



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 16, 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 April 3, 2026, we informed you that we may impose enforcement remedies.

On April 1, 2026, the Minnesota Department of Health and completed a survey and it has been determined that your facility is not in substantial compliance

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

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 17, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 17, 2026. They will

also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 17, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 17, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, THE VILLAS AT BROOKVIEW will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 17, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety,

State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed.

Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file

electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

Feel free to contact me if you have questions.

Sincerely,



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



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April 16, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 2C9F0-H1

Dear Administrator:

The above facility survey was completed on April 1, 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:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

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

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

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 04/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	INITIAL COMMENTS On 4/1/26 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 complaints were reviewed H51868720C / MN2805085 with deficiencies issued at F609, F610, F760 and F842 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.		F0000			05/19/2026	
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance		F0609	R1 has returned from the hospital in stable condition. R1's MD updated with no new orders at this time. R1's medication regimen reviewed for accuracy. All residents will be affected by this practice. Medication administration policy reviewed and facility abuse policy reviewed and both policies remain current. All staff will be mandated reporters. To prevent recurrence education completed with nursing leadership team on investigation and reporting any rehospitalizations with suspected potential alleged violation. Administrator/designee will complete weekly audits of all facility reported incidents to validate timeliness in reporting of alleged violations. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.		05/19/2026	

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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F0609 SS = D	Continued from page 1 with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to report potential neglect (the failure of the facility, it's employees of service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional stress) to the State Agency (SA), no later than 24 hours for 1 of 3 (R1) residents reviewed for reporting. R1 was given insulin at the incorrect time without a provider's order. R1 was sent to the hospital later that day for hypoglycemia (low blood glucose which includes dizziness, fatigue, sweating, and confusion). Findings include: R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin Aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams per deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 – 400 mg/dl give 15 units. Normal blood glucose is 70 mg/dl – 110 mg/dl fasting. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the medication was administered, the number 2 indicating she refused the insulin and the number 15 indicating 15 units of Aspart insulin was given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's nursing progress notes dated 3/14/26 at 12:12 a.m. indicated around 8:00 p.m. R1 was noted to have had cold clammy hands and weak. Her blood glucose was 52 mg/dl. Her mental status was conscious, but incoherent and confused. Her blood pressure was 139/78 (normal reading 120/80), Pulse was 61 beats per minute (normal range 60-100), O2 saturation rate 22 (normal 92-100).		F0609				

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F0609 SS = D	Continued from page 2 R1 was immediately offered a glass of apple juice and blood glucose went up to 74 mg/dl, another glass of orange juice was offered, and the blood glucose rose to 92 mg/dl. R1 continued to be weak and hospitalized. R1's quarterly Minimum Data Set (MDS) dated 3/14/26 indicated R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment. R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma, and respiratory failure. R1's IDT (intradisciplinary team) note dated 3/16/26 indicated the IDT team met to review R1's rehospitalization for low blood glucoses. R1 was noted to have blood glucose of 33 mg/dl despite facilities interventions unable to raise blood glucose levels. R1 was transferred to the hospital for further evaluation. R1 was currently unresponsive in the hospital. Upon interview on 4/1/26 at 9:40 a.m. R1 stated she did not recall any events that happened on 3/13/26 leading up to her hospitalization. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. she heard R1 hysterically crying in her room. RN-A tested R1's blood glucose, and it was above 200 mg/dl. RN-A immediately gave R1 15 units of Aspart insulin. RN-A noticed the day nurse (RN)-B had not recorded R1's noon insulin administration. RN-B was still onsite. RN-A told RN-B that she had taken R1's blood glucose, it was high, and she administered insulin. RN-A told RN-B to chart the insulin as administered at noon because her blood glucose level was high at noon, but not to give the insulin because RN-A gave it around 2:15 p.m. RN-A stated RN-B did chart the insulin as given at noon. RN-A also charted R1's eMAR, the insulin had been given at 5:00 p.m. even though it was given at 2:30 p.m. RN-A stated she called the director of nursing (DON) on 3/13/26 at about 3:00 p.m. and explained the medication error. RN-A was told the DON would take care of the error on the e-MAR and write a progress note. RN-A was not certain if the correction was completed. At approximately 8:00 p.m. on 3/13/26 RN-A found R1 in her room incoherent, cold, and clammy with a blood glucose of 56 mg/dl. RN-A gave R1 juice and got her blood glucose to rise to 92 mg/dl. R1 was still incoherent,			F0609			

