DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 26, 2025

Administrator
The Villas At Brookview
7505 Country Club Drive
Golden Valley, MN 55427

RE: CCN: 245186
Cycle Start Date: February 14, 2025

Dear Administrator:

On March 14, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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March 26, 2025

Administrator
The Villas At Brookview
7505 Country Club Drive
Golden Valley, MN 55427

Re: Reinspection Results
Event ID: 737S12

Dear Administrator:

On March 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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February 20, 2025

Administrator
The Villas At Brookview
7505 Country Club Drive
Golden Valley, MN 55427

RE: CCN: 245186
Cycle Start Date: February 14, 2025

Dear Administrator:

On February 14, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 14, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 14, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 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
F 000	INITIAL COMMENTS On 2/13/25 - 2/14/25, 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 with no deficiency issued. H51867246C / MN110550 The following complaints were reviewed. H51866787C / MN110444 & H51867047C / MN110487 with a deficiency issued at (F660) 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.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge	F 660		3/11/25

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

Electronically Signed | 02/27/2025

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 660	Continued From page 1 rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.	F 660		

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F 660	Continued From page 2 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop and implement discharge plans that addressed all the needs for 1 of 3 (R2) residents reviewed for discharge. R2 was discharged before a waiver evaluation was completed at the facility resulting in discharging to home without a personal care assistant (PCA). In addition, incorrect orders were transcribed as R2 was ordered to have a skilled nurse (SN) from the home care agency, the facility ordered a home health aide instead and R2's medications and dialysis were not ordered correctly.	F 660	1. R2 has discharged from center and verified via phone all services and medications are in place. 2. All residents who have discharged in the past seven days have been contacted for verification of services in place and medications provided. No residents requiring hemodialysis have discharged in the last seven days. 3. To prevent reoccurrence the social services department has been educated on safe discharge planning to include verification of waivered services opened,	

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F 660	Continued From page 3 Findings include: Email correspondence on 1/23/25 at 10:21 a.m. sent by R2's community case manager (CM) to the facility social worker (SW) indicated the CM was asking the SW if she had contacted R2's waiver provider to resume services for his discharge on 1/31/24. Email correspondence on 1/28/25 at 6:57 a.m. sent by R2's CM to the facility SW indicated she was again following up on R2's discharge plans and services. R2's providers discharge summary dated 1/27/25 indicated R2 was to be discharged home on 1/31/25 and continue PT/OT/RN (physical therapy, occupational therapy, and registered nurse) after discharge. Medications would be called into his pharmacy. The summary indicated R2 required the medically necessary services of PT/OT/RN in the home due to the patient's complicated condition and comorbidities that required continued care in the home. R2 was considered homebound. R2's discharge MDS dated 1/31/25 indicated R2 had a BIMS score of 15 indicating R2 was cognitively intact. R2 was discharged from the facility to his home. R2 required moderate assistance for bathing and lower body dressing. For transferring he required supervision or touching assistance. R2 was occasionally incontinent or urine and frequently incontinent of bowels. R2's pertinent diagnoses were acute onset of chronic diastolic congestive heart failure, mobility obesity, muscle weakness, lack of coordination, morbid obesity, and cognitive communication deficit (difficulty with language	F 660	medication delivery, hemodialysis set up and accurate transcription of physician orders for services needed for discharge was completed. 4. Administrator/designee will complete discharge planning audits weekly to ensure orders transcribed accurately, ordered services are set up, hemodialysis services confirmed, and medications received by pharmacy. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 660	Continued From page 4 comprehension and expression). R2's facility discharge instructions and summary dated 1/31/25 at 8:59 a.m. indicated a 30-day supply of all medications were called into a hospital pharmacy. No medications were listed on the discharge summary, there was a note to see the medication summary. R2 was to have occupational therapy (OT) and physical therapy (PT) from a home care agency. Under the heading name of home health agency listed a name with orders for PT/OT/HHA (home health aide) and the name of the agency. R2's primary physician was listed with a phone number. Resident consent to share information was left blank. Items provided included, advance directive, copy of recent laboratory/radiology results, most recent consultation, most recent MDS, comprehensive care plan including goals and most recent H & P (history and physical) were all left blank. No other documents were attached. The discharge summary asked for signature of the responsible party, the nurse and the provider, all signature lines were all left blank. A facility spreadsheet dated 1/31/25 made by the SW indicated R2 had a dialysis appointment, but at a different location than he usually went to in the community. Email correspondence on 2/3/25 at 10:01 a.m. sent by R2's CM to the facility SW indicated she just spoken with R2, and he had no services in place. He reported no mediations were ordered for him upon discharge, and he had no medications over the weekend. R2 reached out to dialysis regarding his schedule and was told they were not notified of his discharge, so no dialysis had been scheduled. The CM sent requests to	F 660		

