



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 26, 2022

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

Re: Reinspection Results
Event ID: V8GT12

Dear Administrator:

On August 24, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 21, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2022

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

RE: CCN: 245186
Cycle Start Date: June 21, 2022

Dear Administrator:

On June 21, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.
- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 21, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 21, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 21, 2022.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 \$11,292; 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 September 21, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Brookview A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 21, 2022. 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, Rapid Response Unit Supervisor

Metro 1, Golden Rule Office

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

85 East Seventh Place, Suite 220

P.O. Box 64900

Saint Paul, Minnesota 55164-0900

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 December 21, 2022 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) 565-9462**

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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 specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 6/21/22, a standard abbreviated survey was conducted at your facility. Brookview A Villa Center was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H51862470C (MN00084297) cited at F661 and F880 The following complaints were found unsubstantiated: H51862590C (MN00084292) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661		7/20/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/08/2022

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

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 661	Continued From page 1 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a summary of the resident stay (recapitulation) for 1 of 1 resident (R1) reviewed for discharge. Findings include: R1's significant change in status minimum data set (MDS) dated 2/4/22, indicated R1 had mild cognitive impairment and diagnoses of anxiety, depression, post-traumatic stress disorder (PTSD) (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), and chronic pain. R1's My Transition Home note dated 6/13/22, indicated R1 was discharged to a residential care facility. R1 note lacked indication of facility	F 661	Identified resident's recapitulation of stay evaluation has been completed. All residents who have discharged from the center have the potential to be affected. All discharged residents in the past 30 days have had recapitulation of stay evaluations completed. Education completed with nurse managers on completion of recapitulation of stay evaluation for discharged residents. Administration/designee will audit three discharges per week for 4 week then monthly times two months to ensure residents' recapitulation of stay evaluation		

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 661	Continued From page 2 outbreak COVID status, recent vitals signs, concerns for pain, or COVID symptoms. R1's medication administration record (MAR) dated 6/22, indicated R1 had pain rated at a seven (7) out of (10) at 7:23 a.m. and was given two tablets of acetaminophen 500 milligrams (mg). R1's MAR further lacked indication R1 was assessed for COVID-19 symptoms at 6:00 a.m. as scheduled. R1's records lacked a nurse progress note, discharge assessment, or discharge summary were completed. On 6/21/22, at 9:09 a.m. ALF registered nurse (RN) - A stated on the day of R1's admission the ALF sent two maintenance staff to the facility to assist R1 to pack up her belongings to move out and into the ALF. RN-A further stated when she spoke to social worker (SW)-A, she had not reported an outbreak of COVID-19 within the facility nor did she report R1 had experienced symptoms of COVID-19. RN-A stated, when R1 arrived to the ALF facility she reported she had body aches, sore throat, and felt like her lymph nodes were swollen. RN-A gave R1 a COVID-19 rapid test on her admission day, and the results were positive for COVID-19. RN-A stated she did not receive a discharge summary or a discharge assessment from the facility for R1. On 6/21/22, at 10:52 social worker (SW)-A stated no nurse to nurse report was given to the ALF unless for something specific is needed. SW-A further stated the facility does not have a protocol in place to notify another facility if in breakout status for COVID. SW-A stated the ALF RN did	F 661	is completed. Results will be brought to the QAPI committee monthly x3 months for continued opportunities for quality improvements.		

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 661	Continued From page 3 On 6/21/22, at 11:29 a.m. the interim director of nursing (DON) verified R1 had no discharge summary completed or discharge assessment on or prior to the day R1 discharged. DON stated her expectation was the discharge summary and plan of care was completed, signed by the resident and uploaded and attached to that resident's electronic medical record. The Interim Guideline for COVID-19 Reporting to External Parties policy dated 5/7/20, indicated the facility are to inform residents, their representatives, families, and staff about COVID-19 through daily website. The facility policy lacked indication they inform facilities discharge residents are transferred to.	F 661			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880			7/20/22

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 4 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880			

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

PRINTED: 08/03/2022
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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 5 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was used by 2 of 2 staff registered nurse (RN)-A and RN-B when direct care was provided in accordance with the Centers for Disease Control (CDC) guidance for COVID-19 for the facility who was in COVID-19 outbreak status. Findings include: The facility COVID Line Listing form dated 5/1/22 to 6/20/22, indicated 14 residents and 11 staff had tested positive for COVID-19. During entrance conference on 6/21/22, at 8:35 a.m. the administrator stated the facility was in a COVID-19 outbreak status and the fourth-floor wing is where the nine (9) residents were with COVID-19 were located. On 6/21/22, at 9:44 a.m. registered nurse (RN)-A was observed on second floor to have walked out of room 220 with goggles on his forehead talking on his cell phone. RN-A continued to walk down the hall past two residents who were not wearing mask. On 6/21/22, at 10:26 a.m. during observation registered nurse (RN)-B stood at the medication cart, prepped medications for a resident with	F 880	R6 no longer residents at the facility. No further action can be taken. All resident have the potential to be affected by this deficient practice. Facility leadership will ensure that there is proper use of PPE for transmission-based precautions and aerosol generating procedures. The DON reviewed polices and procedures for donning/doffing PPE during CVOID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care. DON reviewed policies and procedures regarding standard and TBP precautions and proper use of PPE. Polices remain current. The facility's QAPI committee with assistance from the Infection Preventionist, with Governing Body completed a root cause analysis on to help identify the problems that resulted in this deficiency and developed interventions to prevent reoccurrence. All staff were educated by the DON on the facility's Infection Prevention and Control Program. This included standard infection		

