



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 11, 2025

Administrator
THE VILLAS AT BROOKVIEW
7505 COUNTRY CLUB DRIVE
GOLDEN VALLEY, MN 55427

RE: CCN: 245186

Cycle Start Date: June 18, 2025

Dear Administrator:

On July 24, 2025, we notified you a remedy was imposed. On August 5, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 25, 2025.

As authorized by CMS the remedy of:

- **Mandatory denial of payment for new Medicare and Medicaid admissions effective September 18, 2025 did not go into effect. (42 CFR 488.417 (b))**

In our letter of July 24, 2025, 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 September 18, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 25, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, slightly slanted style.

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

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July 24, 2025

Administrator
THE VILLAS AT BROOKVIEW
7505 COUNTRY CLUB DRIVE
GOLDEN VALLEY, MN 55427

RE: CCN: 245186

Cycle Start Date: June 18, 2025

Dear Administrator:

On July 1, 2025, we informed you that we may impose enforcement remedies.

On July 2, 2025, the Minnesota Departments of Health and Public Safety completed a revisit/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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 18, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 18, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 18, 2025.

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 September 18, 2025, 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 BROOKVIEW will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 18, 2025. 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 December 18, 2025 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 Tamika Brown, at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427			
(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	
E0000	Initial Comments On 06/29/2025 - 07/02/2025, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/25/2025	
F0000	INITIAL COMMENTS On 06/29/2025 - 07/02/2025, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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: H51868059C (MN00106869) with a deficiency cited at F677. The following complaints were reviewed, found in Compliance, with NO deficiencies cited: H51868060C (MN00107701) H51868057C (MN00109555) H51868055C (MN00110713) H51868053C (MN00110947) H51868054C (MN00111387) H51868056C (MN00111442) H51868058C (MN00113468)		F0000			08/25/2025	

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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F0000	Continued from page 1 H51868052C (MN00113728) 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 substantial compliance with the regulations has been attained.		F0000				
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R27) reviewed for self-administration of medication. Findings include: R27's diagnosis report printed 7/2/25, include Type 2 diabetes mellitus, dermatitis (characterized by inflammation and irritation of skin), other prurigo (skin disorder characterized by intensely itchy spots on the skin) and bipolar disorder. R27's annual Minimum Data Set (MDS) dated 6/16/25, indicated R27's cognition was intact. R27's behaviors did not include rejection of care and there was not a noted change in R27's behaviors since last MDS dated. R27 required staff assistance with ADLs. R27's care plan, last reviewed 6/29/25, included direction to administer medications per orders. R27's care plan lacked direction for R27 to self-administer medication or indication of R27 being assessed for self-administration of medication.		F0554	R27's medication removed from her room. Resident's daughter educated to provide over the counter medication to nurse to ensure self-administration of medication policy is being followed. All residents' rooms observed for over-the-counter medications. All residents with medications at bedside have a comprehensive self-administration medication assessment completed. To prevent recurrence all staff educated to alert nurse if medication is seen at bedside to ensure a full comprehensive assessment for self-administration of medication is complete. Director of Nursing/designee will complete weekly audits of five resident rooms for observation of medications at bedside to ensure comprehensive self-administration assessments are in place. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.		08/25/2025	

