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 Therefore, the NATCEP prohibition is rescinded.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 31, 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 6, 2026, we informed you that we may impose enforcement remedies.

On March 20, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is/are as follows:

F656 (20565)

In addition, at the time of this survey/revisit, we identified the following deficiences:

F880, F553, F684 (20555)

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 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 15, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 15, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 15, 2026.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by April 15, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, THE VILLAS AT NEW BRIGHTON will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 15, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 23, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request

for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

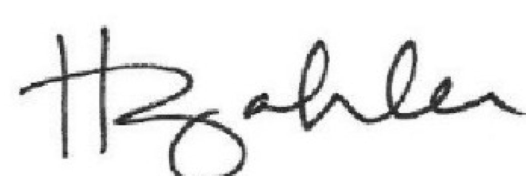
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or

immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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 **03/20/2026**

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 3/19/26 through 3/20/26, 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: H51648901C (2805148) The following complaints were reviewed: H51649040C (2807736 and 2807709), with a deficiencies issued at F553, F684, and F880. 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		04/02/2026
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors	F0553	Immediate Corrective Action: R1 discharged on 3/26/26. Corrective Action as it applies to others: Full house audit was completed to identify other residents who had missed care conferences. Missed care conferences have been scheduled and/or completed. Care planning policy was reviewed and no changes were needed.	04/06/2026

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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F0553 SS = D	Continued from page 1 related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to provide an opportunity for 1 of 3 residents (R1) reviewed for care planning to participate in the development of the plan of care. Findings Include: During an observation on 3/20/26, at 8:30 a.m., R1 was seated at the edge of the floor mattress. Her breakfast tray was positioned to her left side on the floor mattress. R1 was leaning on her left elbow as she reached with a fork, using her right hand to eat the food from her tray. Food was observed falling on to the mattress as she tried to eat. R1’s admission Minimum Data Set (MDS), dated 2/18/26, indicated she had diagnoses of heart failure and respiratory failure, she had severe cognitive impairment, was Hmong speaking, and was dependent for all cares and transfers. R1’s care plan, dated 2/18/26, indicated she was a fall risk and had a fall mat at her bedside. She required	F0553	Continued from page 1 Education completed with social services and IDT related to care conference schedule, timelines, & resident and/or resident representative participation. Recurrence will be prevented by: Audit all new admissions and ARDs weekly x 4 weeks to ensure all care conferences were scheduled within 21 days, quarterly, and significant changes. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator and/or Designee	

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F0553 SS = D	Continued from page 2 assistance with cares including eating, bed mobility, and transfers, using two staff and a full body mechanical lift. R1's electronic medical record lacked documentation of a care conference and indicated she was admitted on 2/18/26. During an interview on 3/19/26, at 4:30 p.m., the administrator stated conferences were offered within three weeks of admission and then quarterly. During an interview on 3/20/26, at 8:35 a.m., NA-B stated R1 frequently crawled off her bed to the mattress on the floor. Staff only put R1 in her wheelchair when her family would be present so they could watch her. She stated they give R1 bed baths because it would take up to three staff to give her a shower. During an interview on 3/20/26, at 8:48 a.m., NA-A stated R1 was eating her breakfast on the floor mattress because they were serving breakfast trays and there was not time to get R1 back into her bed. She was unsure whether it bothered R1. NA-A stated, "some cultures, like Hmong, like to be on the floor." During an interview on 3/20/26, at 10:04 a.m., the social services director (SSD) stated resident preferences are elicited during the initial assessments and a care conference within the first 21 days and then held quarterly. R1 should have had a care conference but did was unable to locate the documentation. She stated it would be located in the forms section of the electronic medical record and mentioned in the progress notes. During an interview on 3/20/26, at 10:16 a.m., the clinical leader/licensed practical nurse (LPN)-A stated care conferences were intended to discuss medications, concerns with cares, comfort, and complaints. She thought care conferences should occur within seven days of admission and quarterly. The floor mattress was intended as a fall prevention intervention when R1 was admitted. She stated R1 seemed comfortable on the floor mattress and liked to sit on it, so she care planned for that.	F0553		

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F0553 SS = D	Continued from page 3	F0553		

During an interview on 3/20/26, at 1:30 p.m., the DON stated resident preferences were determined by their initial assessments and care conferences. The care conferences are held within five days and after that every quarter. R1 had not had a care conference since she was admitted on 2/18/26 but should have had one. The DON stated the purpose of the care conference was to ensure the residents were comfortable, happy and the facility was meeting their needs. It gave an opportunity to keep the residents and family informed.

During an interview on 3/20/26, at 3:15 p.m., FM-A stated she was never offered a care conference. She was in favor of a mattress on the floor next to R1's bed so she would not get hurt but she was not pleased that R1 was left on the floor mattress for hours, she would prefer for R1 to be offered the toilet or commode, would prefer R1 to have a shower instead of a bed bath, and it was not their culture to eat on the floor.

During an interview on 3/20/26, at 3:55 p.m., the administrator stated there had not been a care conference for R1.