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F 660	Continued From page 5 the waiver worker to contact her. The CM requested the SW to contact her ASAP via phone to discuss the needs/services missed. Upon interview on 2/14/25 at 9:12 a.m. R2's community care manager, (CM) stated R2 was discharged from the facility on 1/31/25 which was a Friday, and the CM reached out to him on 2/3/25 a Monday when R2 told her that he did not receive any medications from the facility and missed his medications all weekend. The CM followed-up with the pharmacy the facility stated they had faxed medications to and there were no orders for R2. She stated R2 had called the facility, and the facility stated they had refaxed the medications on 1/31/25. R2 worked with his community primary care physician (PCP) to re-order his medications. The CM picked-up his medications on 2/6/25 and she reported to his PCP that he had missed 6 days of medications. The CM stated she mentioned at R2's facility care conference on 1/23/25 that the facility needed to have the CADI waiver assessment completed at the facility prior to his discharge as the waiver had expired and R2 would need the PCA services. She stated R2 missed a dialysis appointment on 2/23/25 because the facility did not set it up and he missed an appointment with his PCP because R2 was unable to dress himself to go the appointment. Upon interview on 2/14/25 at 9:40 a.m. R2 stated the facility did not fax or call in his prescriptions to the pharmacy. R2 had his CM assist him with him PCP to get the medications sent to the pharmacy he used prior in the community. He stated he had never worked with the pharmacy the facility stated they faxed the medications to. R2 had an appointment set-up with his PCP where the	F 660		

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F 660	Continued From page 6 missed medications were going to be reviewed, but he missed the appointment because he was unable to fully dress himself since he did not have a PCA. He stated in his home he could transfer himself from his wheelchair to the toilet and his chair to his bed. He had difficult cleaning himself after moving his bowels. The inability to clean himself caused him anxiety because of his diabetes he was aware if he got a pressure ulcer he would have a difficult time with healing. He stated he called his daughter to assist him with cleaning himself until his services got settled. Upon interview on 2/14/25 at 10:11 a.m. registered nurse (RN)-B nurse manager stated the social worker (SW) completed the discharges. RN-B was not aware if R2's dialysis was set up or not, what the home care orders were and how the medications were ordered from the community pharmacy. RN-B stated she did not know anything about waiver services for discharging residents. Upon interview on 1/14/25 at 9:45 a.m. the SW stated on 1/31/25 she faxed the medications to the pharmacy that R2 had picked out. She stated she did receive a call from R2, and she refaxed the medications on 1/31/25. She denied any follow-up after refaxing the medications. She stated she did set-up dialysis, but it was at another site, she believed she told R2, but did not have any documentation of the site change. The SW stated she did not know if R2's CADI waiver had closed while he was at the facility. She stated she ordered homecare for OT/PT/HHA stating he needed a home health aide he did not need a nurse. She believed the Nurse Practitioner (NP) had an error when she transcribed the order for skilled nursing. The SW did not follow-up with the	F 660		