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2025	
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F0554 SS = D	Continued from page 2 R27's provider progress note dated 6/16/25, did not include an order for lidocaine 4% (four percent) gel or an order for self-administration of medication. R27's electronic health record (EHR) failed to include an assessment for self-administration of medication. During observation and interview on 6/29/25 at 7:23 p.m., container of Tylenol lidocaine 4% noted in a basket on R27's bedside table. Container was not under other items. R27 stated she used the medication for shoulder pain, she applied this medication on her own. During observation on 6/30/25 at 8:48 a.m., registered nurse (RN)-D brought medications to R27, in her room. RN-D set the medication cup on R27's bedside table, next to the basket with the Tylenol lidocaine 4% visible in the basket. RN-D assisted R27 to take medications and with fluids for the medications. RN-D left R27's room without asking R27 about the Tylenol lidocaine 4% and left it in the basket. During observation on 7/1/25 at 7:53 a.m., container of Tylenol lidocaine 4% remained in a basket on R27's bedside table. Container was on top of other items in the basket, with no items on top of it. During interview, record review and observation on 7/1/25 at 1:10 p.m., RN-C stated a resident would need to be assessed prior to self-administering medications, an order would be in the resident's record and the medication would be listed on the resident's medication administration record (MAR) with specific instructions regarding the self-administration of the medication. RN-C reviewed R27's orders and MAR then verified there was no order for Tylenol lidocaine 4% or for self-administration of medication in R27's MAR. RN-C then verified location of Tylenol lidocaine 4% set on top of items in the basket on R27's bedside table. RN-C left R27's room and left the Tylenol lidocaine in R27's room. During interview on 7/1/25 at 1:26 p.m., nurse manager (NM)-A stated the nurse managers are responsible for completing self-administration of medication assessments. Any resident who desired to self-administer medications is expected to be assessed first to ensure appropriate use of the medication. An order would be obtained from the resident's provider and placed in the resident's EHR and visible in the resident's MAR. NM-A stated R27's family had a history of sneaking medication to R27. NM-A expected the medication was removed from R27's room upon discovering it. NM-A was not aware R27 had Tylenol lidocaine 4% in			F0554			

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F0554 SS = D	Continued from page 3 her room, "no one told me about it." During interview on 7/2/25 at 10:07 a.m. regional nurse consultant (RNC) stated the facility has a policy, "but we can't control what family brings into the room." RNC expected if staff noticed a medication in a resident's room, that staff did something about it. If the medication as seen by a staff member, RNC expected the medication was removed from the room and the nurse manager was made aware. RNC stated it was important for the facility and the resident's provider to be aware of all medications a resident is taking as there could be adverse effects. A facility policy for self-administration of medication was requested but was not provided.		F0554				
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,		F0676	R7's nursing rehabilitation services of passive range of motion (ROM) remains in plan of care. R7's PROM scheduling updated to populate for CNA documentation. All current residents with ROM programs in place reviewed to ensure scheduling is accurately reflected for CNA documentation. To prevent reoccurrence all Certified Nursing Assistants educated on completion and documentation of range of motion programs. Director of Nursing/designee will complete weekly audits of five residents to ensure documentation of ROM program completion is place. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.		08/25/2025	

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F0676 SS = D	Continued from page 4 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure nursing rehabilitation services were provided for 1 of 1 residents (R7) who was care planned for passive range of motion (ROM). Findings include: R7's quarterly Minimum Data Set (MDS) dated 5/9/25, indicated R7 diagnoses of end stage renal disease, altered mental status, muscle weakness, right below the knee amputation and Parkinsonism. R7's MDS further indicated resident was moderately cognitively impaired, and required assist of 1-2 staff for all activities of daily living (ADLs). R7's care plan (print date 7/2/25), indicated R7 had Alteration in mobility related to [end stage renal disease]. R7's care plan further documented the provision of "NURSING REHAB: Passive ROM to upper and lower extremities - 10 [repetitions] to each joint or as tolerated." During multiple observations, from 6/29/25 - 7/2/25 (when not attending dialysis), was observed laying in his bed (sleeping or watching TV). Meals were brought to R7's room, where after set up by staff, fed self. In review of R7's Point of Care section (nursing assistant documentation tool of cares provided) of Point Click Care (PCC - electronic medical record) the ROM section was review and the following was documented:	F0676		

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F0676 SS = D	Continued from page 5 April 2025 - Provided two days "Resident Not Available" six days The reminder were documented as "Not Applicable". May 2025 - Provided five days "Resident Refused" one day "Resident Not Available" five days The reminder were documented as "Not Applicable". June 2025 - Provided 6 days The reminder were documented as "Not Applicable". July 1, 2025 - Documented as "Not Applicable". During interview on 7/1/25 at 9:42 a.m., director of therapy services / physical therapy assistant (PTA) stated physical therapy (PT) only evaluated R7 after his admission in November of 2024. However occupational therapy (OT) did work with resident until R7 plateaued and was taken off of the case load. A functional Maintenance Plan (FMP) was provided to the nursing department for continued passive range of motion for R7. An interview on 7/2/25 at 8:54 a.m., licensed practical nurse (LPN)-A stated she was unaware of any resident on the 2nd floor who received nursing rehab, only the therapy department work with resident on this floor. An interview on 7/2/25 at 9:00 a.m., nursing assistant (NA)-A, stated the only resident on the south wing of the 2nd floor, who received nursing rehab ROM was R48.			F0676			

