

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 7, 2022

Administrator Brookview A Villa Center 7505 Country Club Drive Golden Valley, MN 55427

RE: CCN: 245186 Survey Cycle Start Date: February 2, 2022 Event ID: RQBI11

Dear Administrator:

On February 2, 2022 a survey was completed at your facility by the Minnesota Department of Health to investigate complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. At the time of survey, the complaints were found to be both unsubstantiated and substantiated. However, the facility was found to be in compliance because corrective action was taken prior to the on-site investigation. Therefore, at the time of the investigation, the facility was found to meet federal requirements. A plan of correction is not required.

Also at the time of this survey, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute § 144.653 and/or Minnesota Statute § 144A.10.

The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to federal deficiencies only.

Electronically attached is your copy of the Federal CMS-2567 Form and State Form.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	·		APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	<u>MB NO.</u>	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	245186		B. WING		C 02/02/2022	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BBOOK	IEW A VILLA CENTE	P		7505 COUNTRY CLUB DRIVE		
BROOM		ĸ		GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
F 000	a COVID-19 Focus was conducted at y Department of Hea with Emergency Pro §483.73(b)(6). The compliance. Because you are en- signature is not req page of the CMS-22 correction is require acknowledge recein INITIAL COMMENT On February 1-2, 2 survey was comple complaint investiga be IN compliance w Requirements for L The following comp UNSUBSTANTIATE H5186314C (MN75 H5186315C (MN77 H5186317C (MN78 The following comp SUBSTANTIATED, were cited due to a to the survey: H5186313C (MN73 Also, on February 1	2022, a standard abbreviated ted at your facility to conduct a tion. Your facility was found to with 42 CFR Part 483, ong Term Care Facilities. Plaints were found to be ED: 5104). 7043).	F 00	0		
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electronically Signed						02/09/2022

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

PRINTED: 05/11/2022

		AND HUMAN SERVICES				FORM	05/11/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245186	B. WING) 02/2022
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BROOK	/IEW A VILLA CENTE	R			505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
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F 000	at your facility by th Health to determine Infection Control. T be IN compliance. abbreviated survey The facility is enroll signature is not req page of the CMS-2 correction is require	age 1 le Minnesota Department of e compliance with §483.80 The facility was determined to In addition, a standard was also conducted. led in ePOC and therefore a juired at the bottom of the first 567 form. Although no plan of ed, the facility must pt of the electronic documents.	F	000	· · · · · ·		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00112

If continuation sheet Page 2 of 2

Minnesota Department of Health							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00112	B. WING		02/0	; 2/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BROOK	/IEW A VILLA CENTE	R	INTRY CLUE VALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	was conducted at y the Minnesota Dep	rS: 2nd, 2022, a complaint survey our facility by surveyors from artment of Health (MDH). Your N compliance with the MN					
		laint was found to be					
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 02/09/22	

STATE FORM

6899

If continuation sheet 1 of 2

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COM	E SURVEY PLETED
		00112	B. WING		C 02/02/2022	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
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	UNSUBSTANTIATE H5186314C (MN75 H5186315C (MN77 H5186316C (MN77 H5186317C (MN78	i104). i043). i701).				
	SUBSTANTIATED:	856 and MN73865), however				
	documenting the Si Orders using Feder The facility is enroll signature is not req page of state form. is required, it is req	bartment of Health is tate Licensing Correction ral software. ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility of of the electronic documents.				
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RQBI11