DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 3, 2026

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

RE: CCN:245186
Cycle Start Date: March 17, 2026

Dear Administrator:

On March 17, 2026, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

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, 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 June 17, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 17, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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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April 3, 2026

Administrator
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7505 COUNTRY CLUB DRIVE
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Re: State Nursing Home Licensing Orders
Event ID: 1F3880-H1

Dear Administrator:

The above facility survey was completed on March 17, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

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
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 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	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
F0000	INITIAL COMMENTS On 3/13/26 and 3/17/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51868022C (2745160) without deficiencies issued. The following complaints were reviewed: H51867620C (2792163) and H51868022C (2745160) with deficiencies issued at F656, F686, F689, F697, and F726. As a result of the investigation deficiencies were cited at F655 and F761. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/19/2026
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline	F0655	R2 has been discharged the center on 2/23/2026. The Care Plans-Baseline policy is reviewed and current. Last 30 days of admissions reviewed with baseline care plans in place. All admissions re-offered copy of 48 hours baseline care plan. To prevent recurrence education completed with nurse leadership and social services on completion of 48 hours baseline care plan and offering of copy to resident. Director of Nursing/designee will complete weekly	05/12/2026

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

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

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F0655 SS = D	Continued from page 1 care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to develop and implement a baseline	F0655	Continued from page 1 audits to ensure 48-hour baseline care plan is completed and offered to residents timely. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F0655 SS = D	Continued from page 2 care plan to properly care for 1 of 3 residents (R2) reviewed for baseline care plan. Additionally, the facility failed to provide a summary of the baseline care plan to 1 of 3 residents (R2). Findings include: R2’s Admission Data Collection (nursing assessment) dated 2/16/26 at 12:50 p.m., indicated R2 had pain frequently over the past five days that made it hard to sleep at night and limited day-to-day activities. Pain was rated as moderate pain as a five (5) on a scale of 0-10. Nursing assessment indicated R2 had a wound on the coccyx described as, “right butt has opening.” R2’s progress notes indicated on 2/16/26 at 3:18 p.m., R2 was admitted with a chronic stage IV (4) (full-thickness tissue loss with exposure of muscle, tendon, ligament, or bone) sacral ulcer. R2’s Physical Therapy (PT) Evaluation and Plan of Treatment dated 2/17/26 (no time), indicated R2 had pain which interfered with functional activity and sleep. Nursing would address the pain. R2’s provider progress note dated 2/17/26 (no time), indicated R2 rated pain at 5/10 on 2/16/26 at 1:31 p.m. R2’s pain ratings included the following:2/16/26 at 1:31 p.m., pain rated as 5/102/18/26 at 7:17 a.m., pain rated as 6/102/18/26 at 3:29 p.m., pain rated as 8/102/18/26 at 3:31 p.m., pain rated as 8/10 R2’s 48-Hour Care Plan (baseline care plan) dated 2/18/26, indicated R2 admitted 2/16/26. R2's care plan indicated R2 experienced pain but failed to include interventions to relieve pain. The 48-Hour care plan indicated R2 was on Enhance Barrier Precautions (EBP) related to wounds but failed to include R2 had skin issues or interventions to treat the wounds. The 48-hour care plan failed to indicate if R2, or R2's family/representative was offered a copy of the 48-hour care plan or the opportunity to sign the 48-hour care plan. R2’s admission Minimum Data Set (MDS) dated 2/23/26, indicated R2 admitted with pain that interfered occasionally with sleep, therapy, and day-to-day	F0655		

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F0655 SS = D	Continued from page 3 activities, with pain rated as 5/10 and a Stage III (full-thickness skin injury that extends into the subcutaneous fat but does not expose muscle, tendon or bone) pressure ulcer (PU). During an interview on 3/17/26 at 3:43 p.m., employee (E)- A stated if a resident had pain or pneumonia on admission, they should be addressed on the baseline care plan and there should be a plan for staff to follow to provide care. The resident should be offered a copy and an opportunity to sign the care plan. During an interview on 3/17/26 at 4:30 p.m., E-B stated a care plan was developed right away after admission, and should include pain, pressure ulcers, and skin checks with interventions that match the orders sent by the hospital. The residents should sign the care plan and is offered a copy. During an interview on 3/17/26 at 5:25 p.m., the director of nursing stated if a resident was admitted with pain and/or a pressure ulcer, inventions should be on the resident's 48-Hour care plan and the resident should be provided with a copy. Facility provided document, The Care Plans – Baseline policy dated 7/21/23, indicated the baseline care plan is used until staff can conduct a comprehensive assessment and develop an interdisciplinary person-centered care plan and should include any services and treatments to be administered by the facility.	F0655		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or	F0656	R4's care plan has been reviewed and updated to include preference to eat with their hands and nutritional supplements per MD order. Care Planning policy was reviewed and is current. All residents with diagnosis of malnutrition reviewed. Care plans have been updated as needed to include nutritional supplements per MD orders. All residents with malnutrition diagnosis have had preferences reviewed and updated on meal tickets. To prevent recurrence education completed with dietician to include care planning supplements per MD orders and to obtain food preferences upon admission. All licensed nurses and CNAs educated on reviewing tickets for preferences at meal times and to offer alternatives as needed. CNAs educated to reviewed care	05/12/2026