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F0676 SS = D	Continued from page 6 During interview on 7/2/25 at 9:08 a.m., 2nd floor care manager (RN)-A stated R7 was to receive daily range of motion (ROM), and was to be documented in Point of Care. RN-A stated it appeared the facility staff need to be educated either to the ROM program, or how to correctly document the activity. RN-A confirmed R7's ROM program is not being run as written. An interview on 7/2/25 at 10:25 a.m., interim director or nursing / corporate nurse consultant (Interim DON) stated he knew there were residents in the facility receiving nursing rehab, but due to being and interim, referred questions to the assistant director or nursing (ADON). During interview on 7/2/25 at 10:26 a.m., ADON and Interim DON reviewed R7's ROM documentation. ADON stated last January they facility went through all resident in the facility to see who would benefit from nursing rehab, beside residents with recommendation from the therapy department. When R7's Point of Care was updated for passive ROM, it appeared Point Click Care (PCC) program auto populated R7's ROM program to be implemented every shift. However, that did not explain staff documentation of "Not Applicable". ADON verified current documentation buy facility staff indicated R7's passive ROM program was not being run. An interview on 7/2/25 at 10:30 a.m., PTA provided a screening of R7's current ROM, performed this morning, which indicated there has been no lost of ROM since R7 was last seen by the therapy department. A facility policy for Nursing Rehab services was request, with the following policy received (last updated 3/31/23): "Activities of Daily Living (ADLs)/Maintain Abilities Policy INTENT: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support			F0676			

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F0676 SS = D	Continued from page 7 each resident's preferences, choices, values and beliefs. PROCEDURE: 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene-bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives."		F0676				
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure nail care was completed for 1 of 2 residents (R27) who were reviewed for being		F0677	R27 offered and provided nail care. R27's care plan updated to reflect resistance to nail care services by center staff. R27 provided education on importance of regular nail care. All current residents offered and provided nail care as needed. All residents with refusals provided with education on the importance of regular nail care and plan of care updated to reflect resistance. To prevent recurrence all Certified Nursing Assistants and licensed nurses educated on the importance of		08/25/2025	

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F0677 SS = D	Continued from page 8 dependent on staff for activities of daily living (ADLs). Findings include: R27's diagnosis report printed 7/2/25, include Type 2 diabetes mellitus, dermatitis (characterized by inflammation and irritation of skin), other prurigo (skin disorder characterized by intensely itchy spots on the skin) and bipolar disorder. R27's annual Minimum Data Set (MDS) dated 6/16/25, indicated R27's cognition was intact. R27's behaviors did not include rejection of care and there was not a noted change in R27's behaviors since last MDS dated. R27 required staff assistance with ADLs. R27's care plan included diagnosis methicillin-resistant staphylococcus aureus (MRSA) (bacteria that is resistive to many antibiotics, making infections difficult to treat) to R27's skin. Staff were instructed to educate R27 regarding the importance of hand washing, to remind R27 to wash hands immediately after activities of daily living (ADLs), care tasks and activities. Also, in R27's care plan, it was noted R27 had open lesions due to scratching. Facility document, MHM Weekly Skin Inspection V-5 for R27 completed 6/2/25, 6/9/25 and 6/16/25, noted R27's fingernails and toenails did not require trimming at time of the inspections. R27's nursing progress notes reviewed 6/4/25-6/30/25. Nursing progress notes lacked information of R27's refusal of nail care or refusal to allow assistance with cleaning underneath nails. During observation on 6/30/25 at 8:58 a.m., R27's fingernails on both hands were one-quarter to one-half inch long with unknown dark, brown substance underneath all nails. During observation on 7/1/25 at 7:53 a.m., R27 was noted to have several long, interrupted, scabbed and open areas on her right leg from above the knee to her mid-thigh. R27's nails on both her hands were one-quarter to one-half inch long with unknown dark, brown substance underneath all nails. During observation on 7/2/25 at 11:28 a.m., R27 was not seen scratching during conversation with surveyor. When R27 returned to watching television, she immediately started scratching both her upper arms. R27's nails on both hands were noted to be one-quarter to one-half			F0677	Continued from page 8 offering nail care as needed and to document any refusals of nail care. Director of Nursing/designee will complete weekly audits of five residents to ensure nail care is completed. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.		