A facility policy, Resident Rights, dated 11/2025, directed it is the practice of this facility to uphold the rights of all residents. The policy included a link to the Combined Federal and State Bill of Rights, dated 12/22/2025, which directed the resident has the right to be informed of, and participate in, their treatment, including:

-The right to participate in the development and implementation of their person-centered plan of care, including but not limited to:

-The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

-The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

-The right to be informed, in advance, of changes to the plan of care.

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F0553 SS = D	Continued from page 4 -The right to receive the services and/or items included in the plan of care. -The right to see the care plan, including the right to sign after significant changes to the plan of care. The facility shall inform the residents of the right to participate in their treatment and shall support the residents in this right. The planning process must: facilitate the inclusion of the resident and/or resident representative, include an assessment of the resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing goals of care. A facility policy, Care Planning, dated 11/2024, directed each resident will have a person-centered care plan developed by the interdisciplinary team IDT) for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The IDT, in conjunction with the resident and the resident representative, will develop a comprehensive care plan no later than the 21st day of admission of the resident.	F0553		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document reviews, the facility failed to ensure care was delivered in accordance with professional standards and care planning for 1 of 3 residents (R1) reviewed for quality of care. R1 had severe cognitive impairment and frequently crawled out of bed to the floor. This resulted in Psychosocial harm for R1 when staff would drag R1 from the floor to the bed for repositioning without the care planned use of a mechanical lift. A reasonable person concept is applied in determining what the psychosocial outcome would have on a reasonable person in a similar situation to suffer because of the noncompliance.	F0684	Immediate Corrective Action: R1 discharged on 3/26/26. Corrective Action as it applies to others: All residents could be impacted by the failure of utilizing professional standards and failure to follow plan of care. Full house audit completed to identify those who use fall mats. Residents that use fall mats could be impacted. Facility purchased additional smaller fall mats as a secondary option. Safe patient handling policy has been reviewed and no changes are needed. Nursing staff were educated regarding safe ways to	04/06/2026

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

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F0684 SS = G	Continued from page 5 Findings Include: Observation of R1's room on 3/19/26 at 2:40 p.m., was a shared room, where her space was closest to the door with a privacy curtain between her side and her roommate's side. R1's bed was against the wall, lengthwise. There was a hospital bed mattress located on the floor along R1's bed, which was approximately six inches lower than the bed, as the bed was in the lowest position. There was a bedside table against the wall immediately next to the door and an oxygen concentrator located near the foot of the bed. Review of video from R1's room, on 3/9/26 at 7:45 a.m. was approximately 1 minute 30 seconds. R1's bed was in a low position. R1's body was partially on the bed and on the floor. She was lying on her back, face up, at the width of the bed, with her hips and legs on the floor, and her waist, chest, and head on the bed. R1 was dressed in a gown with no undergarments. Nursing assistant (NA)-A was standing at the center of R1's bed, bending over at her waist, grabbing the front of R1's hospital gown with both hands near each armpit dragging R1 from the mattress on the floor onto the bed. NA-A paused when R1 was partially on the bed, facing up from her midback to her head. R1's left hand appeared to be grasping for NA-A's forearm. Then NA-A walked off R1's bed. NA-A and NA-B pushed R1's right leg up and over her left side on to the bed. NA-A then pushed R1's left hip, with the help of NA-B pushing R1's left leg, to rotate R1 into the center of the bed lengthwise in a prone. R1's head was now at the head of the bed and her feet at the bottom of the bed, she was face down, with her left arm tucked under her chest and right arm off to her right side. R1 moans when NA-A pulled R1's left arm out from under R1's chest. R1 was left in the prone position on her bed, exposed from the waist down without undergarments. R1's hospital admission history and physical, dated 2/11/26, indicated R1 was 98 years old who had cognitive impairment, limited capacity to understand instructions, was very hard of hearing, and required the use of a translator. R1 had been declining for months due to pain and had not been ambulatory using a wheelchair for mobility. R1 was currently living in an assisted living facility. R1 was evaluated and treated for heart failure and would need placement at a skilled nursing facility.	F0684	Continued from page 5 transfer a resident when they are on a floor mat per plan of care, why plan of care must be followed, and where to locate plan of care, as not following the plan of care can lead to psychosocial harm. Education includes hands on training with a fall mat and hoyer lift. Recurrence will be prevented by: Will complete quizzes with 10 nursing staff weekly x 4 weeks in regards to appropriate transfers. Audit 5 resident transfers weekly x 4 weeks to ensure following plan of care and professional standards. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Director of Nursing and/or designee	

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 03/20/2026

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
F0684 SS = G	Continued from page 6	F0684		

R1’s admission Minimum Data Set (MDS), dated 2/18/26, indicated she had diagnoses of heart failure and respiratory failure, severe cognitive impairment, was Hmong speaking, and was dependent on all cares and transfers. R1 was on hospice.

