



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 22, 2024

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

RE: CCN: 245186
Cycle Start Date: September 17, 2024

Dear Administrator:

On October 21, 2024, 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2024

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

RE: CCN: 245186
Cycle Start Date: September 17, 2024

Dear Administrator:

On September 17, 2024, a survey was completed at your facility by the Minnesota Departments 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.

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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 Sassen, Regional Operations Supervisor

St. Cloud A District Office

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: Nicole.Sassen@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 December 17, 2024 (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 March 17, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

The Villas At Brookview

September 25, 2024

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specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a small dot above the 'i' in 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

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

PRINTED: 10/23/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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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
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F 000	<p>INITIAL COMMENTS</p> <p>On 9/16/24 through 9/17/24, a standard abbreviated survey was conducted at your facility.</p> <p>Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed with NO deficiencies cited:</p> <p>H51868224C (MN00103458)</p> <p>H51868240C (MN00104008)</p> <p>H51868209C (MN00106225)</p> <p>H51868080C (MN00106487)</p> <p>H51868227C (MN00103148)</p> <p>H51868226C (MN00103431)</p> <p>The following complaint was reviewed H51868225C (MN00103658) with a deficiency cited at F684.</p> <p>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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/03/2024
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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 000 F 684 SS=D	Continued From page 1 regulations has been attained. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure physician orders were followed to promote good nutritional intake for 1 of 1 residents, (R1), with the diagnoses of end stage renal disease and diabetes. Findings include: R1's annual Minimum Data Set (MDS) dated 7/9/24, identified R1 was cognitively intact. R1's medical diagnoses identified R1 was medically complex, and his diagnoses included anemia, peripheral vascular disease, renal disease and diabetes. R1's physician orders dated 6/11/24, indicated R1 was to receive a regular diet, regular texture, and regular (thin) consistency. In addition, the order indicated R1 was to receive double meat/protein for nutrition. R1's care plan, initiated on 12/26/17, identified R1	F 000 F 684	Resident R1 currently resides in center with no adverse reactions noted from deficient practice. R1's meal ticket updated to include order for double protein. All residents in-house with a physician order for double protein have the potential to be affected. All resident's physician orders reviewed with meal tickets updated to include special instructions for double proteins. To prevent recurrence education with the Dietician completed to ensure all special instructions are reflected on the meal tickets for culinary service providers. Education with culinary service providers completed to ensure meal tickets are reviewed at time of service and orders are fulfilled for double protein per physician orders.	10/15/24

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

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F 684	<p>Continued From page 2</p> <p>had diabetes mellitus II (adult onset). The care plan directed staff to monitor for breaks in skin, and, if noted, to treat promptly as ordered by the doctor. The care plan directed staff to check skin when assisting with activities of daily living (personal cares). The care plan also identified R1 was at potential national risk related to anxiety problems with end stage renal disease with dialysis. The care plan directed staff to serve diet as ordered, explain the prescribed diet and the need for adequate nutritional intake.</p> <p>The care plan identified R1 was to receive double meat portions. In addition to concerns related to renal disease and diabetes, the care plan also identified R1 had impairment to skin integrity related to vascular disease (a disease related to impaired circulation), had surgical interventions on more than one occasion, had a history of venous ulcers (ulcers related to poor circulation), and a history of pressure ulcers.</p> <p>On 9/17/24, at 6:50 p.m., R1 was observed in the dining room during the evening. R1 had been served a pulled pork sandwich on two pieces of bread. In addition to the sandwich, there were was noted to be a sugar cookie, and two beverages. When asked how his evening meal was, R1 commented "I'm a big guy. I should have two sandwiches. There was nothing else served. No chips. Nothing. When they serve corn dogs, I get one corn dog! That's not enough for a big guy like me!" R1 went on to state when he had asked for a second sandwich, he was told he had to wait until the dietary staff was sure there was an adequate amount of sandwiches for those not served yet. R1's ticket was on the table and identified his order for a sandwich. R1's ticket lacked direction to staff to indicate he was to receive double meat/protein. R1 stated he often</p>	F 684	Administrator/designee will complete meal service audits weekly to ensure double protein portions are provided at time of service. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 684	<p>Continued From page 3</p> <p>ordered in food items, or purchased food items to heat up in the microwave, using his own finances, to eat when he did not receive enough food with meals. R1 stated "I shouldn't have to do this."</p> <p>On 9/17/24, at 10:00 a.m., the nutritional consultant (NC) stated resident's may receive a double portion of meal item served if it was requested when meal order was placed the day prior. If a request was received at the time of the meal, the resident was provided a second serving of the requested item after the staff assured there was adequate food for all residents. NC did state if the resident had orders for double meat/protein, the staff would automatically serve them a double portion. In the case of a sandwich, the resident would receive two sandwiches.</p> <p>On 9/17/24, at 2:56 p.m., registered nurse (RN)-A, clinical manager, stated if a resident was to receive double meat/protein, it was listed on the tray ticket. RN-A stated if the resident was to receive double meat/protein and sandwiches were being served, they should have received either a double portion of meat in the sandwich, or a second sandwich. RN-A reviewed the care plan at that time and stated it was not identified in there.</p> <p>On 9/17/24, at 3:22 p.m., an interview was held with licensed practical nurse (LPN)-A, ADON (assistant director of nursing) regarding physician orders for double meat/protein. LPN-A verified the order for double meat/protein was in place on R1's orders, and should have been identified on his tray ticket to alert staff of the order. LPN-A stated education was needed regarding the importance of placing this information on the ticket, to ensure the order was followed and</p>	F 684		