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F0677 SS = D	Continued from page 9 inch long with unknown dark, brown substance underneath all nails. During interview on 7/1/25 at 12:51 p.m. nursing assistant (NA)-B stated nail care, including cutting nails, for residents with diabetes was completed by licensed staff (nurses). The instruction for nail care was found on the care sheets. Nurses should be aware of the information on the care sheets. NA-B would let the nurse know if a resident's nails needed to be cut. If a resident needed dirt or other substance cleaned out from under their nails, the nursing assistants were responsible for this. NA-B stated, if a resident refused to have their nails cleaned, he would let the nurse know. NA-B was not able to recall the last time he attempted to clean under R27's fingernails. During observation and interview on 7/1/25 at 1:10 p.m., registered nurse (RN)-B stated nurses complete nail care for diabetics weekly on the resident's bath day. Nursing assistants were responsible for cleaning under fingernails between bath day. If a resident refused, the nursing assistants alert the nurse it would be charted in the progress notes. RN-B was not aware of R27 refusing to have her fingernails cut or to have them cleaned. RN-B observed R27's fingernails and verified they needed to be cut and the presence of dark, brown substance under each fingernail. RN-B stated the length of R27's fingernails and the unknown substance underneath R27's fingernails were a concern because R27 had a history of scratching and skin infections. During interview on 7/1/25 at 1:26 p.m., nurse manager (NM)-A state R27 had a diagnosis of dermatitis and was, "constantly scratching." R27 had a history of refusing to allow her fingernails to be cut and to have them cleaned. NM-A expected staff to continue to offer and refusals were documented in the progress notes. NM-A verified the lack of documentation in the progress notes regarding R27's refusals, referring to a progress note written on 6/4/25 by NM-A, R27 allowed NM-A to cut her toenails, but refused to allow her fingernails to be cut. NM-A stated that was the last time NM-A attempted to cut and clean R27's fingernails and toenails. NM-A had not looked at R27's fingernails or toenails since that date. During interview on 7/2/25 at 8:41 a.m., NM-A reported she observed R27's fingernails on 7/1/25 after interview with surveyor. NM-A confirmed, R27's fingernails needed to be cleaned. NM-A expected nursing assistants and/or nurses to attempt this. NM-A stated it was important to keep R27's fingernails cut and			F0677			

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F0677 SS = D	Continued from page 10 clean due to R27's scratching her skin and R27's history of skin infections. During interview on 7/2/25 at 10:07 a.m., regional nurse consultant (RNC)-A stated he expected nail care, including cutting and cleaning underneath, was offered when needed. It was important to maintain cut and clean nails to prevent possible infection. RNC-A expected refusals were documented in the progress notes. A facility policy for nail care was requested but was not received.			F0677			
F0684 SS = D	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 observation, interview and record review the facility failed to ensure skin abrasions were adequately assessed and monitored for 1 of 1 resident (R27) reviewed for non-pressure related skin concerns. Findings include: R27's diagnosis report printed 7/2/25, include Type 2 diabetes mellitus, dermatitis (characterized by inflammation and irritation of skin), other prurigo (skin disorder characterized by intensely itchy spots on the skin) and bipolar disorder. R27's annual minimum data set (MDS) dated 6/16/25 indicated no current skin concerns. R27 had intact cognition. R27 had no behavior concerns and there was no change in behavior since last MDS. R27's care plan included diagnosis methicillin-resistant staphylococcus aureus (MRSA) (bacteria that is resistive to many antibiotics, making infections difficult to treat) to R27's skin. Staff were instructed to educate R27 regarding the importance of hand washing, to remind R27 to wash hands immediately after activities of daily living (ADLs),			F0684	R27's new skin impairment to right front thigh assessed. MD was updated with treatment orders put in place. Abrasion has since resolved. All residents in house had full body skin assessment completed. MD updated on any new skin impairments with treatment orders in place. All plan of care updated to reflect current skin impairments. To prevent recurrence all Certified Nursing Assistants educated on the importance of observing and reporting new skin impairments to licensed nurses for further assessment. Licensed nurses educated on completion of assessment of skin on weekly basis. Director of Nursing/designee will complete weekly audits of five residents to ensure full body skin assessment completed by licensed nurse. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.		08/25/2025