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F0609 SS = D	Continued from page 3 cold, and clammy so she was sent to the hospital. RN-A reported the hospitalization to the family and R1's provider, she did not call the DON. RN-A stated the facility had not addressed the medication error or charting with her. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A stated he was aware that R1 had been sent to the hospital for low glucose levels. He denied any knowledge of her rapid acting insulin being given at the incorrect time or both nurses charting the insulin at incorrect times. He was onsite working on 3/13/26 at the time of the incident, however he was not notified. He denied knowledge of a medication error report form filled out or re-education to RN-A. He stated maybe the DON had investigated. Upon interview on 4/1/26 at 2:43 p.m. the DON stated RN-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and RN-A had given the Aspart at 2:15 p.m. The DON stated she instructed RN-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated it appeared that both RN-A and RN-B had charted the insulin. The DON was not certain what dose of insulin was given. The DON denied filling out a medication error form, investigating the error or re-educating RN-A. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware of the medication error, and the facility did not report the incident. She was not certain if the DON had completed a medication error, investigated, or re-educated RN-A if needed. Attempts were made to reach out to RN-B during the survey; however, no response was received. An investigation policy was requested, however none received.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F0610	R1 has returned from the hospital in stable condition. R1's MD updated with no new orders at this time. R1's medication regimen reviewed for accuracy. All residents will be affected by this practice. Medication administration policy reviewed and facility abuse policy reviewed and both policies remain current. Interdisciplinary will review and conduct	05/19/2026

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F0610 SS = D	Continued from page 4 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to initiate an investigation for potential neglect (the failure of the facility, it's employees of service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional stress) for 1 of 3 residents (R1) reviewed for investigation, prevention and correction of alleged allegation. R1 was given insulin at the incorrect time without a provider's order. R1 was sent to the hospital later that day for hypoglycemia (low blood glucose which includes dizziness, fatigue, sweating, and confusion). Findings include: R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin Aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams per deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 – 400 mg/dl give 15 units. Normal blood glucose is 70 mg/dl – 110 mg/dl fasting. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the medication was administered, the number 2 indicating she refused the insulin and the number 15 indicating 15 units of Aspart insulin was given.			F0610	Continued from page 4 investigations into any alleged violation. To prevent recurrence education completed with nursing leadership team on investigation and reporting any rehospitalizations with suspected potential alleged violation. Director of Nursing/designee will complete weekly audits for completion of root cause analysis on all rehospitalizations to ensure initiation of investigations for potential alleged violations. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.		

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 04/01/2026	
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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	
F0610 SS = D	Continued from page 5 R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's nursing progress notes dated 3/14/26 at 12:12 a.m. indicated around 8:00 p.m. R1 was noted to have had cold clammy hands and weak. Her blood glucose was 52 mg/dl. Her mental status was conscious, but incoherent and confused. Her blood pressure was 139/78 (normal reading 120/80), Pulse was 61 beats per minute (normal range 60-100), O2 saturation rate 22 (normal 92-100). R1 was immediately offered a glass of apple juice and blood glucose went up to 74 mg/dl, another glass of orange juice was offered, and the blood glucose rose to 92 mg/dl. R1 continued to be weak and hospitalized. R1's IDT (intradisciplinary team) note dated 3/16/26 indicated the IDT team met to review R1's rehospitalization for low blood glucoses. R1 was noted to have a blood glucose of 33 mg/dl despite facilities interventions unable to raise blood glucose levels. R1 was transferred to the hospital for further evaluation. R1 was currently unresponsive in the hospital. R1's quarterly Minimum Data Set (MDS) dated 3/14/26 indicated R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment. R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma, and respiratory failure. Upon interview on 4/1/26 at 9:40 a.m. R1 stated she did not recall any events that happened on 3/13/26 leading up to her hospitalization. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. she heard R1 hysterically crying in her room. RN-A tested R1's blood glucose, and it was above 200 mg/dl. RN-A immediately gave R1 15 units of Aspart insulin. RN-A noticed the day nurse (RN)-B had not recorded R1's noon insulin administration. RN-B was still onsite. RN-A told RN-B that she had taken R1's blood glucose, it was high, and she administered insulin. RN-A told RN-B to chart the insulin as administered at noon because her blood glucose level was high at noon, but not to give		F0610				

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F0610 SS = D	Continued from page 6 the insulin because RN-A gave it around 2:15 p.m. RN-A stated RN-B did chart the insulin as given at noon. RN-A also charted R1's eMAR, the insulin had been given at 5:00 p.m. even though it was given at 2:30 p.m. RN-A stated she called the director of nursing (DON) on 3/13/26 at about 3:00 p.m. and explained the medication error. RN-A was told the DON would take care of the error on the e-MAR and write a progress note. RN-A was not certain if the correction was completed. At approximately 8:00 p.m. on 3/13/26 RN-A found R1 in her room incoherent, cold, and clammy with a blood glucose of 56 mg/dl. RN-A gave R1 juice and got her blood glucose to rise to 92 mg/dl. R1 was still incoherent, cold, and clammy so she was sent to the hospital. RN-A reported the hospitalization to the family and R1's provider, she did not call the DON. RN-A stated the facility had not addressed the medication error or charting with her. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A stated he was aware that R1 had been sent to the hospital for low glucose levels. He denied any knowledge of her rapid acting insulin being given at the incorrect time or both nurses charting the insulin at incorrect times. He was onsite working on 3/13/26 at the time of the incident, however he was not notified. He denied knowledge of a medication error report form filled out or re-education to RN-A. He stated maybe the DON had investigated. Upon interview on 4/1/26 at 2:43 p.m. the DON stated RN-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and RN-A had given the Aspart at 2:15 p.m. The DON stated she instructed RN-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated it appeared that both RN-A and RN-B had charted the insulin. The DON was not certain what dose of insulin was given. The DON denied filling out a medication error form, investigating the error or re-educating RN-A. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware of the medication error, and the facility did not report the incident. She was not certain if the DON had completed a medication error, investigated, or re-educated RN-A if needed. Attempts were made to reach out to RN-B during the			F0610			

