P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 21, 2019

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

RE: Project Numbers H5186262C and H5186264C

Dear Administrator:

On May 20, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
April 26, 2019

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

RE: Project Numbers H5186260C, H5186261C, H5186262C, H5186263C, and H5186264C

Dear Administrator:

On April 11, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the April 11, 2019 abbreviated survey, the Minnesota Department of Health, completed an investigation of complaint number H5186260C, H5186261C, and H5186263C that were found to be unsubstantiated and H5186262C and H5186264C that were found to be substantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is May 21, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 11, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 11, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

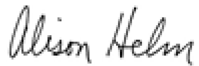
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_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.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. BUILDING ______ B. WING ______	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVIEW A VILLA CENTER	**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 April 10-11, 2019 an abbreviated survey was completed at your facility to conduct a complaint investigation(s). Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be substantiated: H# - H5186262C with deficiency issued at F697. H# - H5186264C was found to be substantiated, with no deficiencies cited. The following complaint(s) (were) found to be unsubstantiated: H# - H5186260C was found to be in compliance at the time of the survey. H# - H5186261C was found to be in compliance at the time of the survey. H# - H5186263C was found to be in compliance at the time of the survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		5/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/03/2019

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

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F 609	Continued From page 1 §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 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 document review, the facility failed to ensure allegations of potential neglect were reported in a timely manner to the state agency (SA) for 1 of 1 residents (R6) whose allegations were reviewed. Findings include: R6's 60-day Minimum Data Set (MDS) dated	F 609	The allegation made by R6 has been reported. It was identified that all residents have the potential to be affected. All staff have been educated regarding reporting requirements. The Administrator/designee will review all accidents/incidents and resident grievances for reportability. Audits will be reviewed by QAPI meeting monthly.	

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F 609	Continued From page 2	F 609		

3/6/19, identified R6 had intact cognition, demonstrated no hallucinations or delusions, and required extensive assistance with bed mobility and transfers. In addition, R6's care plan dated 4/11/19, identified R6 had anxiety, used the call light excessively at times and had potential to make false accusations towards the staff and others.

R6's progress note(s) dated 4/1/19 to 4/11/19, identified the following entries:

On 4/7/19, "[R6] was very mad this [morning], saying she was left in wet linens on the night shift. CNA [nursing assistant] checked her bed, bed was wet, and she was cold. CNA changed her linens right away. No behaviors noted this shift ..."

On 4/9/19, an interdisciplinary team (IDT) note was entered which identified, "IDT met and reviewed patient complaining about night staff not changing her bedding and sitting in wet linens for 8 hours. Investigation to be completed."

During an interview on 4/11/19, at 11:11 a.m. R6 acknowledged a concern recently with her cares on the night shift; however, stated she did not wish to speak about it as it "makes me upset."

R6's medical record was reviewed and lacked any evidence the allegation of potential neglect identified in the recorded progress notes had been reported to the SA.

A facility provided Incident Reports listing printed 4/11/19, identified eight allegations of potential abuse or neglect had been reported to the SA in the past 60 days; however, R6's allegation was

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F 609	Continued From page 3	F 609		

not listed as being reported.

On 4/11/19, at 11:16 a.m. the administrator and director of nursing (DON) were interviewed. R6's allegation had been reported to them the morning of the incident on 4/7/19, and they started an investigation into the situation as R6 had reported being left soiled and naked in bed all night long. A call was placed to the overnight nursing assistant (NA) who reported they had helped R6, despite her accusations, with cares during the shift. However, the DON stated she had not reviewed any corresponding documentation from R6's medical record to corroborate the NA's care being completed. The DON explained R6 had a tendency to fixate on certain things at times and had reported being "naked and afraid" at other times during her stay at the nursing home. They explained R6's allegation recorded in the progress note(s) was not reported to the SA as R6 had a history of false reporting along with making false allegations, and their immediate investigation into the incident did not reveal any reason to report the matter. The DON stated if they had learned something else about the matter through their investigation, which had more firmly suggested neglect, they would have then reported it to the SA. The administrator acknowledged their policy and process was typically to report potential allegations and then investigate them.

