and staff did not offer to help or ask if he showered. R3 was unsure when he last showered. During an interview on 2/23/26 at 12:24 p.m., RN-A acknowledged R3 had a self-care deficit related to weakness, did not bathe weekly, refused showers four weeks in a row, and had no independent showers documented from 1/13/26 to 2/3/26. RN-A stated she was not aware R3 refused showers but may now need reminders and set-up for showers to ensure he bathed regularly. RN-A acknowledged R3's care plan lacked interventions to promote bathing when R3 refused or when R3 did not perform bathing independently. During an interview on 2/23/26 at 1:56 p.m., LPN-A stated she witnessed R3 perform showers on his own but did not see where they were documented. LPN-A acknowledged R3's Weekly Skin Inspections indicated showers were refused from 1/13/26 to 2/3/26 LPN-A stated if R3 refused showers, staff should provide education to R3 about the risks and benefits of not keeping clean, and the care plan should indicate a risk/benefits discussion for refusals and interventions for staff to try in the case of refusals. During an interview on 2/23/26 at 4:37 p.m., the director of nursing (DON)stated when residents refuse a bath, the expectation was for staff to do a risk/benefit with education to the resident, notify the resident's provider, notify the power of attorney, and try different interventions and approaches. The interventions that were successful should be on the resident's care plan. The DON stated care plans should be updated when changes to care are made. Further, the DON stated she was not aware R2 and R3 missed baths for several weeks and acknowledged neither had interventions in their care plans to address care refusals but should have. The Care Planning policy dated 11/2024 indicated the care plan would be used in developing the residents' daily care routines and utilized by staff for the purpose of providing care to the residents. The care	F0656		

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F0656 SS = D	Continued from page 4 plan is to be modified and updated as the condition and care needs of the residents change.	F0656		