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F0610 SS = D	Continued from page 7 survey; however, no response was received.	F0610		
F0760 SS = D	An investigation policy was requested, however none received. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to prevent a significant medication error for 1 of 3 residents reviewed for medication errors. R1's Aspart (a short acting insulin) was given at the incorrect time. The Aspart insulin was ordered as an insulin sliding scale (an order in which the insulin dose is based on a resident's blood glucose level) to be taken with meals and was given at 2:15 p.m. without a meal. In addition, during the survey process R1's 8:00 a.m. medications were administered nearly three hours late. Findings include: Upon observation on 4/1/26 at 10:40 a.m. registered nurse (RN)-C was setting up R1's medications for administration. Upon observation on 4/1/26 at 10:51 a.m. (RN)-C entered R1's room to give R1 her morning medications. R1 was asleep. (RN)-C aroused R1 and assisted her to a sitting position on the side of her bed. R1 stated that her medications were late again and that she had to be woken up to take them. RN-A acknowledged the medications were late to R1 and continued to administer. R1's medication administration record (MAR) dated 4/1/26 indicated the following medications were scheduled for administration at 8:00 a.m. on 4/1/26:Amiodarone HCl tablet 200 mg (milligrams) give one table by mouth daily for antiarrhythmic (irregular heart rate)Apixaban Calcium 80 mg tablet give one tablet one tablet by mouth twice daily for atrial	F0760	R1 has returned from the hospital in stable condition. R1's medication regimen reviewed for accuracy. All residents have the potential to be affected. Medication order policy reviewed and is current. Medication errors form will be filled for any alterations in the medication administration policy. To prevent recurrence education to licensed nurses completed on timely medication administration per MD orders to include insulin administration with meals and updating the MD for further instructions if a delay in administration is noted. Director of Nursing/designee will complete weekly audits on five residents' medication pass to ensure timely administration of medications per MD orders. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	05/19/2026

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F0760 SS = D	Continued from page 8 fibrillation (rapid irregular heart rhythm).Buprenorphine HCL-Naloxone HCl sublingual film 4-1 mg. Give one film sublingually (under the tongue) three times a day for history of substance use.Calcium Carbonate-Vitamin D oral tablet 500-5 mg give one tablet by mouth daily with breakfast for supplemental.Cyclobenzaprine HCl oral tablet give 1 tab by mouth three times a day for muscle spasmsFenofibrate 40 mg tablet give one tablet by mouth daily for cholesterol.Insulin Glargine Solution 100 unit/ml (milliliter) inject 15 units subcutaneously two times a day for diabetes.Lasix 20 mg tablet give three tablets daily for diuretic (water pill).Metoprolol Tartrate give 25 mg by mouth twice daily for hypertension (high blood pressure).MiraLAX oral power 17 gm/scoop (grams) give one scoop by mouth daily for constipation.Mucinex tablet extended release 12-hour 600 mg give one tablet by mouth twice daily for Chronic bronchitis.Potassium 20 meq (milliequivalents) give one tablet by mouth daily for hypokalemia (low potassium).Pregabalin 50 mg capsule give one capsule by mouth three times a day for pain.Prozac 20 mg capsule give one capsule by mouth daily for antidepressantSenna oral tablet 8.6 mg tablet give one tablet by mouth daily for constipation.Spiriva Respimat inhalation aerosol solution 2.5 mcg (microgram) inhale two puffs orally daily for COPD (chronic obstructive pulmonary disease).Thiamine HCl 100 mg tablet give one tablet by mouth daily for supplemental.Nystop External Powder 100000 unit/gram apply to peri-area twice daily for skin protection R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams/deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 – 400 mg/dl give 15 units. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the Aspart insulin was administered, the number 2 indicating R1 refused the insulin and the number 15 indicating 15 units were given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered.		F0760				