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F 660	Continued From page 7 NP regarding the discrepancy. Upon interview on 2/14/25 the NP stated she did intend R2 to have skilled nursing services in the home because of his complicated medication conditions of diabetes, dialysis, congestive heart failure and weakness. She was not aware that a home health aide was ordered instead of a skilled nurse. The NP was aware that R2 received PCA services prior and would have PCA again through the county, so she was confused why the facility wanted a home health aide as well. Upon interview on 1/14/25 at 1:16 p.m. the DON stated the facility was not to discharge a resident who was waiver eligible or had a prior waiver to discharge without it. In addition, the services should be included on the discharge summary. Upon interview on 1/14/25 at 1:25 p.m. the Administrator stated she believed R2's CM was notified of the discharge date. She stated R2 should not have gone home without the waiver in place no matter whose fault it was. She stated if the NP orders skilled nursing services, then the facility must follow the NP's orders. A facility policy titled Discharge Planning process dated 1/2025 indicated the facility to identify each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the residents stay to ensure a successful discharge. The discharge coordinator is to involve the intradisciplinary team.	F 660		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 20, 2025

Administrator
The Villas At Brookview
7505 Country Club Drive
Golden Valley, MN 55427

Re: State Nursing Home Licensing Orders
Event ID: 737S11

Dear Administrator:

The above facility was surveyed on February 13, 2025 through February 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00112	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/13/25 - 2/14/25, 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 was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H51867246C / MN110550 The following complaints were reviewed. H51866787C / MN110444 & H51867047C / MN110487 with a licensing order issued at (ST1625) 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	2 000		

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2 000	Continued From page 2 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.	2 000		
21625	MN Rule 4658.1350 Subp. 1 Disposition of Medications; On Discharge Subpart 1. Drugs given to discharged residents. Current medications, except controlled substances listed in Minnesota Statutes, section 152.02, subdivision 3, belonging to a resident must be given to the resident, or the resident's legal guardian or designated representative, when discharged or transferred and must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to release medications to 2 of 2 residents (R1 & R2) or their designated representative upon facility discharge. R1's designated representative chose to discharge against medical advice and R2 had completed his rehabilitation in the transitional care unit (TCU). R1 and R2 missed medications due to the failure of the facility to ensure the residents had medications at discharge. Finds include:	21625	Corrected	3/11/25

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21625	Continued From page 3 A Minnesota Revisor viewed 2/14/25 https://www.revisor.mn.gov/ Office of the Revisor of Statutes, Minnesota Administrative Rules 4658.1350 Disposition of medications Subpart 1. Drugs give to discharged residents. Current mediations, except controlled substances listed in Minnesota Statutes section 152.02, subdivision 3, belonging to a resident must be given to the resident, or the residents legal guardian or designated representative, when discharged or transferred and must be recorded in the clinical record. R1's admission Minimum Data Set (MDS) dated 1/23/25 indicated a Brief Interview for Mental Status (BIMs) interview could not be conducted on R1. R1 had physical behaviors directed towards others. R1 required supervision or touching assistance with dressing, hygiene, and transfers. R1's pertinent diagnoses included developmental disorder of scholastic skills (academic skills) and mild cognitive impairment. R1's physician orders dated 1/23/25 medication list included: Dayquil severe + Vapocool Oral liquid 5-10-200-325 milligrams (mg) 15 milliliters (ml) daily (cough suppressant). Carbamide peroxide Otic (ear) solution instill five drops in both ears daily. Topiramate oral tablet give two 200 mg tablets 200 by month at bedtime (anticonvulsant). Senna-Docusate sodium 8.6-50 mg tablet two tablets by mouth twice daily. (laxative). Lactulose oral solution 20 grams/30 ml give 30 mg twice daily (laxative) Acetaminophen oral tablet 650 mg 1 tablet daily (pain reliever). Oxybutynin Chloride ER (extended release) 10 mg daily (anticholergics, relaxes bladder	21625		