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F0656 SS = D	Continued from page 4 maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and document review the facility failed to comprehensively develop and implement care plan interventions for 1 of 3 residents (R4) when R4 had poor nutritional intake with a diagnosis of malnutrition. Findings include: R4's admission Minimum Data Sheet (MDS) dated 2/5/26, indicated R4 admitted to the facility on 1/30/26, with intact cognition, required set-up assistance for meals, and diagnoses included pneumonia and malnutrition.	F0656	Continued from page 4 sheets for assistance to eat as needed. Director of Nursing/designee will complete weekly audits to ensure residents with a malnutrition diagnosis have preferences on meal tickets and supplements care planned as needed. Weekly audits of meal intake to be completed to ensure accuracy of meal consumption, following dietary preferences and assisting with feeding as needed. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F0656 SS = D	Continued from page 5 R4's care plan dated 2/2/26, indicated a potential nutritional problem related to moderate malnutrition with interventions to assist with meal set-up, record nutritional intakes, take orders at meals and offer alternatives. The care plan failed to include interventions for when R4 did not eat meals as well as direction when to offer nutritional supplement that was ordered. During an observation and interview on 3/13/26 at 12:56 p.m., R4 independently drank fluids from her glass, drank her fruit cup instead of using utensils, and ate a few bites of the fish from her plate with her fingers. R4 did not eat the rest of her meal that included pasta and a vegetable. R4 stated she did not like her meal, "it was fish but didn't taste like fish." During an observation and interview on 3/13/26 at 1:21 p.m., E-G entered R4's room, asked if R4 was done eating. R4 replied she was done. Employee G removed R4's tray. E-G stated R4 ate about 10% of her noon meal. E-G was aware R4 disliked the facility food. E-G stated when residents didn't eat, staff should offer an alternative food choice or ask if the resident required assistance to eat. E-G acknowledged she did not do either. E-G stated she should look at the care plan for how a resident eats, or for their food preferences, but had not done this for R4 and stated the nurse managers were responsible to update the care plans. During an interview on 3/13/26 at 2:20 p.m., E-H stated R4 ate about 50% of her noon meal and she charted it in R4's medical record. E-H acknowledged she had not removed the tray from R4's room and had not seen R4 eat, but 50-75% was what R4 typically ate. E-H further acknowledged charting R4 ate 50% of the noon meal was not accurate, the amount R4 actually ate was about 25%. E-H stated typically staff would offer to help a resident eat or offered an alternative food choice if the resident did not eat well. E-H acknowledged she had not done this. On 3/17/26 at 9:00 a.m., upon review of R4's care plan, the care plan was not updated with interventions for what to do if R4 did not want to eat, nor with food preferences. During interview on 3/17/26 at 3:01 p.m., R4 stated she didn't think staff had ever asked her about her food preferences.	F0656		

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F0656 SS = D	Continued from page 6 During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated R4's noon meal charted on 3/13/26, indicated R4 ate 50-75% of her meal. The DON stated if a resident does not eat well, staff should ask the resident if they didn't like the meal, offer something else and if the appetite has declined, notify the nurse, dietician, and provider. In addition, DON expected more monitoring was put place for the resident. DON acknowledged this was not done for R4. DON expected interventions were in the care plan. The Care Planning Policy dated 11/2024 indicated the comprehensive care plan was used to develop the resident's daily care routines and was utilized by staff for the purposes of providing care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F0656		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure pressure ulcer prevention interventions were utilized as ordered for residents at risk of developing pressure ulcers for 2 of 3 residents (R1, R4) reviewed who were at risk for pressure ulcers. Findings include:	F0686	R1 no longer resides in center. R4's skin care plan reviewed and is up to date. Skin Assessment and Wound policy reviewed and current. All residents noted to be at risk for developing pressure ulcers reviewed with skin care plan updated to include preventative interventions. To prevent recurrence education to licensed nurses and CNAs completed to include proper turning and repositioning and float heels with pillows. Director of Nursing/designee will complete weekly audits on five residents to ensure proper turning, repositioning and floating of heels. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	05/12/2026

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F0686 SS = D	Continued from page 7 R1 R1's significant change Minimum Data Set (MDS) dated 11/4/25, indicated R1 was severely cognitively impaired, at risk for pressure ulcers and used pressure reducing devices for her chair and bed. R1's diagnoses included a brain tumor, difficulty speaking, diabetes, and paralysis on the right, dominant side. R1's care plan dated 11/6/25, directed to float heels with pillow and turn and reposition every two-to-three hours and as needed (PRN). R1's care plan lacked an update or mention of precautions to prevent friction and sheer, although the progress notes indicated that risk. R1's provider orders dated 11/10/25 indicated weekly skin inspection by licensed nurse. R1's progress notes indicated the following:11/20/25 at 2:47 p.m., makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Friction and Shear is a potential problem.12/2/25 at 2:15 p.m., order placed for air mattress to prevent skin breakdown. R1's hospice progress notes indicated the following:11/28/26 at 4:16 p.m., poor skin turgor (reduced elasticity in skin making it more vulnerable to damage) and anasarca (severe, total-body swelling that severely compromises skin integrity and potential breakdown)12/1/25 at 11:11 a.m., patient's son had nurse speak to facility about making sure they reposition and place patient on their side, checked coccyx to ensure there is no skin breakdown; there is none During an interview on 3/18/26 at 8:30 a.m., family member (FM)-A, who returned a call that was placed on 313/26 at 10:08 a.m., stated staff's version of turning R1 was putting a towel under the shoulder, and when hospice staff came, they [hospice] turned R1 correctly. During an interview on 3/17/26 at 3:43 p.m., Employee (E)-E stated a resident could not be positioned properly with a towel, but instead staff used pillows. A resident would not stay in position with only the support of a towel.	F0686		

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F0686 SS = D	Continued from page 8	F0686		

R4

R4’s admission MDS dated 2/5/26, indicated intact cognition, risk for pressure ulcers and used pressure reducing devices for her chair and bed. R4's diagnoses included malnutrition, pneumonia, and respiratory failure.

R4’s provider orders dated 2/24/26, indicated apply TED hose (Thrombo-Embolism-Deterrent compression stockings used to reduce swelling in the legs in the presence of edema), every day shift for edema. Provider orders dated 3/6/26, indicated apply ACE wraps on in the morning and off at bedtime to help manage swelling.