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F0760 SS = D	Continued from page 9 R1's nursing progress notes dated 3/14/26 at 12:12 a.m. indicated around 8:00 p.m. R1 had cold clammy hands and weakness. Her blood glucose was 52 mg/dl. Her mental status was conscious, but incoherent and confused. Her blood pressure was 139/78 (normal reading 120/80), her pulse was 61 beats per minute (normal range 60-100), her oxygen saturation rate was 92 (normal 92-100). R1 was immediately offered a glass of apple juice and her blood glucose rose to 74 mg/dl, another glass of orange juice was offered, and the blood glucose was 92 mg/dl. R1 continued to be weak and thus the hospitalization. R1's IDT (intradisciplinary team) note dated 3/16/26 indicated the IDT team met to review R1's rehospitalization for low blood glucoses. R1 was noted to have a blood glucose of 33 mg/dl despite the facilities interventions unable to raise blood glucose levels. R1 was transferred to the hospital for further evaluation. R1 was currently unresponsive in the hospital. R1's quarterly Minimum Data Set (MDS) dated 3/14/26 indicted R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment. R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma and respiratory failure. R1's hospital discharge order summary dated 3/27/26 indicated R1's morning medications were:Amiodarone HCl tablet 200 mg (milligrams) give one table by mouth daily for antiarrhythmic (irregular heart rate)Apixaban Calcium 80 mg tablet give one tablet one tablet by mouth twice daily for atrial fibrillation (rapid irregular heart rhythm).Buprenorphine HCL-Naloxone HCl sublingual film 4-1 mg. Give one film sublingually (under the tongue) three times a day for history of substance use.Calcium Carbonate-Vitamin D oral tablet 500-5 mg give one tablet by mouth daily with breakfast for supplemental.Cyclobenzaprine HCl oral tablet give 1 tab by mouth three times a day for muscle spasmsFenofibrate 40 mg tablet give one tablet by mouth daily for cholesterol.Insulin Glargine Solution 100 unit/ml (milliliter) inject 15 units subcutaneously two times a day for diabetes.Lasix 20 mg tablet give three tablets daily for diuretic (water pill).Metoprolol Tartrate give 25 mg by mouth twice daily for hypertension (high blood pressure).MiraLAX oral power 17 gm/scoop (grams) give one scoop by mouth daily for		F0760				

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F0760 SS = D	Continued from page 10 constipation.Mucinex tablet extended release 12-hour 600 mg give one tablet by mouth twice daily for Chronic bronchitis.Potassium 20 meq (milliequivalents) give one tablet by mouth daily for hypokalemia (low potassium).Pregabalin 50 mg capsule give one capsule by mouth three times a day for pain.Prozac 20 mg capsule give one capsule by mouth daily for antidepressantSenna oral tablet 8.6 mg tablet give one tablet by mouth daily for constipation.Spiriva Respimat inhalation aerosol solution 2.5 mcg (microgram) inhale two puffs orally daily for COPD (chronic obstructive pulmonary disease).Thiamine HCl 100 mg tablet give one tablet by mouth daily for supplemental. Upon interview on 4/1/26 at 9:40 a.m. R1 was in her room seated on bed. R1 had completed breakfast, her breakfast tray on her wheelchair chair ready to be removed from her room. R1 stated she was waiting for medications which should have been given on or around 8:00 a.m. with her breakfast. R1 did not recall the incidents that happened on 3/13/26 which led to her hospitalization; however, she was told her blood glucose was very low. R1 she was glad the hospital discontinued her Aspart rapid acting insulin and kept her on a scheduled dosage of insulin only. Upon interview on 4/1/26 at 11:00 a.m. R1 stated her medications were given late a few times a week. R1 stated when her medications are over an hour late, it messed with pain control and her breathing because of having to wait for the medications. R1 asked if it was safe for her insulin to be administered almost three hours late because then the second dose would be given early, and she has had hyper and hypoglycemia (high and low blood glucose levels) episodes at the facility which led her to the hospital. R1 stated when her pain medication is given late her pain sets in and then it takes longer for it to go away, and her breathing becomes more obstructed when she has had to wait on her Mucinex. Upon interview on 4/1/26 at 11:11 a.m. R1's Nurse Practitioner (NP) stated the Aspart insulin should not have been given between meals because rapid acting insulin without food can drop the blood glucose levels significantly. The facility nurse should have called the provider if they felt the need or the resident was requesting the insulin be administered at an off-scheduled time. The NP's expectation was that the facility administered the medications an hour before or an after the scheduled time, if they cannot meet those time frames they should change the times.			F0760			

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F0760 SS = D	Continued from page 11 Upon interview on 4/1/26 at 11:55 a.m. the Pharmacist stated R1's Glargine insulin and her Mucinex should be given as close to 12-hours as they can be for the best results for diabetic and COPD control. It is important to keep pain medications on a schedule as well because it prevents pain from becoming severe and harder to manage. As far as the nurse who gave the Aspart insulin incorrectly, may or may not be the reason her blood glucose dropped to abnormal levels requiring her to be sent to the hospital. There are too many factors unknown. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. she heard R1 hysterically crying in her room. (RN)-A tested R1's blood glucose and found it was above 200 mg/dl. (RN)-A immediately gave R1 15 units of Aspart insulin. RN-A then noticed the day nurse (RN)-B had not recorded R1's noon Aspart insulin administration. (RN)-B was still onsite. (RN)-A told (RN)-B that she had given R115 units of Aspart insulin because her blood glucose was 356 mg/dl. (RN)-A then told (RN)-B to chart the Aspart insulin as administered at noon because her blood glucose level was also high at noon, but not to give any insulin. (RN)-A stated (RN)-B charted the insulin as administered at noon, even though it was not. (RN)-A also charted insulin administration under the 5:00 p.m. slot on the eMAR, even though it was given at 2:15 p.m. and not charted. (RN)-A stated she called the director of nursing (DON) on 3/13/26 at about 3:00 p.m. and explained the medication error. (RN)-A was told the DON would take care of the error on the e-MAR and write a progress note for (RN)-A. (RN)-A was not certain if the correction was completed by the DON. At approximately 8:00 p.m. on 3/13/26 RN-A found R1 in her room incoherent, cold, and clammy with a blood glucose of 56 mg/dl. RN-A gave R1 juice and her blood glucose rose to 92 mg/dl. R1 was still incoherent, cold, and clammy was sent to the hospital. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A the nurse manager denied knowledge that R1's Aspart insulin had been given at 2:15 p.m. and the eMAR documentation indicated the Aspart insulin was administered at 12:00 p.m. and 5:00 p.m. (LPN)-A stated he was working onsite and the (RN)-A should have reached out to him and he would have directed (RN)-A to call the provider because giving the insulin between the meal times was a medication error.		F0760				