R1’s care plan, dated 2/18/26, indicated she was a fall risk and had a goal to be safe and free from falls. Interventions included R1 to use a soft touch call light for assistance, a fall mat at bedside when in bed, keeping the bed in a low position and to monitor R1 for falls determining possible root causes. R1 had an alteration in mobility with a goal to move safely within her environment. Interventions included to assist with movement in bed and in/out of bed, and assistance of two staff with a Hoyer lift and medium sling size.

R1’s NA guide, undated, indicated she required assistance from two staff and mechanical lift for transfers with medium sling size. Assistance of one staff to turn and reposition R1 every two to three hours, offer a bed pain or check and change her incontinent brief upon rising, before or after meals, at bedtime and as needed. R1 frequently removes incontinent brief, reapply when observed. She was a fall risk with bed in low position and a floor mat beside bed. R1 lies on floor mat occasionally per preference. Hmong speaking with translator phone numbers were listed.

A facility staff schedule dated 3/9/26, indicated NA-A and NA-B were both working 6:30 a.m. to 2:30 p.m. on 3/9/26.

During an interview on 3/19/26, at 3:33 p.m., family member (FM)-A stated she could hear R1 saying “hurt, hurt” in Hmong when she watched the video of the transfer on 3/9/26. She stated she felt it was abusive and thought R1 was scared and in pain. FM-A stated the staff were supposed to use the mechanical lift to move her. Following another interview with FM-A on 3/20/26 at 3:15 p.m. she had not been offered a care conference or asked for preference of care. She stated it was not R1’s preference or culture to stay on the floor.

During an interview on 3/20/26, at 8:35 a.m., NA-B stated R1 frequently crawled off her bed to the

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F0684 SS = G	Continued from page 7 mattress on the floor. She was aware R1 was to be transferred with the mechanical lift and two staff but there was no room to bring the mechanical lift into the room and fit it around the large floor mattress. She and NA-A were frequently transferring R1 back to bed in a similar manner, without using a mechanical lift, over the previous weeks. NA-B stated neither she nor NA-A told the nurses, clinical leader or director of nursing (DON) they were not using the mechanical lift to transfer R1 into bed from her floor mattress because it was difficult. During an interview on 3/20/26, at 8:48 a.m., NA-A stated she and NA-B had R1 crawl up on the bed on 3/9/26, then pushed her hip to roll her over and never dragged R1 by her clothing. She stated she was aware R1 was to be transferred with the mechanical lift and two staff. She stated she thought they were doing the right thing and did not talk to a nurse, clinical leader, or DON regarding transferring R1 into bed from her floor mattress. During an interview on 3/20/26, at 9:55 a.m., the nurse practitioner (NP) stated she was informed of an inappropriate transfer but had not seen the video. Transferring R1 with the mechanical lift was the safest manner to avoid orthopedic injuries such as dislocation and muscle strains. During an interview on 3/20/26, at 10:16 a.m., the clinical leader/licensed practical nurse (LPN)-A stated R1 was to be transferred with assistance of two staff and a mechanical lift. She was not made aware of any challenges staff had with transfers. During an interview on 3/20/26, at 12:25 p.m., the administrator stated R1 appeared uncomfortable during the transfer seen on the video from 3/9/26 and none of the staff had previously approached her about challenges with transferring R1 back into her bed. During an interview on 3/20/26, at 1:30 p.m., the DON stated R1 required a mechanical lift and assistance from two staff because she could not stand on her own or bear her own weight. She stated the video demonstrated an improper transfer and R1 should always be transferred with the mechanical lift and two staff. She stated NA-A and NA-B should have asked a manager if they were not sure how to safely transfer R1.	F0684		

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F0684 SS = G	Continued from page 8 The facility Safe Resident Handling policy, dated 11/2025, directed all resident care will be provided in a safe, appropriate, and timely manner in accordance with the individual resident's care plan. Manual lifting of all residents who are unable to bear weight will be minimized. Residents identified as totally dependent or extensive assistance, for example, will be transferred by means of lift equipment and/or other resident assistance devices instead of a manual lift. The facility Care Planning, dated 11/2024, directed the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purpose of providing care or services to the residents. The plan of care will be utilized to provide care for the residents. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F0684		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	Immediate Corrective Action: R1 discharged on 3/26/26. Corrective Action as it applies to others: All residents have the potential to be impacted. Hand hygiene and standard precautions policy was reviewed and no changes were needed. Completed education with nursing staff on hand hygiene, including glove changes in regards to peri-care. Recurrence will be prevented by: Audit 10 employees weekly x 4 weeks regarding hand hygiene and glove changes with peri-cares. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.	04/06/2026

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F0880 SS = D	Continued from page 9 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to follow established infection control practices for 1 of 3 residents (R1) reviewed for hand	F0880	Continued from page 9 Corrections will be monitored by: Director of Nursing and/or Designee	