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 6 goggles on her forehead. RN-B than locked medication cart and proceeded to walk down the hallway with her goggles on her forehead and enter into resident's room number 415. At 10:28 a.m. RN-B walked out of room 415 with her goggles still on her forehead. The room was roughly 12 feet away from a section of the floor dedicated for COVID-19 positive residents during the outbreak. On 6/21/22, at 10:28 a.m. registered nurse (RN)-B stated she should have been wearing eye protection over her eyes and not placed on her forehead. RN-B stated she had forgotten to reposition the eye protection prior to entering the room. On 6/21/22, at 10:35 a.m. licensed practical nurse (LPN)-A stated staff are expected to wear PPE as recommended, especially because of the current outbreak status. LPN-A stated she would provide education immediately on proper use of PPE. On 6/21/22, at 11:29 a.m. the interim director of nursing (DON) stated her expectation was for all staff to wear PPE as directed including when entering resident room to provide cares. The interim DON the facility is currently in outbreak status since 5/31/22, and it is important for staff to wear PPE as directed to protect the residents and themselves from getting COVID-19. The Interim DON further stated the facility tested again today and had another resident turn positive who is unable to leave his room or the facility. Guideline for Standard and Transmission-based Precautions policy dated 11/9/20, indicated the guideline was four ensuring standard and	F 880	control practices, transmission-based precautions, appropriate use of PPE, and donning and doffing of PPE. Residents and their representative will also receive education on the facility's Infection Prevention and Control Program. All staff completed a competency post-test. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits will continue until 100% compliance is met. Audits will include donning/doffing of PPE with transmission-base precautions, PPE use with aerosolizing procedures, and proper us of gowns. Audit result will be reviewed at QAPI to determine the need to continued monitoring and compliance.		

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 7 transmission-based precautions are to be followed to prevent the spread of infection, in accordance with CDC requirements. The policy directed staff to use PPE whenever there is an expectation of possible exposure to infectious agent.	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: V8GT11

Dear Administrator:

The above facility was surveyed on June 21, 2022 through June 21, 2022 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

Brookview A Villa Center

June 29, 2022

Page 2

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, Rapid Response Unit Supervisor

Metro 1, Golden Rule Office

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

85 East Seventh Place, Suite 220

P.O. Box 64900

Saint Paul, Minnesota 55164-0900

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/21/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/08/22

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H51862470C/ MN00084297 with a licensing order issued at tag identification 1375. The following complaint was found to be UNSUBSTANTIATED: H51862590C/MN00084292. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000			

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was used by 2 of 2 staff registered nurse (RN)-A and RN-B when direct care was provided in accordance with the Centers for Disease Control (CDC) guidance for COVID-19 for the facility who was in COVID-19 outbreak status. Findings include: The facility COVID Line Listing form dated 5/1/22 to 6/20/22, indicated 14 residents and 11 staff had tested positive for COVID-19. During entrance conference on 6/21/22, at 8:35 a.m. the administrator stated the facility was in a	21375	Center in compliance		7/20/22

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 3 COVID-19 outbreak status and the fourth-floor wing is where the nine (9) residents were with COVID-19 were located. On 6/21/22, at 9:44 a.m. registered nurse (RN)-A was observed on second floor to have walked out of room 220 with goggles on his forehead talking on his cell phone. RN-A continued to walk down the hall past two residents who were not wearing mask. On 6/21/22, at 10:26 a.m. during observation registered nurse (RN)-B stood at the medication cart, prepped medications for a resident with goggles on her forehead. RN-B then locked medication cart and proceeded to walk down the hallway with her goggles on her forehead and enter into resident's room number 415. At 10:28 a.m. RN-B walked out of room 415 with her goggles still on her forehead. The room was roughly 12 feet away from a section of the floor dedicated for COVID-19 positive residents during the outbreak. On 6/21/22, at 10:28 a.m. registered nurse (RN)-B stated she should have been wearing eye protection over her eyes and not placed on her forehead. RN-B stated she had forgotten to reposition the eye protection prior to entering the room. On 6/21/22, at 10:35 a.m. licensed practical nurse (LPN)-A stated staff are expected to wear PPE as recommended, especially because of the current outbreak status. LPN-A stated she would provide education immediately on proper use of PPE. On 6/21/22, at 11:29 a.m. the interim director of nursing (DON) stated her expectation was for all staff to wear PPE as directed including when	21375			

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 06/21/2022
NAME OF PROVIDER OR SUPPLIER BROOKVIEW A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 4 entering resident room to provide cares. The interim DON the facility is currently in outbreak status since 5/31/22, and it is important for staff to wear PPE as directed to protect the residents and themselves from getting COVID-19. The Interim DON further stated the facility tested again today and had another resident turn positive who is unable to leave his room or the facility. Guideline for Standard and Transmission-based Precautions policy dated 11/9/20, indicated the guideline was four ensuring standard and transmission-based precautions are to be followed to prevent the spread of infection, in accordance with CDC requirements. The policy directed staff to use PPE whenever there is an expectation of possible exposure to infectious agent. 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.	21375			