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F0760 SS = D	Continued from page 12 Upon interview on 4/1/26 at 2:43 p.m. the DON stated (RN)-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and (RN)-A had given the Aspart insulin at 2:15 p.m. The DON stated she instructed (RN)-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated it appeared that both (RN)-A and (RN)-B had charted the insulin as administered. The DON was not certain what dose of insulin was actually given. The DON stated (RN)-A's giving insulin at the incorrect time was a medication error and (RN)-C giving medications almost three hours late was a medication error. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware that R1's Aspart insulin was administered at 2:15 p.m., however documented on the eMAR at 12:00 p.m. and 5:00 p.m. as administered. The Administrator stated all medications should be given within an hour before or after the ordered time of the medication. If they cannot be for any reason the nurse needed to notify the provider for any further details. Attempts were made to reach out to RN-B during the survey; however, no response was received. An insulin medication policy was requested. A facility standing order sheet was provided titled Standing Orders for nursing Facilities and Skilled Nursing facilities dated 2026. The order sheet did not indicate an intervention for hyperglycemia treatment in regard to a sliding scale.	F0760					
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records.	F0842	R1 has returned from the hospital in stable condition. R1's medication regimen reviewed for accuracy. All residents have the potential to be affected. Medication order policy reviewed and is current. To prevent recurrence education to all licensed nurses on accurate documentation of medication administration in the medical record to include correct time of medication administration. Director of Nursing/designee will complete five weekly audits of medication administration to include timely and accurate documentation in medication administration record. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.			05/19/2026	

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F0842 SS = D	Continued from page 13 §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.		F0842				

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F0842 SS = D	Continued from page 14 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to maintain accurate medical records for 1 of 3 residents (R1) reviewed for resident records. R1's medication administration was inaccurately documented when R1's medication Aspart (fast acting insulin) was only administered on 3/13/26 at 2:15 p.m. R1's electronic medical record (eMAR) indicated R1's Aspart insulin was administered on 3/13/26 at 12:00 p.m. and 5:00 p.m. Findings include: R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin Aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams/deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 – 400 mg/dl give 15 units. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the Aspart insulin was administered, the number 2 indicating R1 refused the insulin and the number 15 indicating 15 units were given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's	F0842		

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 04/01/2026
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427	
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F0842 SS = D	Continued from page 15 blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's quarterly Minimum Data Set (MDS) dated 3/14/26 indicated R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment. R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma, and respiratory failure. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. (RN)-A gave R1 15 units of Aspart insulin. (RN)-A was aware that the timing of the Aspart administration was not as ordered. (RN)-A told (RN)-B to document that she had given the Aspart insulin at noon because R1 had refused at that time. (RN)-B documented at 12:00 p.m. that the insulin was refused, however 15 units was administered. (RN)-A documented 15 units of insulin was given at 5:00 p.m. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A denied knowledge that R1's Aspart insulin had been given at 2:15 p.m. and the eMAR documentation indicated the Aspart insulin was administered at 12:00 p.m. and 5:00 p.m. Upon interview on 4/1/26 at 2:43 p.m. the DON stated (RN)-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and RN-A had given the Aspart insulin at that time. The DON stated she instructed (RN)-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated both (RN)-A and (RN)-B had charted the insulin as administered. The DON was not certain what dose of insulin was given. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware that R1's Aspart insulin was administered at 2:15 p.m., however documented on the eMAR at 12:00 p.m. and 5:00 p.m. as administered. Attempts were made to reach out to RN-B during the survey; however, no response was received. A medical records policy was requested, however none	F0842		

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 04/01/2026	
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F0842 SS = D	Continued from page 16 received.			F0842			

Minnesota State Department of Health

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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 4/1/26 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. The following complaints were reviewed. H51868720C /		20000			05/19/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 MN2805085 with orders issued at ST20610 and ST 21545 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				
20610	Clinical Record; Form entres & authentication CFR(s): MN Rule 4658.0445 Subp. 2 Subp. 2. Form of entries and authentication. Data collected must be timely, accurate, and complete. All entries must be entered, authenticated, and dated by the person making the entry. If a nursing home uses an electronic paperless means of storing the clinical record, the nursing home must comply with part 4658.0475. All entries must be made as soon as possible after the observation or treatment in order to keep the clinical record current. In cases where authentication		20610	Corrected.		05/19/2026	