R4’s provider note dated 3/17/26, indicated 3+ (three-plus- a clinical grading of pitting edema) (moderate-to-severe pitting edema, where significant fluid retention leaves a deep, prolonged indentation after pressure is applied) edema in lower extremities.

R4’s progress notes indicated the following:3/10/26 at 1:57 p.m., indicated a 10 pound weight gain over a month, with legs that looked “quite edematous,” and wearing compression stockings.3/17/26 at 10:46 a.m., discussion with daughter related to weight gain, and new order for compression to bilateral lower extremities to assist with edema.3/17/26 at 4:42 p.m., weight remains elevated due to edema and fluid retention

R4’s care plan dated 2/2/26, indicated turn and reposition and offload (reduction or redistribution of pressure on a specific area) every 2-3 (two-to-three) hours and as needed.

During continuous observation and interview on 3/13/26 from 11:52 a.m., to 2:20 p.m., R4 was lying in bed on her back, with the head of bed raised, feet resting on a pillow, and a pillow resting on top of her feet at the base of the bed. At 2:20 p.m., staff entered the room to assist R4 to reposition. R4 was not wearing TED hose or ACE wraps as ordered.

During an interview on 3/13/26 at 2:14 p.m., E-K stated R4 required assistance to reposition and to move up in

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F0686 SS = D	Continued from page 9 bed, and staff was supposed to do that every two hours as R4 could turn a little bit on her own, but needed help. At 1:55 p.m., R4 stated her feet were still on the pillow and she didn't know why there was a pillow laying on her legs, but it felt heavy on them. During an observation and interview on 3/13/26 at 2:20 p.m., E-H, a licensed nurse, acknowledged R4's feet and legs had a lot of swelling, and the top R4's socks were making indentations in R4's feet. E-H stated R4 was at risk to get sores from the socks being too tight. R4's heels were directly on a pillow instead of floated off the bed, and the E-H acknowledged R4's heels were on the pillow instead of floated, and was not wearing TED hose but should have been. The Employee E stated she put the pillow on R4's feet when she repositioned R4 in the morning and forgot to remove it. E-H did not reposition R4's lower extremities to float the heels, did not remove the socks or apply the TED stockings before leaving the room. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated pressure ulcer prevention included a turning and repositioning program, incontinence care, floating heels, padding bony prominences and using an air mattress. The DON stated offloading pressure from heels meant putting a pillow under the legs, with the heels off the pillow so the heels were floating. The Skin Assessment and Wound policy dated 2/2025, indicated the facility would implement appropriate preventative skin measures including a mobility and repositioning plan and pressure redistribution plan. The facility would update the care plan to identify risks for skin breakdown.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F0689	R5 was assessed with no injury noted. Policy related to transfers, use of mechanical lifts was reviewed and current. All residents who use mechanical lifts for transfers had the potential to be affected. Corrective action and competency re-done for identified employee. To prevent recurrence education to all licensed nurses and CNAs completed to ensure two people are used for lift transfers. Lift competencies completed with all CNAs. Director of Nursing/designee will complete five weekly	05/12/2026

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F0689 SS = D	Continued from page 10 accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide safe transfers for 1 of 3 residents (R5) when one staff transferred R5 with an EZ Stand (mechanical lift used to move a person who can bear weight from one surface to another) but required assistance of two staff with an EZ Stand for safe transfers. Findings include: R5's annual Minimum Data Set (MDS) dated 1/8/26 indicated intact cognition, dependence on staff for all transfers, and diagnoses that included heart failure and morbid obesity. R5's care plan dated 6/3/24, indicated R5 required assistance of two staff transfers with the EZ Stand and was at risk for falls related to impaired mobility. The care plan dated 9/3/24, indicated care in pairs. R5's orders dated 2/10/26 indicated care in pairs. R5's provider notes dated 3/11/26, with no time, indicated R5 weighed 543 pounds. During an observation on 3/13/26 at 11:47 a.m., R5 's door was closed, and then opened by nursing assistant (NA)-A who was in the room alone with R5. R5 thanked NA-A for helping her out of bed, and NA-A exited the room with an EZ Stand. No other staff left R5's room or was in the area of R5's room. During an interview on 3/13/26 at 11:49 a.m., R5 stated only NA-A helped her up with the EZ Stand, and stated staff used one person instead of two when staff couldn't find another person to assist with the two-person transfer. During an interview on 3/13/26 at 12:41 p.m., Employee (E)-J stated R5 transferred with an EZ Stand with two staff for safety. E-J stated all residents who transferred with any mechanical lift required two staff for transfers.	F0689	Continued from page 10 audits to observe that two people are present for mechanical lift transfers. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F0689 SS = D	Continued from page 11 During an interview on 3/13/26 at 2:14 p.m., NA-A acknowledged she transferred R5 without assistance from another staff with the EZ Stand even though she was supposed to use two staff for safety. The NA-A stated she could not find another staff to help her with the transfer but should have waited until another staff was available and was aware R5 was supposed to have care in pairs due to past allegations against staff. Further, NA-A stated she could get in trouble for using one staff, and the resident or she could be injured without another staff to assist with R5's transfers with the EZ Stand. During an interview on 3/17/26 at 4:30 p.m., E-D stated R5 transferred with an EZ Stand, and always with two staff for safety. E-D stated if only one was staff assisted R5 with the EZ Stand transfer, R5 could fall, break their legs, or break their necks, or the staff could be injured. E-D stated if she witnessed staff doing an EZ Stand transfer independently with R5, E-D would educate that staff about how to do the transfer safely. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated all mechanical lifts in the facility required two staff for safe transfers, and a NA or other trained employee, can ask a nurse, nurse manager, call the DON, or can wait for help when the NA needs another person to help with safe transfers. The Fall Prevention and Management policy dated 11/2025 indicated staff would identify and implement relevant interventions to try to minimize serios consequences of falling.	F0689		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0697	R2 no longer resides in center. Pain medication was obtained prior to discharge and administered per MD orders. Policy regarding pain management was reviewed and current. Last 30 days of admissions reviewed with pain management care planning in place to include non-pharmacological pain management interventions in place. To prevent recurrence education to all licensed nurses completed to ensure non-pharmacological pain interventions are offered and documented as needed. All	05/12/2026