A facility Abuse, Exploitation, Mistreatment and Misappropriation of Resident Property policy dated 11/28/17, identified the nursing home administrator or designee would report abuse to the state agency per State and Federal requirements. A section labeled, "Reporting and Response," directed all alleged violations involving abuse, neglect, exploitation or

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F 609	Continued From page 4 mistreatment would be reported to the state agency immediately but not later than 24 hours after the allegation is made if the allegation did not involve abuse or result in serious bodily injury.	F 609		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote comfort for 1 of 3 residents (R10) reviewed for pain management and who voiced complaints of new and worsening shoulder pain. Findings include: R10's admission Minimum Data Set (MDS) dated 2/26/19, identified R10 had moderate cognitive impairment, demonstrated no delusions or hallucinations and required extensive assistance with her activities of daily living (ADLs). R10 was recorded as not having arthritis or a fracture, and the MDS identified R10 received scheduled and as-needed (PRN) medications for pain control. Further, R10 was recorded as having pain within the previous five days which she rated, at it's worst, as a 5/10 on a 0-10 scale. R10's most recent Pain Data Collection and Assessment V1 completed 2/19/19, identified	F 697	R10 has been assessed for pain. MD was involved with ordering x-ray, which concluded negative for any abnormalities. Pain MD was involved, and continues to be involved, and reassessed medications. Interventions were reviewed and updated. All residents who trigger in MDS section J (Pain) will be reviewed to ensure appropriate assessment and intervention are in place. All nursing staff will be educated on recognizing and reporting new pain. DON/designee will audit all pain alert triggers through daily clinical start up. Audits will be reviewed monthly at QAPI.	5/20/19

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F 697	Continued From page 5	F 697		

R10 had fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, fatigue, and tenderness in localized areas) and had a history of narcotic pain medication use. The assessment recorded R10 as, "appears to be having discomfort," and listed the pain as being a throbbing, soreness sensation with movement and at rest. A section labeled, "D. Location of Pain," listed several spaces to record which area of the human body was experiencing pain. R10 was recorded as having generalized and back pain "almost constantly;" however, no other sections, including joint and soft tissue, were completed and had been left blank. Further, the assessment identified R10's goals for pain management, which directed, "I always have pain but am tolerant with a 4 [out of 10 rating] but sometimes a 5 is OK as well."

R10's care plan revised 3/4/19, identified R10 had potential for acute and chronic pain. The plan listed several interventions to help R10 be free of non-verbal indicators of pain which included anticipating the need for pain relief and responding to any complaints of pain, and completing a pain assessment upon admission, quarterly and, "... with new complaints of pain, change of condition and [as needed]."

On 4/11/19, at 8:40 a.m. R10 was observed lying in bed in her room. R10 was interviewed and expressed she had been at the facility for rehabilitation following a hospitalization. R10 stated she had "excruciating pain" in her left shoulder, which seemed to have gotten worse in the past few weeks causing her to be unable to help dress herself even. R10 explained the shoulder pain was a result of falling from her sofa prior to her admission to the nursing home, and

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F 697	Continued From page 6	F 697		

rated her pain at rest conversing at a 7 out of 10.

R10's progress note(s) were reviewed since her admission on 2/19/19. On 3/18/19, R10 was recorded as having complaints of shoulder region pain rated at 7/10 with movement. On 4/4/19, R10 was recorded as having left shoulder pain and was given PRN Tramadol (a pain medication) which was effective. Further, an additional note on 4/4/19, identified R10 was invited to group activities but declined, "...until her shoulder feels better." Further, on 4/9/19, R10 was recorded as again having PRN medication to help with complaints of left shoulder pain. The progress note(s) reviewed since 2/19/19, lacked any recorded evidence of reported or suspected left shoulder pain until 3/18/19.