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20610	Continued from page 2 is done electronically or by rubber stamp, safeguards to prevent unauthorized use must be in place, and a rubber stamp may be used only if allowed by the licensing rules for that health care professional. Nursing assistants may document in the nursing notes if allowed by nursing home policy. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to maintain accurate medical records for 1 of 3 residents (R1) reviewed for resident records. R1's medication administration was inaccurately documented when R1's medication Aspart (fast acting insulin) was only administered on 3/13/26 at 2:15 p.m. R1's electronic medical record (eMAR) indicated R1's Aspart insulin was administered on 3/13/26 at 12:00 p.m. and 5:00 p.m. Findings include: R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin Aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams/deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 – 400 mg/dl give 15 units. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the Aspart insulin was administered, the number 2 indicating R1 refused the insulin and the number 15 indicating 15 units were given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's quarterly Minimum Data Set (MDS) dated 3/14/26 indicated R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment. R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma, and respiratory failure. Upon interview on 4/1/26 at 2:09 p.m. registered nurse			20610			

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20610	Continued from page 3 (RN)-A stated on 3/13/23 at around 2:15 p.m. (RN)-A gave R1 15 units of Aspart insulin. (RN)-A was aware that the timing of the Aspart administration was not as ordered. (RN)-A told (RN)-B to document that she had given the Aspart insulin at noon because R1 had refused at that time. (RN)-B documented at 12:00 p.m. that the insulin was refused, however 15 units was administered. (RN)-A documented 15 units of insulin was given at 5:00 p.m. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A denied knowledge that R1's Aspart insulin had been given at 2:15 p.m. and the eMAR documentation indicated the Aspart insulin was administered at 12:00 p.m. and 5:00 p.m. Upon interview on 4/1/26 at 2:43 p.m. the DON stated (RN)-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and RN-A had given the Aspart insulin at that time. The DON stated she instructed (RN)-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated both (RN)-A and (RN)-B had charted the insulin as administered. The DON was not certain what dose of insulin was given. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware that R1's Aspart insulin was administered at 2:15 p.m., however documented on the eMAR at 12:00 p.m. and 5:00 p.m. as administered. Attempts were made to reach out to RN-B during the survey; however, no response was received. A medical records policy was requested, however none received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			20610			
21545	Medication Errors			21545	Corrected.		05/19/2026

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21545	Continued from page 4 CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to prevent a significant medication error for 1 of 3 residents reviewed for medication		21545				

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21545	Continued from page 5 errors. R1’s Aspart (a short acting insulin) was given at the incorrect time. The Aspart insulin was ordered as an insulin sliding scale (an order in which the insulin dose is based on a resident’s blood glucose level) to be taken with meals and was given at 2:15 p.m. without a meal. In addition, during the survey process R1’s 8:00 a.m. medications were administered nearly three hours late. Findings include: Upon observation on 4/1/26 at 10:40 a.m. registered nurse (RN)-C was setting up R1’s medications for administration. Upon observation on 4/1/26 at 10:51 a.m. (RN)-C entered R1’s room to give R1 her morning mediations. R1 was asleep. (RN)-C aroused R1 and assisted her to a sitting position on the side of her bed. R1 stated that her medications were late again and that she had to be woken up to take them. RN-A acknowledged the medications were late to R1 and continued to administer. R1’s medication administration record (MAR) dated 4/1/26 indicated the following medications were scheduled for administration at 8:00 a.m. on 4/1/26:Amiodarone HCl tablet 200 mg (milligrams) give one table by mouth daily for antiarrhythmic (irregular heart rate)Apixaban Calcium 80 mg tablet give one tablet one tablet by mouth twice daily for atrial fibrillation (rapid irregular heart rhythm).Buprenorphine HCL-Naloxone HCl sublingual film 4-1 mg. Give one film sublingually (under the tongue) three times a day for history of substance use.Calcium Carbonate-Vitamin D oral tablet 500-5 mg give one tablet by mouth daily with breakfast for supplemental.Cyclobenzaprine HCl oral tablet give 1 tab by mouth three times a day for muscle spasmsFenofibrate 40 mg tablet give one tablet by mouth daily for cholesterol.Insulin Glargine Solution 100 unit/ml (milliliter) inject 15 units subcutaneously two times a day for diabetes.Lasix 20 mg tablet give three tablets daily for diuretic (water pill).Metoprolol Tartrate give 25 mg by mouth twice daily for hypertension (high blood pressure).MiraLAX oral power 17 gm/scoop (grams) give one scoop by mouth daily for constipation.Mucinex tablet extended release 12-hour 600 mg give one tablet by mouth twice daily for Chronic bronchitis.Potassium 20 meq (milliequivalents) give one tablet by mouth daily for hypokalemia (low potassium).Pregabalin 50 mg		21545				