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F0697 SS = D	Continued from page 12 Based on interview and document review the facility failed to sufficiently manage pain or offer non-medication pain management interventions for 1 of 3 residents (R2) reviewed for pain management. R2's Admission Data Collection (nursing assessment) dated 2/16/26 at 12:50 p.m., indicated R2 had pain frequently over the past five days that made it hard to sleep at night, limited day-to-day activities, and affected sleep, rated as moderate pain at five (5) on a scale of 0-10. R2 received scheduled and as needed (PRN) pain medication and non-medicine interventions to relieve pain. R2's Physical Therapy (PT) Evaluation and Plan of Treatment dated 2/17/26, (no time) indicated R2 had pain that interfered with functional activity and sleep, and nursing would address the pain. R2's provider progress notes dated 2/17/26, (no time) indicated R2 rated pain at 5/10 (five out of ten) on 2/16/26 at 1:31 p.m. R2's provider orders indicated the following:Lidocaine external patch 4%, apply to painful site topically one time a day for pain starting 2/21/26Oxycodone-acetaminophen (Percocet – a narcotic pain medication used to treat moderate to severe pain) oral tablet 10-325 milligrams (mg), give one tablet by mouth every six hours as needed for pain, ordered 2/18/26 at 6:00 a.m. R2's pain ratings included the following:2/16/26 at 1:31 p.m., pain rated as 5/102/18/26 at 7:17 a.m., pain rated as 6/102/18/26 at 3:29 p.m., pain rated as 8/102/18/26 at 3:31 p.m., pain rated as 8/102/19/26 at 2:25 a.m., pain rated as 8/102/19/26 at 10:13 a.m., pain rated as 7/102/19/26 at 2:42 p.m., pain rated as 5/102/20/26 at 3:33 p.m., pain rated as 6/102/20/26 at 11:37 p.m., pain rated as 9/102/21/26 at 8:02 a.m., pain rated as 5/102/21/26 at 2:11 p.m., pain rated as 5/102/22/26 at 9:35 a.m., pain rated as 5/102/22/26 at 6:42 p.m., pain rated as 6/102/23/26 at 7:27 a.m., pain rated as 6/10 R2's nursing progress notes and February 2026 Medication Administration Record (MAR) indicated the following:2/16/26 at 3:31 p.m., R2 admitted and indicated pain was rated as 5/10. The note lacked mention of what pain interventions were	F0697	Continued from page 12 licensed nurses educated on house standing orders for additional comfort medications as needed. Director of Nursing/designee will complete five weekly audits to ensure non-pharmacological pain medication is offered as needed. All admissions to be audited for use of house standing orders for comfort as needed. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F0697 SS = D	Continued from page 13 provided.2/17/26 at 9:45 am., R2 requested pain medications as she was on long-term opioids but came with no orders for pain medications. Pain provider updated and awaiting new orders.2/18/26 at 7:17 a.m., first dose of Percocet was administered.2/19/26 at 4:57 a.m., the medication was noted as effective, but lacked mention of other non-medication pain interventions tried before use of opioid.2/20/26 at 3:33 p.m., Percocet was administered for pain rated as 6/10 per the MAR; the progress notes lacked mention of non-medication pain relief interventions tried.On 2/20/26 at 11:37 p.m., Percocet was administered for pain rated as 9/10 per the MAR; the progress notes lacked mention of non-medication pain relief interventions tried.The progress notes lacked mention of non-medication interventions for pain with any of the administration of Percocet doses. R2’s 48-Hour Care Plan (Baseline Care Plan) dated 2/18/26, indicated R2 admitted 2/16/26, with pain but lacked interventions to relieve pain. R2’s care plan dated 2/18/26, indicated an alteration in comfort with interventions that included provide non-medicinal forms of pain relief such as positioning, rest, and massage. R2’s admission Minimum Data Set (MDS) dated 2/23/26, indicated R2 had intact cognition and admitted with pain that interfered occasionally with sleep, therapy, and day-to-day activities, with pain rated as 5/10. During an interview on 3/13/26 at 10:53 a.m., R2 stated when she arrived she was told, by nursing, she didn’t have an order for her usual pain medication, Percocet. R2 stated she had a history of seizures when her pain wasn’t managed. R2 stated her pain wasn’t greater than it was before but was afraid it could be without the Percocet and she was typically in a lot of pain related to her diagnosis of transverse myelitis (a neurological disorder caused by inflammation around the spinal cord resulting in pain, muscle weakness, paralysis, sensory alterations and bowel and bladder dysfunction). During an interview on 3/17/26 at 4:20 p.m., Employee (E)-C stated when residents arrived from the hospital, the care plan was developed, and pain interventions should be on the care plan. E-C stated if a resident reported pain, the nurse would do an assessment, determine the location of the pain, check vital signs,	F0697		