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

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F0880 SS = D	Continued from page 10 hygiene when staff failed to perform hand hygiene. Findings Include: During an observation on 3/19/26, at 2:40 p.m., nursing assistant (NA)-C and NA-D performed incontinence cares for R1 in her bed. NA-D assisted with positioning of R1 in her bed as NA-C removed the soiled brief, wiped R1's perineum and buttocks, then discarded the brief and wipes. She failed to remove her gloves and perform hand hygiene. NA-C proceeded to place a clean brief under R1, apply barrier cream to her perineum, fasten the brief, position draw sheet, assist to lift R1 with NA-D, position bedding, clip the call light to the bedding, positioned R1's oxygen tubing in her nostrils, moved the bed back to its original location and positioned the privacy curtain before NA-C removed her soiled gloves and performed hand hygiene. R1's admission Minimum Data Set (MDS), dated 2/18/26, indicated she had diagnoses of heart failure and respiratory failure, severe cognitive impairment, was frequently incontinent of bowel and bladder, and was dependent on facility staff for all cares and transfers, and was Hmong speaking. R1's care plan, dated 2/18/26, indicated she required assistance with cares including bed mobility, transfers, and incontinent care. R1's NA guide, undated, indicated she required assistance with incontinence care every 2 - 3 hours. A facility grievance/complaint form, dated 3/16/26, indicated LPN-A was aware staff were not changing gloves between changing R1's brief and adjusting her oxygen tubing in her nose. During an interview on 3/19/26, at 2:52 p.m., NA-C stated she should have changed her gloves and performed hand hygiene after performing peri care to prevent infection. During an interview on 3/19/26, at 3:33 p.m., family member (FM)-A stated she had observed staff not changing their gloves after performing peri care on the camera she had set up in R1's room. She stated this was	F0880		

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F0880 SS = D	Continued from page 11 shared with the clinical leader/licensed practical nurse (LPN)-A on 3/16/26. During an interview on 3/20/26, at 10:16 a.m., LPN-A stated gloves should be changed between dirty and clean tasks. Hand hygiene should be performed any time gloves are changed. LPN-A stated she received a grievance regarding R1’s cares and staff failing to change their gloves after changing her brief on 3/16/26 and provided verbal education to nursing staff. During an interview on 3/20/26, at 1:30 p.m., the director of nursing (DON) stated gloves should be changed before and after providing care and after changing briefs. Hand hygiene should be performed before and after each care provided to the residents to reduce infection risk. A facility document, Handwashing Policy, dated 11/2019, directed proper hand washing techniques should be used to protect the spread of infection: after changing incontinent products. When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.	F0880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 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 6, 2026, we informed you that we may impose enforcement remedies.

On March 20, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is/are as follows:

F656 (20565)

In addition, at the time of this survey/revisit, we identified the following deficiences:

F880, F553, F684 (20555)

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 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 15, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 15, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 15, 2026.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by April 15, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, THE VILLAS AT NEW BRIGHTON will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 15, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 23, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request

for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

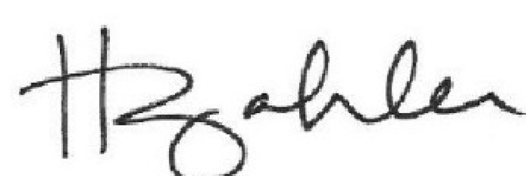
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or

immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 1F55D0-H1

Dear Administrator:

The above facility survey was completed on March 20, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

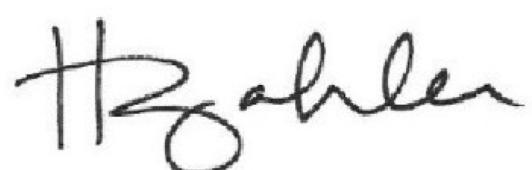
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

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

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

Please feel free to call me with any questions.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245164**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/20/2026**

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 3/19/26 through 3/20/26, 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: H51648901C (2805148) The following complaints were reviewed: H51649040C (2807736 and 2807709), with a deficiencies issued at F553, F684, and F880. 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		04/02/2026
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors	F0553	Immediate Corrective Action: R1 discharged on 3/26/26. Corrective Action as it applies to others: Full house audit was completed to identify other residents who had missed care conferences. Missed care conferences have been scheduled and/or completed. Care planning policy was reviewed and no changes were needed.	04/06/2026

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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F0553 SS = D	Continued from page 1 related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to provide an opportunity for 1 of 3 residents (R1) reviewed for care planning to participate in the development of the plan of care. Findings Include: During an observation on 3/20/26, at 8:30 a.m., R1 was seated at the edge of the floor mattress. Her breakfast tray was positioned to her left side on the floor mattress. R1 was leaning on her left elbow as she reached with a fork, using her right hand to eat the food from her tray. Food was observed falling on to the mattress as she tried to eat. R1's admission Minimum Data Set (MDS), dated 2/18/26, indicated she had diagnoses of heart failure and respiratory failure, she had severe cognitive impairment, was Hmong speaking, and was dependent for all cares and transfers. R1's care plan, dated 2/18/26, indicated she was a fall risk and had a fall mat at her bedside. She required	F0553	Continued from page 1 Education completed with social services and IDT related to care conference schedule, timelines, & resident and/or resident representative participation. Recurrence will be prevented by: Audit all new admissions and ARDs weekly x 4 weeks to ensure all care conferences were scheduled within 21 days, quarterly, and significant changes. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator and/or Designee	