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21625	Continued From page 4 muscles). Polyethylene Glycol Power give 17 grams by mouth daily (laxative). Clonazepam 1 mg tablet daily (benzodiazepine, central nervous system depressant). Fluvoxamine Maleate oral tablet 100 mg, give 300 mg daily (serotonin reuptake inhibitor, maintain mental balance). Quetiapine Fumarate tablet 100 mg twice daily (antipsychotic). Quetiapine Fumarate tablet 100 mg ER 150 mg, give two tablets twice daily (antipsychotic). Multivitamin adult one tablet daily. Haloperidol tablet 0.5 mg daily as needed (antipsychotic). Levetiracetam 1000 mg oral tablet daily (anticonvulsant). Guaifenesin oral syrup 10 ml daily as needed (cough suppressant). Cholecalciferol 500 mg daily (Vitamin D3 supplement) Calcium Carbonate chewable 500 mg daily (supplement) Atenolol tablet 50 mg daily (beta-blocker for cardiac blood flow) Diclofenac sodium 1% gel apply to knees and upper arms daily (topical pain reliever). Ingrezza 40 mg capsule daily (for tardative dyskinesia -a condition that affects the nervous system due to long term use of some psychiatric drugs). Upon interview on 2/13/25 at 1:38 p.m. the social worker (SW) stated R1 was only in the facility for a day he was admitted on 1/22/25 and left against medical advice (AMA) on 1/23/25. R1 had behaviors and was striking out at staff so the facility called family member (FM)-A to the facility to assist in calming R1 down. FM-A (R1's representative) decided to take R1 home on	21625		

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21625	Continued From page 5 1/23/25. The SW stated when a resident leaves the facility AMA the facility does not complete any referrals send any medications home with the resident or complete a discharge summary. Upon interview on 2/13/25 at 3:37 p.m. FM-A stated the facility called her to assist the staff and give ideas to make R1 more comfortable. FM-A arrived at the facility on 1/23/25 at approximately 9:30 a.m. to find R1 "traumatized" FM-A felt that the facility was unable to "handle" R1. She stated she asked for R1's medication because she did not have a place for R1 to go except for home with her until R1's group home could take him back. R1 stayed with FM-A for two weeks in the home until physical therapy (PT) rehabilitated him to a level where he could return to his group home. FM-A was not certain of how many medications R1 missed over the two weeks. She was able to get "some" medications from his group home. She reached out to R1's community psychiatric nurse was able to order a few of his prn (as needed) medications. FM-A called the facility on 1/25/24 and spoke with licensed practical nurse (LPN)-A and asked for R1's Ingrezza because she could not get that refilled. LPN-A had not destroyed or sent the medications back to the pharmacy and gave R1's Ingrezza to FM-A. Upon interview on 2/14/25 at 10:10 a.m. LPN-A stated when a resident leaves AMA the facility does not dispense their medications to them. She stated she dispensed R1's Ingrezza to FM-A because she "felt bad" for FM-A. She did not dispense any of R1's other medications to FM-A even though the medications were still at the facility. Upon interview on 2/14/25 at 10:51 a.m. LPN-B,	21625		

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21625	Continued From page 6 the assistant director of nursing (ADON) stated she was not certain how the facility decides whether a resident takes the medications with them or not upon discharge. She believed it was due to the payor source of the resident and stated the SW makes the decision whether the medications are sent or not. Upon interview on 1/14/25 at 1:16 p.m. the director of nursing (DON) stated R1 did not receive his medications due to leaving AMA and she was not aware that LPN-A gave him his Ingrezza at a later date. Upon interview on 1/14/25 at 1:25 p.m. the Administrator stated the facility does not dispense medications to residents who leave AMA because the facility does not have orders to do so. Upon interview on 1/14/25 at 3:10 p.m. a Pharmacist who works with the facility stated pharmacy will only take unused medications and credit the resident. In addition, the pharmacy will not take eye drops, ear drops, creams, or narcotics even unopened. She stated R1's payor was Medicaid, and the facility does not own the medications and does not receive any reimbursed for unused medications. R2's discharge MDS dated 1/31/25 indicated R2 had a BIMS score of 15 indicating R2 was cognitively intact. R2 was discharged from the facility to his home. R2 required moderate assistance for bathing and lower body dressing. For transferring he required supervision or touching assistance. R1 was occasionally incontinent or urine and frequently incontinent of bowels. R2's pertinent diagnoses were acute onset of chronic diastolic congestive heart failure, mobility obesity, muscle weakness, lack of	21625		