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F0697 SS = D	Continued from page 14 inform the provider immediately, and the nurse would chart the assessment in the progress notes. Staff would use non-medication interventions, like position change or distraction until the medication came. If the resident didn't admit with a prescription, the nurse would call the provider to get a prescription, and the medication could be obtained from the medication bank as soon as the pharmacist had the prescription. The resident could have the medication as soon as the provider sent the prescription. During an interview on 3/1726 at 4:30 p.m., E-D stated the facility had standing orders for Tylenol that can be offered to a resident for pain, and if the resident required a narcotic medication, the nurse could call a provider to get an order. Staff can try rest, reposition, music, snack, a conversation, and ice for pain relief before using an opioid and would document the interventions that worked. E-D acknowledged she did not see documentation of non-medication interventions attempted for R2. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated if a resident did not have pain medications upon admission, and experienced pain rated as 5/10, staff would offer Tylenol per the standing orders and perform a thorough pain assessment and then contact the pain provider team. The pain team can send an e-prescription to the pharmacy, and then nurses can get a code from pharmacy to get the prescription from the medication bank. The nurses were expected to try non-pharmacological interventions and document them. Further, the DON stated a resident may have overall deterioration in their condition from having pain, the resident may be unhappy, blood pressure and heart rate may elevate, and the resident may not want to eat. The DON expected nurses to document the assessment, interventions, and the resident's response to the interventions, and acknowledged that process was not followed for R2. The Pain Management Protocol dated 3/23/23, indicated residents with pain or at risk of pain have an effective pain management plan in place. The interdisciplinary team performs an assessment of the residents' diagnoses and conditions that commonly predispose to pain and reviews current medications and treatments, including non-pharmacological treatments. The nurse would assess the resident upon admission, and with input from the resident, the provider and staff establish goals of pain treatment. Staff document	F0697		

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F0697 SS = D	Continued from page 15 history of pain and its treatment. If there is a delay in obtaining pain medication, the provider is notified, and alternative medications or interventions would be obtained to meet the resident's pain management needs.	F0697		
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure nurses were timely and competently trained on medication administration for 1 of 3 residents (R1) reviewed with specific orders for administration of oral medication.	F0726	R1 no longer resides in center. All residents with current orders for sulotabs requiring slurry have had order directions in place to assist with administration. Medication administration policy reviewed and is current. To prevent recurrence education to all licensed nurses completed to ensure competency on administration of slurried medication. Director of Nursing/designee will complete five weekly observations of medication administration competencies of oral medications to ensure accurate medication passes. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	05/12/2026

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F0726 SS = D	Continued from page 16 Findings include: R1's diagnoses list dated 11/4/25, indicated diagnoses that included cancer of the frontal lobe of the brain. R1's significant change Minimum Data Set (MDS) dated 11/26/25, indicated R1 was significantly cognitively impaired, was dependent upon staff for activities of daily living, had complaints of difficulty or pain with swallowing, and received scheduled and as needed (PRN) pain medications. R1's hospice progress notes indicated the following:12/5/25 at 3:05 a.m., indicated a facility nurse contacted the hospice provider to request all medications be discontinued because R1 was having difficulty swallowing, and indicated R1 had Synthroid and morphine. The hospice provider provided education about lorazepam (medication used to manage anxiety and agitation) and morphine (pain medication used for moderate to severe pain) being comfort medications and advised it was ok to administer morphine.12/5/25 at 9:54 a.m., indicated R1's family requested the facility administer the morphine and lorazepam as a slurry (fluid mixture of medication in water designed for faster absorption)12/5/25 at 10:08 p.m., indicated R1 passed away on 12/5/26 at 8:50 p.m.12/8/25 at 10:20 a.m., documentation for 12/5/25, report from on-call triage and RNCM (registered nurse case manager) that facility staff require education on medication administration. Staff were providing solutab (form of medication which dissolves quickly and absorbs in the mouth without swallowing) comfort medications using applesauce that was draining out of patient's mouth, unable to swallow. Also reported that facility staff called to request to discontinue comfort medications due to inability to swallow, did not know that medications dissolve in mouth without swallowing. Facility nurse managers were updated about the concerns. R2's provider orders indicated the following:12/5/25 at 10:00 a.m. lorazepam soluble, give 0.5 milligrams (mg) every 4 hours PRN12/5/25 at 12:00 p.m. morphine solutab, give 5 mg every 6 hours for pain or shortness of breath12/5/25 at 10:00 p.m., indicated OK to slurry morphine and Ativan solutab in small amount of water and give sublingual. R1's Grievance Form – Medication Issue dated 12/10/25, indicated the facility received a call from R1's	F0726		

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 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427

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F0726 SS = D	Continued from page 17 hospice provider who stated R1's son expressed concern about medication administration related to sublingual (medication administered under the tongue to dissolve and enter the bloodstream through the mucous membranes) medication. The Grievance Form indicated the son wanted staff to administer the medication in a slurry, and the order was obtained. Staff attempted to educate the son on sublingual medication, but son still felt medication needed to be given with water. A facility meeting PowerPoint presentation dated 12/15/25, indicated hospice medication administration related to solutabs, liquids, medication directions, and slurry. The content of the education regarding the definition of a slurry and how to make a slurry was not included on the PowerPoint presentation. During an interview on 3/18/26 at 8:30 a.m., (attempted to call 3/13/26 at 10:08 a.m., and 3/17/26 at 8:58 a.m., a call back was received on 3/18/26), family member (FM)-A stated he saw staff attempt to administer the morphine solutabs, and tried to get R1 to swallow the solutabs several times. R1 would cough and gurgle and, "Seeing someone choke for 10-15 seconds each time is hard to see." FM-A stated he informed the hospice provider, who, "had several conversations with staff about how to give the medication." During an interview on 3/17/26 at 3:43 p.m., Employee (E)-E, a licensed nurse, stated she did not know what a sublingual medication was and stated, "That's a liquid, right?" E-E further stated she did not know what a medication slurry was. E-E stated sublingual medication, if swallowed, would not harm the resident because the resident would still get pain relief, but just not work as well as it would if it was administered sublingually. During an interview on 3/17/26 at 4:20 p.m., E-F, a licensed nurse, stated she did not know what a slurry was and was not familiar with the term. During an interview on 3/17/26 at 4:30 p.m., E-D, a licensed nurse, stated she did not know what a slurry was. E-D stated for R1 there was an order to slurry meds and give sublingually, and further stated, "I have them swallow it for hospice patients," and further stated if a resident swallowed a sublingual medication, "It dissolves."	F0726		