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F0553 SS = D	Continued from page 2 assistance with cares including eating, bed mobility, and transfers, using two staff and a full body mechanical lift. R1's electronic medical record lacked documentation of a care conference and indicated she was admitted on 2/18/26. During an interview on 3/19/26, at 4:30 p.m., the administrator stated conferences were offered within three weeks of admission and then quarterly. During an interview on 3/20/26, at 8:35 a.m., NA-B stated R1 frequently crawled off her bed to the mattress on the floor. Staff only put R1 in her wheelchair when her family would be present so they could watch her. She stated they give R1 bed baths because it would take up to three staff to give her a shower. During an interview on 3/20/26, at 8:48 a.m., NA-A stated R1 was eating her breakfast on the floor mattress because they were serving breakfast trays and there was not time to get R1 back into her bed. She was unsure whether it bothered R1. NA-A stated, "some cultures, like Hmong, like to be on the floor." During an interview on 3/20/26, at 10:04 a.m., the social services director (SSD) stated resident preferences are elicited during the initial assessments and a care conference within the first 21 days and then held quarterly. R1 should have had a care conference but did was unable to locate the documentation. She stated it would be located in the forms section of the electronic medical record and mentioned in the progress notes. During an interview on 3/20/26, at 10:16 a.m., the clinical leader/licensed practical nurse (LPN)-A stated care conferences were intended to discuss medications, concerns with cares, comfort, and complaints. She thought care conferences should occur within seven days of admission and quarterly. The floor mattress was intended as a fall prevention intervention when R1 was admitted. She stated R1 seemed comfortable on the floor mattress and liked to sit on it, so she care planned for that.	F0553		

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F0553 SS = D	Continued from page 3	F0553		

During an interview on 3/20/26, at 1:30 p.m., the DON stated resident preferences were determined by their initial assessments and care conferences. The care conferences are held within five days and after that every quarter. R1 had not had a care conference since she was admitted on 2/18/26 but should have had one. The DON stated the purpose of the care conference was to ensure the residents were comfortable, happy and the facility was meeting their needs. It gave an opportunity to keep the residents and family informed.

During an interview on 3/20/26, at 3:15 p.m., FM-A stated she was never offered a care conference. She was in favor of a mattress on the floor next to R1's bed so she would not get hurt but she was not pleased that R1 was left on the floor mattress for hours, she would prefer for R1 to be offered the toilet or commode, would prefer R1 to have a shower instead of a bed bath, and it was not their culture to eat on the floor.

During an interview on 3/20/26, at 3:55 p.m., the administrator stated there had not been a care conference for R1.

A facility policy, Resident Rights, dated 11/2025, directed it is the practice of this facility to uphold the rights of all residents. The policy included a link to the Combined Federal and State Bill of Rights, dated 12/22/2025, which directed the resident has the right to be informed of, and participate in, their treatment, including:

-The right to participate in the development and implementation of their person-centered plan of care, including but not limited to:

-The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

-The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

-The right to be informed, in advance, of changes to the plan of care.

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F0553 SS = D	Continued from page 4 -The right to receive the services and/or items included in the plan of care. -The right to see the care plan, including the right to sign after significant changes to the plan of care. The facility shall inform the residents of the right to participate in their treatment and shall support the residents in this right. The planning process must: facilitate the inclusion of the resident and/or resident representative, include an assessment of the resident’s strengths and needs and incorporate the resident’s personal and cultural preferences in developing goals of care. A facility policy, Care Planning, dated 11/2024, directed each resident will have a person-centered care plan developed by the interdisciplinary team IDT) for the purpose of meeting the resident’s individual medical, physical, psychosocial, and functional needs. The IDT, in conjunction with the resident and the resident representative, will develop a comprehensive care plan no later than the 21st day of admission of the resident.	F0553		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document reviews, the facility failed to ensure care was delivered in accordance with professional standards and care planning for 1 of 3 residents (R1) reviewed for quality of care. R1 had severe cognitive impairment and frequently crawled out of bed to the floor. This resulted in Psychosocial harm for R1 when staff would drag R1 from the floor to the bed for repositioning without the care planned use of a mechanical lift. A reasonable person concept is applied in determining what the psychosocial outcome would have on a reasonable person in a similar situation to suffer because of the noncompliance.	F0684	Immediate Corrective Action: R1 discharged on 3/26/26. Corrective Action as it applies to others: All residents could be impacted by the failure of utilizing professional standards and failure to follow plan of care. Full house audit completed to identify those who use fall mats. Residents that use fall mats could be impacted. Facility purchased additional smaller fall mats as a secondary option. Safe patient handling policy has been reviewed and no changes are needed. Nursing staff were educated regarding safe ways to	04/06/2026