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21545	Continued from page 6 capsule give one capsule by mouth three times a day for pain.Prozac 20 mg capsule give one capsule by mouth daily for antidepressantSenna oral tablet 8.6 mg tablet give one tablet by mouth daily for constipation.Spiriva Respimat inhalation aerosol solution 2.5 mcg (microgram) inhale two puffs orally daily for COPD (chronic obstructive pulmonary disease).Thiamine HCl 100 mg tablet give one tablet by mouth daily for supplemental.Nystop External Powder 100000 unit/gram apply to peri-area twice daily for skin protection R1's hospital discharge order dated 2/24/26 indicated R1 was prescribed insulin aspart pen (a rapid acting insulin) 100 units/ml (milliliter) 1-15 units subcutaneous (below the skin) three times a day with meals. If blood glucose is 150-199 mg/dl (milligrams/deciliter) give 3 units, 200-249 mg/dl give 6 units, 250-299 mg/dl give 9 units, 300-349 mg/dl give 12 units, 350 – 400 mg/dl give 15 units. R1's electronic Medication Administration Record (eMAR) dated 3/13/26 at 12:00 p.m. indicated R1's blood glucose was 355 mg/dl, the eMAR had a check mark indicating the Aspart insulin was administered, the number 2 indicating R1 refused the insulin and the number 15 indicating 15 units were given. R1's eMAR dated 3/13/26 at 5:00 p.m. indicated R1's blood glucose was 356 mg/dl and 15 units of Aspart insulin was administered. R1's nursing progress notes dated 3/14/26 at 12:12 a.m. indicated around 8:00 p.m. R1 had cold clammy hands and weakness. Her blood glucose was 52 mg/dl. Her mental status was conscious, but incoherent and confused. Her blood pressure was 139/78 (normal reading 120/80), her pulse was 61 beats per minute (normal range 60-100), her oxygen saturation rate was 92 (normal 92-100). R1 was immediately offered a glass of apple juice and her blood glucose rose to 74 mg/dl, another glass of orange juice was offered, and the blood glucose was 92 mg/dl. R1 continued to be weak and thus the hospitalization. R1's IDT (intradisciplinary team) note dated 3/16/26 indicated the IDT team met to review R1's rehospitalization for low blood glucoses. R1 was noted to have a blood glucose of 33 mg/dl despite the facilities interventions unable to raise blood glucose levels. R1 was transferred to the hospital for further evaluation. R1 was currently unresponsive in the		21545				

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21545	Continued from page 7 hospital. R1's quarterly Minimum Data Set (MDS) dated 3/14/26 indicted R1's Brief Inventory of Mental Status (BIMS) score was a 99 indicating R1 did not participate in the assessment. R1's pertinent diagnoses were cancer, cardiorespiratory conditions, diabetes, anxiety, depression, asthma and respiratory failure. R1's hospital discharge order summary dated 3/27/26 indicated R1's morning medications were:Amiodarone HCl tablet 200 mg (milligrams) give one table by mouth daily for antiarrhythmic (irregular heart rate)Apixaban Calcium 80 mg tablet give one tablet one tablet by mouth twice daily for atrial fibrillation (rapid irregular heart rhythm).Buprenorphine HCL-Naloxone HCl sublingual film 4-1 mg. Give one film sublingually (under the tongue) three times a day for history of substance use.Calcium Carbonate-Vitamin D oral tablet 500-5 mg give one tablet by mouth daily with breakfast for supplemental.Cyclobenzaprine HCl oral tablet give 1 tab by mouth three times a day for muscle spasmsFenofibrate 40 mg tablet give one tablet by mouth daily for cholesterol.Insulin Glargine Solution 100 unit/ml (milliliter) inject 15 units subcutaneously two times a day for diabetes.Lasix 20 mg tablet give three tablets daily for diuretic (water pill).Metoprolol Tartrate give 25 mg by mouth twice daily for hypertension (high blood pressure).MiraLAX oral power 17 gm/scoop (grams) give one scoop by mouth daily for constipation.Mucinex tablet extended release 12-hour 600 mg give one tablet by mouth twice daily for Chronic bronchitis.Potassium 20 meq (milliequivalents) give one tablet by mouth daily for hypokalemia (low potassium).Pregabalin 50 mg capsule give one capsule by mouth three times a day for pain.Prozac 20 mg capsule give one capsule by mouth daily for antidepressantSenna oral tablet 8.6 mg tablet give one tablet by mouth daily for constipation.Spiriva Respimat inhalation aerosol solution 2.5 mcg (microgram) inhale two puffs orally daily for COPD (chronic obstructive pulmonary disease).Thiamine HCl 100 mg tablet give one tablet by mouth daily for supplemental. Upon interview on 4/1/26 at 9:40 a.m. R1 was in her room seated on bed. R1 had completed breakfast, her breakfast tray on her wheelchair chair ready to be removed from her room. R1 stated she was waiting for medications which should have been given on or around 8:00 a.m. with her breakfast. R1 did not recall the		21545				