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F0726 SS = D	Continued from page 18 During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated a slurry was made by mixing a solutab with 5-10 cubic centimeters (cc) of water and is administered by placing it under the tongue; it was not swallowed. The DON stated hospice came to the facility to provide education about that in December, 2025. A policy about pain management was provided, but did not contain information about how to administer sublingual or slurried pain medications. A medication administration policy was requested but not provided.	F0726		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure medications were stored	F0761	Medication cart locked at time of survey. All medication carts observed and locked. Medication storage policy reviewed and is current. To prevent recurrence education to all licensed nurses completed to ensure all medication carts are locked when unattended. Director of Nursing/designee will complete weekly observations of three medication carts during randomized shift times to ensure they are locked while unattended. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	05/12/2026

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F0761 SS = E	Continued from page 19 securely in areas where residents, staff and guests could not access medications in 1 of 1 medication carts observed, potentially affecting one unit, Unit 400, of the facility. Findings include: During observation and interviews on 3/13/26 at 12:27 p.m., Employee (E)-I walked away from the medication cart, leaving it unlocked in the hallway of the 400 unit, stationed between resident rooms. At 12:31 p.m., the Director of Social Services (DSS)-A walked by the cart and pulled on the locked narcotics drawer. The DSS-A stated she was making sure the drawer was locked and then walked away. The cart remained unlocked and unattended until 12:37 p.m., when E-I returned to the cart. From 12:27 p.m. to 12:37 p.m. one resident wheeled by the cart, and two nursing assistants (NA) walked by the unlocked cart. E-I acknowledged the medication cart was unlocked when she left but should have been locked when she stepped away. Further, E-I stated the cart was supposed to be locked to ensure other staff and residents could not take medications from the cart, which could make them sick. During an interview on 3/17/26 at 3:43 p.m., E-E stated if she walked away from a medication cart, it had to be locked. During an observation and interview on 3/13/26 at 2:27 p.m., the medication cart in the hallway of the 400 unit, stationed between resident rooms was found unlocked and unattended. From 2:27 p.m., to 2:47 p.m., NAs walked by the unlocked cart five times. At 2:47 p.m., the director of nursing (DON) walked by the cart and pushed the lock to lock the medication cart and stated it was not good that the cart was unlocked, medications could go missing, and the cart was supposed to be locked when staff walked away from the cart. The Storage of Medications policy dated May 2022 indicated the medication supply was accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. Medication carts were locked when not attended by people with authorized access.	F0761		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/13/26 and 3/17/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		05/19/2026

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

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20000	Continued from page 1 The following complaint was reviewed with no deficiency issued. H51868022C (2745160). The following complaints were reviewed: H51867620C (2792163) and H51868022C (2745160) with licensing orders issued at 0300, 0565, and 0900. As a result of the investigation a licensing order was issued at 1610. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20300	Competency	20300	Completed	05/12/2026

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20300	Continued from page 2 CFR(s): MN Rule 4658.0105 A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure nurses were timely and competently trained on medication administration for 1 of 3 residents (R1) reviewed with specific orders for administration of oral medication. Findings include: R1’s diagnoses list dated 11/4/25, indicated diagnoses that included cancer of the frontal lobe of the brain. R1’s significant change Minimum Data Set (MDS) dated 11/26/25, indicated R1 was significantly cognitively impaired, was dependent upon staff for activities of daily living, had complaints of difficulty or pain with swallowing, and received scheduled and as needed (PRN) pain medications. R1’s hospice progress notes indicated the following:12/5/25 at 3:05 a.m., indicated a facility nurse contacted the hospice provider to request all medications be discontinued because R1 was having difficulty swallowing, and indicated R1 had Synthroid and morphine. The hospice provider provided education about lorazepam (medication used to manage anxiety and agitation) and morphine (pain medication used for moderate to severe pain) being comfort medications and advised it was ok to administer morphine.12/5/25 at 9:54 a.m., indicated R1’s family requested the facility administer the morphine and lorazepam as a slurry (fluid mixture of medication in water designed for faster absorption)12/5/25 at 10:08 p.m., indicated R1 passed away on 12/5/26 at 8:50 p.m.12/8/25 at 10:20 a.m., documentation for 12/5/25, report from on-call triage and RNCM (registered nurse case manager) that facility staff require education on medication administration. Staff were providing solutab (form of medication which dissolves quickly and absorbs in the mouth without swallowing) comfort medications using	20300		

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20300	Continued from page 3 applesauce that was draining out of patient's mouth, unable to swallow. Also reported that facility staff called to request to discontinue comfort medications due to inability to swallow, did not know that medications dissolve in mouth without swallowing. Facility nurse managers were updated about the concerns. R2's provider orders indicated the following:12/5/25 at 10:00 a.m. lorazepam soluble, give 0.5 milligrams (mg) every 4 hours PRN12/5/25 at 12:00 p.m. morphine solutab, give 5 mg every 6 hours for pain or shortness of breath12/5/25 at 10:00 p.m., indicated OK to slurry morphine and Ativan solutab in small amount of water and give sublingual. R1's Grievance Form – Medication Issue dated 12/10/25, indicated the facility received a call from R1's hospice provider who stated R1's son expressed concern about medication administration related to sublingual (medication administered under the tongue to dissolve and enter the bloodstream through the mucous membranes) medication. The Grievance Form indicated the son wanted staff to administer the medication in a slurry, and the order was obtained. Staff attempted to educate the son on sublingual medication, but son still felt medication needed to be given with water. A facility meeting PowerPoint presentation dated 12/15/25, indicated hospice medication administration related to solutabs, liquids, medication directions, and slurry. The content of the education regarding the definition of a slurry and how to make a slurry was not included on the PowerPoint presentation. During an interview on 3/18/26 at 8:30 a.m., (attempted to call 3/13/26 at 10:08 a.m., and 3/17/26 at 8:58 a.m., a call back was received on 3/18/26), family member (FM)-A stated he saw staff attempt to administer the morphine solutabs, and tried to get R1 to swallow the solutabs several times. R1 would cough and gurgle and, "Seeing someone choke for 10-15 seconds each time is hard to see." FM-A stated he informed the hospice provider, who, "had several conversations with staff about how to give the medication." During an interview on 3/17/26 at 3:43 p.m., Employee (E)-E, a licensed nurse, stated she did not know what a sublingual medication was and stated, "That's a liquid, right?" E-E further stated she did not know what a medication slurry was. E-E stated sublingual	20300		