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F0684 SS = G	Continued from page 5 Findings Include: Observation of R1's room on 3/19/26 at 2:40 p.m., was a shared room, where her space was closest to the door with a privacy curtain between her side and her roommate's side. R1's bed was against the wall, lengthwise. There was a hospital bed mattress located on the floor along R1's bed, which was approximately six inches lower than the bed, as the bed was in the lowest position. There was a bedside table against the wall immediately next to the door and an oxygen concentrator located near the foot of the bed. Review of video from R1's room, on 3/9/26 at 7:45 a.m. was approximately 1 minute 30 seconds. R1's bed was in a low position. R1's body was partially on the bed and on the floor. She was lying on her back, face up, at the width of the bed, with her hips and legs on the floor, and her waist, chest, and head on the bed. R1 was dressed in a gown with no undergarments. Nursing assistant (NA)-A was standing at the center of R1's bed, bending over at her waist, grabbing the front of R1's hospital gown with both hands near each armpit dragging R1 from the mattress on the floor onto the bed. NA-A paused when R1 was partially on the bed, facing up from her midback to her head. R1's left hand appeared to be grasping for NA-A's forearm. Then NA-A walked off R1's bed. NA-A and NA-B pushed R1's right leg up and over her left side on to the bed. NA-A then pushed R1's left hip, with the help of NA-B pushing R1's left leg, to rotate R1 into the center of the bed lengthwise in a prone. R1's head was now at the head of the bed and her feet at the bottom of the bed, she was face down, with her left arm tucked under her chest and right arm off to her right side. R1 moans when NA-A pulled R1's left arm out from under R1's chest. R1 was left in the prone position on her bed, exposed from the waist down without undergarments. R1's hospital admission history and physical, dated 2/11/26, indicated R1 was 98 years old who had cognitive impairment, limited capacity to understand instructions, was very hard of hearing, and required the use of a translator. R1 had been declining for months due to pain and had not been ambulatory using a wheelchair for mobility. R1 was currently living in an assisted living facility. R1 was evaluated and treated for heart failure and would need placement at a skilled nursing facility.	F0684	Continued from page 5 transfer a resident when they are on a floor mat per plan of care, why plan of care must be followed, and where to locate plan of care, as not following the plan of care can lead to psychosocial harm. Education includes hands on training with a fall mat and hoyer lift. Recurrence will be prevented by: Will complete quizzes with 10 nursing staff weekly x 4 weeks in regards to appropriate transfers. Audit 5 resident transfers weekly x 4 weeks to ensure following plan of care and professional standards. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Director of Nursing and/or designee	

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

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F0684 SS = G	Continued from page 6 R1's admission Minimum Data Set (MDS), dated 2/18/26, indicated she had diagnoses of heart failure and respiratory failure, severe cognitive impairment, was Hmong speaking, and was dependent on all cares and transfers. R1 was on hospice. R1's care plan, dated 2/18/26, indicated she was a fall risk and had a goal to be safe and free from falls. Interventions included R1 to use a soft touch call light for assistance, a fall mat at bedside when in bed, keeping the bed in a low position and to monitor R1 for falls determining possible root causes. R1 had an alteration in mobility with a goal to move safely within her environment. Interventions included to assist with movement in bed and in/out of bed, and assistance of two staff with a Hoyer lift and medium sling size. R1's NA guide, undated, indicated she required assistance from two staff and mechanical lift for transfers with medium sling size. Assistance of one staff to turn and reposition R1 every two to three hours, offer a bed pain or check and change her incontinent brief upon rising, before or after meals, at bedtime and as needed. R1 frequently removes incontinent brief, reapply when observed. She was a fall risk with bed in low position and a floor mat beside bed. R1 lies on floor mat occasionally per preference. Hmong speaking with translator phone numbers were listed. A facility staff schedule dated 3/9/26, indicated NA-A and NA-B were both working 6:30 a.m. to 2:30 p.m. on 3/9/26. During an interview on 3/19/26, at 3:33 p.m., family member (FM)-A stated she could hear R1 saying "hurt, hurt" in Hmong when she watched the video of the transfer on 3/9/26. She stated she felt it was abusive and thought R1 was scared and in pain. FM-A stated the staff were supposed to use the mechanical lift to move her. Following another interview with FM-A on 3/20/26 at 3:15 p.m. she had not been offered a care conference or asked for preference of care. She stated it was not R1's preference or culture to stay on the floor. During an interview on 3/20/26, at 8:35 a.m., NA-B stated R1 frequently crawled off her bed to the	F0684		