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F0684 SS = D	Continued from page 11 care tasks and activities and to monitor skin integrity. Also, in R27's care plan, it was noted R27 had open lesions on R27's clavicle (collar bone) and right forearm due to scratching. Facility document, MHM Weekly Skin Inspection V-5 indicated the following: - 6/2/25- Resident has multiple scabbed area. NO new skin issues noted. - 6/9/25- Skin intact - 6/16/25- No new skin condition noted - 6/30/25- No new skin condition not ed [educated] today R27's provider progress note dated 6/16/25 noted, "Patient does have pruritic and itching all over the place. She does have abrasions from itching at this time cannot tell but does not appear to be any scabies." Note also indicated no changes to current plan of care. R27's nursing progress notes reviewed 6/4/25-6/30/25. Nursing progress notes lacked information of R27's open lesions to right lower extremity (RLE) knee to thigh. During observation on 6/30/25 at 8:59 a.m., R27 was noted to have several open and scabbed over lesions on RLE knee to thigh. During interview on 7/1/25 at 7:53 a.m. R27 stated, "It itched so I scratched it," motioning with her hand to the lesions on RLE. "It's been that way for a while, at least a week." During interview and observation on 7/1/25 at 12:51 p.m., nursing assistant (NA)-B stated any new or existing skin concerns were reported to the nurse. NA-B observed R27's RLE then reported the open lesions were new, not noted earlier today. The scabbed lesions had been there during cares a few days prior. NA-B stated he reported the skin lesions to the nurse. During interview and observation on 7/1/25 at 1:10 p.m., registered nurse (RN)-B verified the open and scabbed lesions on R27's RLE, knee to thigh. RN-B stated she was not aware of the lesions on R27's RLE prior to today, but RN-B had not worked with R27 for the past few days. RN-B stated expecting nursing assistants to make the nurses aware of all open and scabbed areas, regardless of how new or old the areas	F0684		

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F0684 SS = D	Continued from page 12 appeared. During interview on 7/1/25 at 1:26 p.m., nurse manager (NM)-A stated she was aware R27 had lesions on her clavicle and right forearm. NM-A was not aware R27 had new and scabbed lesions on her RLE. NM-A reviewed progress notes and skin inspection completed 6/20/25 and confirmed no documentation was noted regarding the new and scabbed skin lesions. During interview on 7/2/25 at 8:41 a.m., NM-A stated she observed R27's skin on 7/1/25 after interview with surveyor. NM-A reported updating R27's provider after her observation. NM-A expected nurses to monitor skin daily and with weekly skin check. NM-a stated the scabbed lesions were more than a couple days old and R27's provider should have been updated sooner than 7/1/25. R27 had a history of skin infections, including MRSA. Not updating the provider timely of the skin lesions could lead to more skin infections. During interview on 7/2/25 at 10:07 a.m. regional nurse consultant (RNC) stated he expected skin checks were completed weekly and as needed. New areas of concern were reported to the nurse manager and the resident's provider at the time they were found. A facility policy on non-pressure related skin concerns was requested but was not received.	F0684		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F0791	R13 seen by dentist with dental fabrication initiated. All dental visits recommendations from the past six months reviewed to ensure recommendations for denture fabrication is being pursued. To prevent recurrence Nurse Managers, Social Services and Health Information Manager personnel have been educated to ensure that dentist recommendations are being followed as needed. Director of Nursing/designee will complete audits post dentist visits to ensure all recommendations are offered. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	08/25/2025