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F 684	<p>Continued From page 4</p> <p>resident was receiving double meat/protein servings. .</p> <p>On 9/17/24, at 3:40 p.m., the registered dietitian, (RD), stated R1 had a history of skin and wound concerns, including ulcerations, and subsequent amputations. RD stated she had just amended R1's tray ticket to reflect double meat/protein servings after having been contacted by ADON. RD acknowledged R1 frequently ordered in food items independently from other sources and indicated R1 was not always following his recommended dietary limitations when obtaining/consuming outside food. RD stated R1's labs and weight are stable.</p> <p>A facility policy, undated, titled Diet Manual and Diet Orders, identified it was the facility policy to provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily, nutritional, and special dietary needs. The policy directed staff when changes were received for a dietary order, the person who accepted the order was to make the changes in the patient ' s medical record. The person would then ensure the culinary services department received a written notice.</p>	F 684		
F 770 SS=E	<p>Laboratory Services CFR(s): 483.50(a)(1)(i)</p> <p>§483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493</p>	F 770		10/15/24

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F 770	<p>Continued From page 5 of this chapter. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the agency failed to maintain current certification for the Clinical Laboratory Improvement Amendments (CLIA) waiver, which is required for agencies performing blood testing. This had the potential to affect patients who received blood testing by the agency, including those residents who had received routine glucose testing (check of blood sugar). This included R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, and R35.</p> <p>On 9/16/24, at 10:00 a.m. a review of the facility certifications was completed upon entrance to the facility. At this time, a document dated 11/17/22, indicated the CLIA waiver became effective 9/1/22 and expired on 8/31/24.</p> <p>On 9/17/24, at 2:00 p.m. inquired of administrator if there had been a CLIA certificate received following the date of expiration on 8/31/24. An email was received in follow up at 2:50 p.m. and indicated there was not an updated CLIA waiver in house, however, identified they were in the process of renewal. Additionally, correspondence was received at 3:34 p.m. to indicate the facility lacked documentation of the application for renewal.</p> <p>A review of the current resident population via the electronic medication administration record indicated the following residents had orders for blood glucose monitoring at the below listed frequency for the identified diagnosis: R9 had blood glucose monitoring three times</p>	F 770	<p>Center has completed payment for an updated CLIA waiver. Confirmation of payment and pending waiver is posted in center.</p> <p>Residents requiring blood sugar checks have the potential to be affected by this practice.</p> <p>To prevent recurrence education with the Administrator has been completed to ensure timely application for CLIA waiver is submitted.</p> <p>Administrator/designee will complete a review of CLIA waivers annually to ensure application and payment is completed timely. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.</p>	

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F 770	Continued From page 6 a day for Diabetes Mellitus Type II. R10 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R11 had blood glucose monitoring four times a day for Diabetes Mellitus. R12 had blood glucose monitoring twice daily for Diabetes Mellitus Type II. R13 had blood glucose monitoring four times a day for Diabetes Mellitus. R14 had blood glucose monitoring three times a day for Diabetes Mellitus Type II. R15 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R16 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R17 had blood glucose monitoring three times a day for Diabetes Mellitus Type II. R18 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R19 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R20 had blood glucose monitoring daily for Diabetes Mellitus Type II. R21 had blood glucose monitoring four times a day for Diabetes due to underlying condition. R22 had blood glucose monitoring three times a day for Diabetes due to underlying condition. R23 had blood glucose monitoring three times a day for Diabetes Mellitus Type II. R24 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R25 had blood glucose monitoring four times a day for Diabetes due to underlying condition. R26 had blood glucose monitoring three times a day for Diabetes Mellitus Type II. R27 had blood glucose monitoring three times a week for Diabetes Type II. R28 had blood glucose monitoring three	F 770		

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F 770	Continued From page 7 times a day for Diabetes Mellitus Type II. R29 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R30 had blood glucose monitoring daily for Diabetes due to underlying condition. R31 had blood glucose monitoring daily for Diabetes Mellitus Type II. R32 had blood glucose monitoring four times a day for Diabetes Mellitus Type II. R33 had blood glucose monitoring three times a day for Diabetes Mellitus. R34 had continuous blood glucose monitoring for Diabetes Mellitus Type II. and R35 had blood glucose monitoring twice daily for Diabetes Mellitus Type II. A policy was requested for maintenance of the CLIA waiver was requested, however, was not available per the administrator.	F 770			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: BREQ11

Dear Administrator:

The above facility was surveyed on September 16, 2024 through September 17, 2024 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:

Nikki Sassen, Regional Operations Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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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) COMPLETE DATE
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 9/16/24 through 9/17/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed with NO licensing orders were issued:</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/03/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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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) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>H51868224C (MN00103458) H51868225C (MN00103658) H51868240C (MN00104008) H51868209C (MN00106225) H51868080C (MN00106487) H51868227C (MN00103148) H51868226C (MN00103431)</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		