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F0684 SS = G	Continued from page 7 mattress on the floor. She was aware R1 was to be transferred with the mechanical lift and two staff but there was no room to bring the mechanical lift into the room and fit it around the large floor mattress. She and NA-A were frequently transferring R1 back to bed in a similar manner, without using a mechanical lift, over the previous weeks. NA-B stated neither she nor NA-A told the nurses, clinical leader or director of nursing (DON) they were not using the mechanical lift to transfer R1 into bed from her floor mattress because it was difficult. During an interview on 3/20/26, at 8:48 a.m., NA-A stated she and NA-B had R1 crawl up on the bed on 3/9/26, then pushed her hip to roll her over and never dragged R1 by her clothing. She stated she was aware R1 was to be transferred with the mechanical lift and two staff. She stated she thought they were doing the right thing and did not talk to a nurse, clinical leader, or DON regarding transferring R1 into bed from her floor mattress. During an interview on 3/20/26, at 9:55 a.m., the nurse practitioner (NP) stated she was informed of an inappropriate transfer but had not seen the video. Transferring R1 with the mechanical lift was the safest manner to avoid orthopedic injuries such as dislocation and muscle strains. During an interview on 3/20/26, at 10:16 a.m., the clinical leader/licensed practical nurse (LPN)-A stated R1 was to be transferred with assistance of two staff and a mechanical lift. She was not made aware of any challenges staff had with transfers. During an interview on 3/20/26, at 12:25 p.m., the administrator stated R1 appeared uncomfortable during the transfer seen on the video from 3/9/26 and none of the staff had previously approached her about challenges with transferring R1 back into her bed. During an interview on 3/20/26, at 1:30 p.m., the DON stated R1 required a mechanical lift and assistance from two staff because she could not stand on her own or bear her own weight. She stated the video demonstrated an improper transfer and R1 should always be transferred with the mechanical lift and two staff. She stated NA-A and NA-B should have asked a manager if they were not sure how to safely transfer R1.	F0684		

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F0684 SS = G	Continued from page 8 The facility Safe Resident Handling policy, dated 11/2025, directed all resident care will be provided in a safe, appropriate, and timely manner in accordance with the individual resident's care plan. Manual lifting of all residents who are unable to bear weight will be minimized. Residents identified as totally dependent or extensive assistance, for example, will be transferred by means of lift equipment and/or other resident assistance devices instead of a manual lift. The facility Care Planning, dated 11/2024, directed the care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purpose of providing care or services to the residents. The plan of care will be utilized to provide care for the residents. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F0684		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	Immediate Corrective Action: R1 discharged on 3/26/26. Corrective Action as it applies to others: All residents have the potential to be impacted. Hand hygiene and standard precautions policy was reviewed and no changes were needed. Completed education with nursing staff on hand hygiene, including glove changes in regards to peri-care. Recurrence will be prevented by: Audit 10 employees weekly x 4 weeks regarding hand hygiene and glove changes with peri-cares. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits.	04/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER: THE VILLAS AT NEW BRIGHTON	STREET ADDRESS, CITY, STATE, ZIP CODE: 825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112		

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F0880 SS = D	Continued from page 9 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to follow established infection control practices for 1 of 3 residents (R1) reviewed for hand	F0880	Continued from page 9 Corrections will be monitored by: Director of Nursing and/or Designee	

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

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F0880 SS = D	Continued from page 10 hygiene when staff failed to perform hand hygiene. Findings Include: During an observation on 3/19/26, at 2:40 p.m., nursing assistant (NA)-C and NA-D performed incontinence cares for R1 in her bed. NA-D assisted with positioning of R1 in her bed as NA-C removed the soiled brief, wiped R1's perineum and buttocks, then discarded the brief and wipes. She failed to remove her gloves and perform hand hygiene. NA-C proceeded to place a clean brief under R1, apply barrier cream to her perineum, fasten the brief, position draw sheet, assist to lift R1 with NA-D, position bedding, clip the call light to the bedding, positioned R1's oxygen tubing in her nostrils, moved the bed back to its original location and positioned the privacy curtain before NA-C removed her soiled gloves and performed hand hygiene. R1's admission Minimum Data Set (MDS), dated 2/18/26, indicated she had diagnoses of heart failure and respiratory failure, severe cognitive impairment, was frequently incontinent of bowel and bladder, and was dependent on facility staff for all cares and transfers, and was Hmong speaking. R1's care plan, dated 2/18/26, indicated she required assistance with cares including bed mobility, transfers, and incontinent care. R1's NA guide, undated, indicated she required assistance with incontinence care every 2 - 3 hours. A facility grievance/complaint form, dated 3/16/26, indicated LPN-A was aware staff were not changing gloves between changing R1's brief and adjusting her oxygen tubing in her nose. During an interview on 3/19/26, at 2:52 p.m., NA-C stated she should have changed her gloves and performed hand hygiene after performing peri care to prevent infection. During an interview on 3/19/26, at 3:33 p.m., family member (FM)-A stated she had observed staff not changing their gloves after performing peri care on the camera she had set up in R1's room. She stated this was	F0880		

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F0880 SS = D	Continued from page 11 shared with the clinical leader/licensed practical nurse (LPN)-A on 3/16/26. During an interview on 3/20/26, at 10:16 a.m., LPN-A stated gloves should be changed between dirty and clean tasks. Hand hygiene should be performed any time gloves are changed. LPN-A stated she received a grievance regarding R1's cares and staff failing to change their gloves after changing her brief on 3/16/26 and provided verbal education to nursing staff. During an interview on 3/20/26, at 1:30 p.m., the director of nursing (DON) stated gloves should be changed before and after providing care and after changing briefs. Hand hygiene should be performed before and after each care provided to the residents to reduce infection risk. A facility document, Handwashing Policy, dated 11/2019, directed proper hand washing techniques should be used to protect the spread of infection: after changing incontinent products. When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.	F0880		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/19/26 through 3/20/26, 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(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		04/02/2026