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20300	Continued from page 4 medication, if swallowed, would not harm the resident because the resident would still get pain relief, but just not work as well as it would if it was administered sublingually. During an interview on 3/17/26 at 4:20 p.m., E-F, a licensed nurse, stated she did not know what a slurry was and was not familiar with the term. During an interview on 3/17/26 at 4:30 p.m., E-D, a licensed nurse, stated she did not know what a slurry was. E-D stated for R1 there was an order to slurry meds and give sublingually, and further stated, “I have them swallow it for hospice patients,” and further stated if a resident swallowed a sublingual medication, “It dissolves.” During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated a slurry was made by mixing a solutab with 5-10 cubic centimeters (cc) of water and is administered by placing it under the tongue; it was not swallowed. The DON stated hospice came to the facility to provide education about that in December, 2025. A policy about pain management was provided, but did not contain information about how to administer sublingual or slurried pain medications. A medication administration policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure appropriate training is in place for staff who hold certifications/licensure about how to administer sublingual meds and how to prepare and administer a slurry. The DON or designee could educate all appropriate staff on those systems,. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20300		
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used	20565	Completed	05/12/2026

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20565	Continued from page 5 by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and document review the facility failed to comprehensively develop and implement care plan interventions for 1 of 3 residents (R4) when R4 had poor nutritional intake with a diagnosis of malnutrition. Findings include: R4's admission Minimum Data Sheet (MDS) dated 2/5/26, indicated R4 admitted to the facility on 1/30/26, with intact cognition, required set-up assistance for meals, and diagnoses included pneumonia and malnutrition. R4's care plan dated 2/2/26, indicated a potential nutritional problem related to moderate malnutrition with interventions to assist with meal set-up, record nutritional intakes, take orders at meals and offer alternatives. The care plan failed to include interventions for when R4 did not eat meals as well as direction when to offer nutritional supplement that was ordered. During an observation and interview on 3/13/26 at 12:56 p.m., R4 independently drank fluids from her glass, drank her fruit cup instead of using utensils, and ate a few bites of the fish from her plate with her fingers. R4 did not eat the rest of her meal that included pasta and a vegetable. R4 stated she did not like her meal, "it was fish but didn't taste like fish." During an observation and interview on 3/13/26 at 1:21 p.m., E-G entered R4's room, asked if R4 was done eating. R4 replied she was done. Employee G removed R4's tray. E-G stated R4 ate about 10% of her noon meal. E-G was aware R4 disliked the facility food. E-G stated when residents didn't eat, staff should offer an alternative food choice or ask if the resident required assistance to eat. E-G acknowledged she did not do either. E-G stated she should look at the care plan for how a resident eats, or for their food preferences, but had not done this for R4 and stated the nurse managers were responsible to update the care plans. During an interview on 3/13/26 at 2:20 p.m., E-H stated R4 ate about 50% of her noon meal and she charted it in	20565		

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20565	Continued from page 6 R4's medical record. E-H acknowledged she had not removed the tray from R4's room and had not seen R4 eat, but 50-75% was what R4 typically ate. E-H further acknowledged charting R4 ate 50% of the noon meal was not accurate, the amount R4 actually ate was about 25%. E-H stated typically staff would offer to help a resident eat or offered an alternative food choice if the resident did not eat well. E-H acknowledged she had not done this. On 3/17/26 at 9:00 a.m., upon review of R4's care plan, the care plan was not updated with interventions for what to do if R4 did not want to eat, nor with food preferences. During interview on 3/17/26 at 3:01 p.m., R4 stated she didn't think staff had ever asked her about her food preferences. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated R4's noon meal charted on 3/13/26, indicated R4 ate 50-75% of her meal. The DON stated if a resident does not eat well, staff should ask the resident if they didn't like the meal, offer something else and if the appetite has declined, notify the nurse, dietician, and provider. In addition, DON expected more monitoring was put place for the resident. DON acknowledged this was not done for R4. DON expected interventions were in the care plan. The Care Planning Policy dated 11/2024 indicated the comprehensive care plan was used to develop the resident's daily care routines and was utilized by staff for the purposes of providing care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care planned interventions are followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20565		
20900	Rehab - Pressure Ulcers	20900	Completed	05/12/2026

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(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
20900	Continued from page 7 CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure pressure ulcer prevention interventions were utilized as ordered for residents at risk of developing pressure ulcers for 2 of 3 residents (R1, R4) reviewed who were at risk for pressure ulcers. Findings include: R1 R1's significant change Minimum Data Set (MDS) dated 11/4/25, indicated R1 was severely cognitively impaired, at risk for pressure ulcers and used pressure reducing devices for her chair and bed. R1's diagnoses included a brain tumor, difficulty speaking, diabetes, and paralysis on the right, dominant side. R1's care plan dated 11/6/25, directed to float heels with pillow and turn and reposition every two-to-three hours and as needed (PRN). R1's care plan lacked an update or mention of precautions to prevent friction and sheer, although the progress notes indicated that risk. R1's provider orders dated 11/10/25 indicated weekly skin inspection by licensed nurse.	20900		