R10's physician progress note(s) dated 2/20/19 to 4/11/19, were reviewed. On 3/11/19, R10 was recorded by the physician as having, "...some left shoulder pain but cannot describe any further with regards to timing, duration, intensity." The note identified corresponding assessment(s) and treatment(s) for her condition, which included, "Chronic pain syndrome," and listed a treatment plan, which read, "Multiple medications. PT/OT." The note lacked any specific assessment of R10's reported left shoulder pain. On 3/5/19, and again on 3/25/19, R10 was seen by medical doctor (MD)-A with chief complaints being listed as, "Fibromyalgia and back pain." A section was listed which was used to record the pain location which was completed on both notes as, "multi side, low back." None of the completed physician note(s) had any recorded mention or specific assessment for R10's reported left shoulder pain(s) to determine if they were of new onset, a potential chronic condition or something which

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	245186	A. BUILDING ______ B. WING ______	C **04/11/2019**

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BROOKVIEW A VILLA CENTER	**7505 COUNTRY CLUB DRIVE** **GOLDEN VALLEY, MN 55427**

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F 697	Continued From page 7	F 697		

had previously been addressed.

R10's medical record was reviewed and lacked evidence R10's left shoulder pain had been assessed to determine if the pain was newly onset or symptom of her chronic fibromyalgia pains, nor did the record reflect any specific interventions developed to address the shoulder pain which was not identified on the original pain assessment the facility completed on 2/19/19.

During interview on 4/11/19, at 9:15 a.m. nursing assistant (NA)-A stated R10 had "recently" started complaining about pain in her left shoulder and in her left side. NA-A explained R10 reported the pain in her shoulder stemmed from a fall prior to her admission to the nursing home, and R10's daughter had recently commented on maybe getting the left shoulder x-rayed due to the complaints of pain. NA-A stated she first heard R10 voice complaints of her left shoulder "last week," which she reported to the nurses.

On 4/11/19, at 9:48 a.m. registered nurse (RN)-A was interviewed. RN-A explained the facility completed pain assessments on a quarterly basis and with "something significant." R10 had "ongoing" issues with pain and was a long-time opioid user, and RN-A explained she had recently visited with R10's daughter who had requested an x-ray for R10's left shoulder and arm as she was reporting complaints with pain with it. RN-A stated she was unaware R10's reported left shoulder pain was potentially "something different" for R10. RN-A reviewed R10's medical record and verified it lacked any assessment or reassessment of R10's pain since the left shoulder pain was first identified in the provider progress note on 3/11/19. RN-A stated R10's

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F 697	Continued From page 8	F 697		

shoulder pain should have been assessed if it was "something new" for her.

During interview on 4/11/19, at 11:56 a.m. MD-A described R10 as being deconditioned and having fibromyalgia which would cause her pain locations and intensity to fluctuate at times. MD-A stated nothing had ever stood out with her reported complaints of pain and he did not see the benefit of completing an x-ray on her left shoulder. MD-A stated he felt R10's left shoulder pain had been assessed and handled appropriately; however, added he was not sure if maybe the facility was lacking some documentation to support this.

R10's subsequent Physician's Orders dated 4/11/19, identified MD-A ordered a left shoulder x-ray with a diagnosis listed, "Left shoulder pain." The note indicated this was discussed with R10's daughter.

A Pain Management policy dated 11/28/17, identified a purpose of ensuring adequate and individualized pain management interventions are identified and implemented to meet an acceptable level of comfort for a resident. The policy listed several guidelines to be implemented, which included treating reports of pain as highly individual and being "what the resident says it is," and gathering both objective and subjective information for a completed pain observation. A section labeled, "Follow Up," directed each resident would be assessed for pain, "...at a minimum of quarterly or at any time that a significant change of condition occurs."