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/02/2025	
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F0791 SS = D	Continued from page 13 §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure recommended dental services were provided for 1 of 2 residents (R13) reviewed for dental services. Findings include: R13's quarterly minimum data set (MDS) dated 5/12/25, indicated R13 was cognitively intact, and was independent with activities of daily living. R13 had diagnosis of protein-calorie malnutrition. R13's dental care assessment area (CAA) dated 2/18/25, indicated R13 was edentulous (having no teeth) which can put resident at risk for nutritional deficits.			F0791			

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F0791 SS = D	Continued from page 14 When interviewed on 6/29/25, at 2:27 p.m. R13 stated he had no teeth, had waited a long time for them but had not received them and was not aware of what was happened with getting his dentures. A dental visit note dated 10/24/24, indicated R13 had previously declined to start denture fabrication process because he believed he would be discharged within a few weeks. Dental group spoke with social worker who reported he was on the list for a new placement, believed he would be discharged by end of year. If something changed and patient would be here long-term, could start denture fabrication. the note identified action required by nursing home staff: Patient is expected to discharge by the end of the year, per discussion with social worker. Not indicated to start dentures if there was not enough time to complete the procedure. If circumstances changed and patient will definitively be here for at least 6-7 months, let us know, and we would start denture making process. When interviewed on 7/01/25, at 3:36 p.m. social services (SS)-A stated she did not have direct contact with dental service, did not update dental service that resident had not discharged by the end of the year. When interviewed on 7/02/25, at 8:16 a.m. medical record director (MRD) stated R13 was on the list to have a annual dental exam on 7/8/25 but was not sure if the dentures would be addressed. MRD was unable to locate any documentation that dental group was updated that R13 had not discharged by the end of the year. When interviewed on 7/02/25, at 8:30 a.m. licensed practical nurse (LPN)-A stated R13 had mentioned multiple times he was waiting for dentures, he did not like having no teeth. When interviewed on 7/02/25, at 11:09 a.m. administrator stated social services covered dental service during admission and at care conferences, and medical records was responsible to schedule appointments. A facility policy and/or procedure on dental services was requested, however, none was provided.		F0791				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/30/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Villas at Brookview was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			07/31/2025

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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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427			
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K0000	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The Villas At Brookview is a 3-story building with a partial basement that was constructed in 1972 and was determined to be of Type II (222) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for fire department notification.			K0000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/30/2025	
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K0000	Continued from page 2			K0000			
K0353 SS = D	The facility has a capacity of 104 beds and had a census of 85 at the time of the survey.			K0353			07/31/2025
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:						
	Sprinkler System - Maintenance and Testing						
	CFR(s): NFPA 101						
	Sprinkler System - Maintenance and Testing						
	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.						
	a) Date sprinkler system last checked _____						
	b) Who provided system test _____						
	c) Water system supply source _____						
	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.						
	9.7.5, 9.7.7, 9.7.8, and NFPA 25						
	This STANDARD is NOT MET as evidenced by:						
	Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a isolated impact on the residents within the facility.						
	Findings include:						
	1. On 06/30/2025 between at 11:50 AM, it was revealed by observation that there were wires resting on the						
					The wires resting on the sprinkler pipe in the ceiling near room 317 have been zip ensure they are no longer resting on the sprinkler pipe. The wires resting on the sprinkler pipe above the ceiling on the north 1st floor smoke barrier door have been zip tied to ensure the are no longer resting on the sprinkler pipe.		
					To prevent recurrence all maintenance personnel have been educated to ensure sprinkler pipes are free of resting wires.		
					Maintenance Director and/or designee will complete weekly audits of five areas for observation of sprinkler pipes to ensure they are free of resting wires. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.		
					Maintenance Director is responsible for corrective actions and monitoring of compliance.		
					Date of correction: 7/31/2025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/30/2025	
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K0353 SS = D	Continued from page 3 sprinkler pipe above the ceiling on the third floor near room 317. 2. On 06/30/2025 between at 11:57 AM, it was revealed by observation that there were wires resting on the sprinkler pipe above the ceiling on the 1st floor smoke barrier north. An interview with the Administrator, Regional Maintenance Directors and the Maintenance Director verified these deficient findings at the time of discovery.			K0353			