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20900	Continued from page 8 R1’s progress notes indicated the following:11/20/25 at 2:47 p.m., makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Friction and Shear is a potential problem.12/2/25 at 2:15 p.m., order placed for air mattress to prevent skin breakdown. R1’s hospice progress notes indicated the following:11/28/26 at 4:16 p.m., poor skin turgor (reduced elasticity in skin making it more vulnerable to damage) and anasarca (severe, total-body swelling that severely compromises skin integrity and potential breakdown)12/1/25 at 11:11 a.m., patient’s son had nurse speak to facility about making sure they reposition and place patient on their side, checked coccyx to ensure there is no skin breakdown; there is none During an interview on 3/18/26 at 8:30 a.m., family member (FM)-A, who returned a call that was placed on 313/26 at 10:08 a.m., stated staff’s version of turning R1 was putting a towel under the shoulder, and when hospice staff came, they [hospice] turned R1 correctly. During an interview on 3/17/26 at 3:43 p.m., Employee (E)-E stated a resident could not be positioned properly with a towel, but instead staff used pillows. A resident would not stay in position with only the support of a towel. R4 R4’s admission MDS dated 2/5/26, indicated intact cognition, risk for pressure ulcers and used pressure reducing devices for her chair and bed. R4's diagnoses included malnutrition, pneumonia, and respiratory failure. R4’s provider orders dated 2/24/26, indicated apply TED hose (Thrombo-Embolism-Deterrent compression stockings used to reduce swelling in the legs in the presence of edema), every day shift for edema. Provider orders dated 3/6/26, indicated apply ACE wraps on in the morning and off at bedtime to help manage swelling. R4’s provider note dated 3/17/26, indicated 3+ (three-plus- a clinical grading of pitting edema) (moderate-to-severe pitting edema, where significant fluid retention leaves a deep, prolonged indentation	20900		

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20900	Continued from page 9 after pressure is applied) edema in lower extremities. R4's progress notes indicated the following:3/10/26 at 1:57 p.m., indicated a 10 pound weight gain over a month, with legs that looked "quite edematous," and wearing compression stockings.3/17/26 at 10:46 a.m., discussion with daughter related to weight gain, and new order for compression to bilateral lower extremities to assist with edema.3/17/26 at 4:42 p.m., weight remains elevated due to edema and fluid retention R4's care plan dated 2/2/26, indicated turn and reposition and offload (reduction or redistribution of pressure on a specific area) every 2-3 (two-to-three) hours and as needed. During continuous observation and interview on 3/13/26 from 11:52 a.m., to 2:20 p.m., R4 was lying in bed on her back, with the head of bed raised, feet resting on a pillow, and a pillow resting on top of her feet at the base of the bed. At 2:20 p.m., staff entered the room to assist R4 to reposition. R4 was not wearing TED hose or ACE wraps as ordered. During an interview on 3/13/26 at 2:14 p.m., E-K stated R4 required assistance to reposition and to move up in bed, and staff was supposed to do that every two hours as R4 could turn a little bit on her own, but needed help. At 1:55 p.m., R4 stated her feet were still on the pillow and she didn't know why there was a pillow laying on her legs, but it felt heavy on them. During an observation and interview on 3/13/26 at 2:20 p.m., E-H, a licensed nurse, acknowledged R4's feet and legs had a lot of swelling, and the top R4's socks were making indentations in R4's feet. E-H stated R4 was at risk to get sores from the socks being too tight. R4's heels were directly on a pillow instead of floated off the bed, and the E-H acknowledged R4's heels were on the pillow instead of floated, and was not wearing TED hose but should have been. The Employee E stated she put the pillow on R4's feet when she repositioned R4 in the morning and forgot to remove it. E-H did not reposition R4's lower extremities to float the heels, did not remove the socks or apply the TED stockings before leaving the room. During an interview on 3/17/26 at 5:25 p.m., the	20900		

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20900	Continued from page 10 director of nursing (DON) stated pressure ulcer prevention included a turning and repositioning program, incontinence care, floating heels, padding bony prominences and using an air mattress. The DON stated offloading pressure from heels meant putting a pillow under the legs, with the heels off the pillow so the heels were floating. The Skin Assessment and Wound policy dated 2/2025, indicated the facility would implement appropriate preventative skin measures including a mobility and repositioning plan and pressure redistribution plan. The facility would update the care plan to identify risks for skin breakdown. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to ensure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure medications were stored securely in areas where residents, staff and guests could not access medications in 1 of 1 medication carts observed, potentially affecting one unit, Unit 400, of the facility.	21610	Completed	05/12/2026

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21610	Continued from page 11 Findings include: During observation and interviews on 3/13/26 at 12:27 p.m., Employee (E)-I walked away from the medication cart, leaving it unlocked in the hallway of the 400 unit, stationed between resident rooms. At 12:31 p.m., the Director of Social Services (DSS)-A walked by the cart and pulled on the locked narcotics drawer. The DSS-A stated she was making sure the drawer was locked and then walked away. The cart remained unlocked and unattended until 12:37 p.m., when E-I returned to the cart. From 12:27 p.m. to 12:37 p.m. one resident wheeled by the cart, and two nursing assistants (NA) walked by the unlocked cart. E-I acknowledged the medication cart was unlocked when she left but should have been locked when she stepped away. Further, E-I stated the cart was supposed to be locked to ensure other staff and residents could not take medications from the cart, which could make them sick. During an interview on 3/17/26 at 3:43 p.m., E-E stated if she walked away from a medication cart, it had to be locked. During an observation and interview on 3/13/26 at 2:27 p.m., the medication cart in the hallway of the 400 unit, stationed between resident rooms was found unlocked and unattended. From 2:27 p.m., to 2:47 p.m., NAs walked by the unlocked cart five times. At 2:47 p.m., the director of nursing (DON) walked by the cart and pushed the lock to lock the medication cart and stated it was not good that the cart was unlocked, medications could go missing, and the cart was supposed to be locked when staff walked away from the cart. The Storage of Medications policy dated May 2022 indicated the medication supply was accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. Medication carts were locked when not attended by people with authorized access. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all	21610		

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21610	Continued from page 12 medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21610		