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21625	Continued From page 7 coordination, morbid obesity, and cognitive communication deficit (difficulty with language comprehension and expression). R2's physician orders dated 12/20/24 indicated R2's medications were as follows: Midodrine HCT 10 mg tablets one tablet three times a day (alpha-adrenergic agonist - to treat low blood pressure). Polyethylene Glycol 3350 power 17 grams daily (laxative). Losartan potassium 50 mg tablet daily (hypokalemia - low potassium). Apixaban 5 mg tablet twice daily (anticoagulant - blood thinner). Methocarbamol 750 mg daily (muscle relaxant). Calcitriol 0.25 micrograms (MCG) daily (calcium supplement). Carvedilol 3.125 mg daily (alpha and beta blocker - lowers heart rate). Acetaminophen 1000 mg daily (over the counter pain reliever). Upon interview on 2/14/25 at 9:12 a.m. R2's community care manager, (CM) stated R1 was discharged from the facility on 1/31/25 which was a Friday, and the CM reached out to him on 2/3/25 a Monday when R1 told her that he did not receive any medications from the facility and missed his medications all weekend. The CM followed-up with the pharmacy the facility stated they had faxed medications to and there were no orders for R2. She stated R2 had called the facility, and the facility stated they had refaxed the medications on 1/31/25. R2 worked with his community primary care physician (PCP) to re-order his medications. The CM picked-up his medications on 2/6/25 and she reported to his PCP that he had missed 6 days of medications.	21625		

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21625	Continued From page 8 Upon interview on 2/14/25 at 9:40 a.m. R2 stated the facility did not fax or call in his prescriptions to the pharmacy. R2 had his CM assist him with him PCP to get the medications to the pharmacy he used prior in the community. He stated he had never worked with the pharmacy the facility stated they faxed the medications to. R2 stated he had an appointment set-up with his PCP physician where the missed medications were going to be reviewed, but he missed the appointment because he was unable to fully dress himself as home care services had not been set-up in his home. Upon interview on 1/14/25 at 9:45 a.m. the SW stated on 1/31/25 she faxed the medications to the pharmacy that R2 had picked out. She stated she did receive a call from R2, and she refaxed the medications on 1/31/25, she denied any follow-up after refaxing. She stated the reason R2 was not sent home with any medications because the R2 was on Medicare and the facility pays for the medication and gets reimbursed for the medications, so technically the medications belong to the residents who are Medicare. Upon interview on 1/14/25 at 1:16 p.m. the DON stated some payor sources do not have their medications sent along with them; she was not certain of the exact process since the SW handles the discharges. She stated the medications get reconciled with the discharging nurse, who takes directions from the SW as to dispense to the resident or not. She stated some medications are destroyed at the facility and some are sent back to the pharmacy. Upon interview on 1/14/25 at 1:25 p.m. the Administrator stated she was not aware of R2	21625		

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21625	Continued From page 9 was sent home with medications or not since the SW makes that determination based on the payor source of the resident. Upon interview on 1/14/25 at 3:10 p.m. the Pharmacist the facility uses stated R2 had a managed plan meaning the facility pays for the medications and then bills the insurance company. The medications are not credited to the facility. The medications belong to the resident as it is their insurance that should be billed. She stated they facility does return a lot of medications, and the pharmacy destroys them. A facility policy titled Discharge Planning process dated 1/2025 did indicated the disposition of resident's medications upon discharge. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21625		