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

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20000	Continued from page 1 The following complaints were reviewed with no deficiency issued: H51648901C (2805148) The following complaints were reviewed: H51649040C (2807736 and 2807709), with a licensing order issued at 4658.0405,Subpart 1. 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 corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive	20555	Corrected.	04/06/2026

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20555	Continued from page 2 resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to provide an opportunity for 1 of 3 residents (R1) reviewed for care planning to participate in the development of the plan of care. Findings Include: During an observation on 3/20/26, at 8:30 a.m., R1 was seated at the edge of the floor mattress. Her breakfast tray was positioned to her left side on the floor mattress. R1 was leaning on her left elbow as she reached with a fork, using her right hand to eat the food from her tray. Food was observed falling on to the mattress as she tried to eat. R1's admission Minimum Data Set (MDS), dated 2/18/26, indicated she had diagnoses of heart failure and respiratory failure, she had severe cognitive impairment, was Hmong speaking, and was dependent for all cares and transfers. R1's care plan, dated 2/18/26, indicated she was a fall risk and had a fall mat at her bedside. She required assistance with cares including eating, bed mobility, and transfers, using two staff and a full body mechanical lift. R1's electronic medical record lacked documentation of a care conference and indicated she was admitted on 2/18/26. During an interview on 3/19/26, at 4:30 p.m., the administrator stated conferences were offered within three weeks of admission and then quarterly. During an interview on 3/20/26, at 8:35 a.m., NA-B	20555		

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20555	Continued from page 3 stated R1 frequently crawled off her bed to the mattress on the floor. Staff only put R1 in her wheelchair when her family would be present so they could watch her. She stated they give R1 bed baths because it would take up to three staff to give her a shower. During an interview on 3/20/26, at 8:48 a.m., NA-A stated R1 was eating her breakfast on the floor mattress because they were serving breakfast trays and there was not time to get R1 back into her bed. She was unsure whether it bothered R1. NA-A stated, “some cultures, like Hmong, like to be on the floor.” During an interview on 3/20/26, at 10:04 a.m., the social services director (SSD) stated resident preferences are elicited during the initial assessments and a care conference within the first 21 days and then held quarterly. R1 should have had a care conference but did was unable to locate the documentation. She stated it would be located in the forms section of the electronic medical record and mentioned in the progress notes. During an interview on 3/20/26, at 10:16 a.m., the clinical leader/licensed practical nurse (LPN)-A stated care conferences were intended to discuss medications, concerns with cares, comfort, and complaints. She thought care conferences should occur within seven days of admission and quarterly. The floor mattress was intended as a fall prevention intervention when R1 was admitted. She stated R1 seemed comfortable on the floor mattress and liked to sit on it, so she care planned for that. During an interview on 3/20/26, at 1:30 p.m., the DON stated resident preferences were determined by their initial assessments and care conferences. The care conferences are held within five days and after that every quarter. R1 had not had a care conference since she was admitted on 2/18/26 but should have had one. The DON stated the purpose of the care conference was to ensure the residents were comfortable, happy and the facility was meeting their needs. It gave an opportunity to keep the residents and family informed. During an interview on 3/20/26, at 3:15 p.m., FM-A stated she was never offered a care conference. She was in favor of a mattress on the floor next to R1’s bed so	20555		

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20555	Continued from page 4	20555		

Continued from page 4

she would not get hurt but she was not pleased that R1 was left on the floor mattress for hours, she would prefer for R1 to be offered the toilet or commode, would prefer R1 to have a shower instead of a bed bath, and it was not their culture to eat on the floor.

During an interview on 3/20/26, at 3:55 p.m., the administrator stated there had not been a care conference for R1.

A facility policy, Resident Rights, dated 11/2025, directed it is the practice of this facility to uphold the rights of all residents. The policy included a link to the Combined Federal and State Bill of Rights, dated 12/22/2025, which directed the resident has the right to be informed of, and participate in, their treatment, including:

-The right to participate in the development and implementation of their person-centered plan of care, including but not limited to:

-The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

-The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

-The right to be informed, in advance, of changes to the plan of care.

-The right to receive the services and/or items included in the plan of care.

-The right to see the care plan, including the right to sign after significant changes to the plan of care.

The facility shall inform the residents of the right to participate in their treatment and shall support the residents in this right. The planning process must: facilitate the inclusion of the resident and/or resident representative, include an assessment of the resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing goals of care.

Minnesota State Department of Health

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20555	Continued from page 5 A facility policy, Care Planning, dated 11/2024, directed each resident will have a person-centered care plan developed by the interdisciplinary team IDT) for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The IDT, in conjunction with the resident and the resident representative, will develop a comprehensive care plan no later than the 21st day of admission of the resident. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could audit all current residents' charts for care conferences. The DON, or designee, could educate nurse leadership and social services on the policy and process for care conferences. The DON could share audit findings to the facility's Quality Assessment Performance Improvement (QAPI) committee to monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		