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427			
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21545	Continued from page 8 incidents that happened on 3/13/26 which led to her hospitalization; however, she was told her blood glucose was very low. R1 she was glad the hospital discontinued her Aspart rapid acting insulin and kept her on a scheduled dosage of insulin only. Upon interview on 4/1/26 at 11:00 a.m. R1 stated her medications were given late a few times a week. R1 stated when her medications are over an hour late, it messed with pain control and her breathing because of having to wait for the medications. R1 asked if it was safe for her insulin to be administered almost three hours late because then the second dose would be given early, and she has had hyper and hypoglycemia (high and low blood glucose levels) episodes at the facility which led her to the hospital. R1 stated when her pain medication is given late her pain sets in and then it takes longer for it to go away, and her breathing becomes more obstructed when she has had to wait on her Mucinex. Upon interview on 4/1/26 at 11:11 a.m. R1's Nurse Practitioner (NP) stated the Aspart insulin should not have been given between meals because rapid acting insulin without food can drop the blood glucose levels significantly. The facility nurse should have called the provider if they felt the need or the resident was requesting the insulin be administered at an off-scheduled time. The NP's expectation was that the facility administered the medications an hour before or an after the scheduled time, if they cannot meet those time frames they should change the times. Upon interview on 4/1/26 at 11:55 a.m. the Pharmacist stated R1's Glargine insulin and her Mucinex should be given as close to 12-hours as they can be for the best results for diabetic and COPD control. It is important to keep pain medications on a schedule as well because it prevents pain from becoming severe and harder to manage. As far as the nurse who gave the Aspart insulin incorrectly, may or may not be the reason her blood glucose dropped to abnormal levels requiring her to be sent to the hospital. There are too many factors unknown. Upon interview on 4/1/26 at 2:09 p.m. registered nurse (RN)-A stated on 3/13/23 at around 2:15 p.m. she heard R1 hysterically crying in her room. (RN)-A tested R1's blood glucose and found it was above 200 mg/dl. (RN)-A immediately gave R1 15 units of Aspart insulin. RN-A		21545				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427			
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21545	Continued from page 9 then noticed the day nurse (RN)-B had not recorded R1's noon Aspart insulin administration. (RN)-B was still onsite. (RN)-A told (RN)-B that she had given R115 units of Aspart insulin because her blood glucose was 356 mg/dl. (RN)-A then told (RN)-B to chart the Aspart insulin as administered at noon because her blood glucose level was also high at noon, but not to give any insulin. (RN)-A stated (RN)-B charted the insulin as administered at noon, even though it was not. (RN)-A also charted insulin administration under the 5:00 p.m. slot on the eMAR, even though it was given at 2:15 p.m. and not charted. (RN)-A stated she called the director of nursing (DON) on 3/13/26 at about 3:00 p.m. and explained the medication error. (RN)-A was told the DON would take care of the error on the e-MAR and write a progress note for (RN)-A. (RN)-A was not certain if the correction was completed by the DON. At approximately 8:00 p.m. on 3/13/26 RN-A found R1 in her room incoherent, cold, and clammy with a blood glucose of 56 mg/dl. RN-A gave R1 juice and her blood glucose rose to 92 mg/dl. R1 was still incoherent, cold, and clammy was sent to the hospital. Upon interview on 4/1/26 at 2:28 p.m. licensed practical nurse (LPN)-A the nurse manager denied knowledge that R1's Aspart insulin had been given at 2:15 p.m. and the eMAR documentation indicated the Aspart insulin was administered at 12:00 p.m. and 5:00 p.m. (LPN)-A stated he was working onsite and the (RN)-A should have reached out to him and he would have directed (RN)-A to call the provider because giving the insulin between the meal times was a medication error. Upon interview on 4/1/26 at 2:43 p.m. the DON stated (RN)-A had called her on 3/13/26 between 2:30 p.m. and 3:00 p.m. stating R1's blood glucose was over 400 mg/dl and (RN)-A had given the Aspart insulin at 2:15 p.m. The DON stated she instructed (RN)-A to document the insulin because she had given it. No further instructions were given. The DON viewed the eMAR during the survey and stated it appeared that both (RN)-A and (RN)-B had charted the insulin as administered. The DON was not certain what dose of insulin was actually given. The DON stated (RN)-A's giving insulin at the incorrect time was a medication error and (RN)-C giving medications almost three hours late was a medication error. Upon interview on 4/1/26 at 3:15 p.m. the Administrator stated she was not aware that R1's Aspart insulin was administered at 2:15 p.m., however documented on the		21545				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BROOKVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427			
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21545	Continued from page 10 eMAR at 12:00 p.m. and 5:00 p.m. as administered. The Administrator stated all medications should be given within an hour before or after the ordered time of the medication. If they cannot be for any reason the nurse needed to notify the provider for any further details. Attempts were made to reach out to RN-B during the survey; however, no response was received. An insulin medication policy was requested. A facility standing order sheet was provided titled Standing Orders for nursing Facilities and Skilled Nursing facilities dated 2026. The order sheet did not indicate an intervention for hyperglycemia treatment in regard to a sliding scale. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			21545			