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 26, 2019

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

Re: State Nursing Home Licensing Orders - Project Number H5186260C, H5186261C, H5186262C, H5186263C, and H5186264C

Dear Administrator:

The above facility was surveyed on April 10, 2019 through April 11, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5186260C, H5186261C, and H5186263C that were found to be unsubstantiated and H5186262C and H5186264C that was found to be unsubstantiated. 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 <u>only a suggestion</u> 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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.

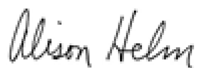
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Susie Haben, Unit Supervisor
Metro A Survey Team
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: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00112	A. BUILDING: ______ B. WING ______	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVIEW A VILLA CENTER	**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 April 10-11, 2019, an abbreviated survey was conducted to determine compliance. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing	

Minnesota Department of Health

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

Electronically Signed — 05/03/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The following complaint(s) was/were found to be substantiated: H# - H5186262C Correction order(s) issued at (MN Statute 626.557 Subd. 4A-). H# - H5186264C was found to be substantiated, with no MN Rule or MN Statute issued. The following complaint(s) were not found to be substantiated: H# - H5186260C was found to be in compliance at the time of the survey. H# - H5186261C was found to be in compliance at the time of the survey. H# - H5186263C was found to be in compliance at the time of the survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000	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. On April 10-11, 2019, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction.	

Minnesota Department of Health

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	00112	A. BUILDING: ______ B. WING ______	C **04/11/2019**

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2 000	Continued From page 2	2 000	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.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote comfort for 1 of 3 residents (R10) reviewed for pain management and who voiced complaints of new and worsening shoulder pain.	2 830	Corrected	5/20/19

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2 830	Continued From page 3	2 830		

Findings include:

R10's admission Minimum Data Set (MDS) dated 2/26/19, identified R10 had moderate cognitive impairment, demonstrated no delusions or hallucinations and required extensive assistance with her activities of daily living (ADLs). R10 was recorded as not having arthritis or a fracture, and the MDS identified R10 received scheduled and as-needed (PRN) medications for pain control. Further, R10 was recorded as having pain within the previous five days which she rated, at it's worst, as a 5/10 on a 0-10 scale.

R10's most recent Pain Data Collection and Assessment V1 completed 2/19/19, identified R10 had fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, fatigue, and tenderness in localized areas) and had a history of narcotic pain medication use. The assessment recorded R10 as, "appears to be having discomfort," and listed the pain as being a throbbing, soreness sensation with movement and at rest. A section labeled, "D. Location of Pain," listed several spaces to record which area of the human body was experiencing pain. R10 was recorded as having generalized and back pain "almost constantly;" however, no other sections, including joint and soft tissue, were completed and had been left blank. Further, the assessment identified R10's goals for pain management, which directed, "I always have pain but am tolerant with a 4 [out of 10 rating] but sometimes a 5 is OK as well."

R10's care plan revised 3/4/19, identified R10 had potential for acute and chronic pain. The plan listed several interventions to help R10 be free of non-verbal indicators of pain which included

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2 830	Continued From page 4	2 830		

Continued From page 4

anticipating the need for pain relief and responding to any complaints of pain, and completing a pain assessment upon admission, quarterly and, "... with new complaints of pain, change of condition and [as needed]."

On 4/11/19, at 8:40 a.m. R10 was observed lying in bed in her room. R10 was interviewed and expressed she had been at the facility for rehabilitation following a hospitalization. R10 stated she had "excruciating pain" in her left shoulder, which seemed to have gotten worse in the past few weeks causing her to be unable to help dress herself even. R10 explained the shoulder pain was a result of falling from her sofa prior to her admission to the nursing home, and rated her pain at rest conversing at a 7 out of 10.

R10's progress note(s) were reviewed since her admission on 2/19/19. On 3/18/19, R10 was recorded as having complaints of shoulder region pain rated at 7/10 with movement. On 4/4/19, R10 was recorded as having left shoulder pain and was given PRN Tramadol (a pain medication) which was effective. Further, an additional note on 4/4/19, identified R10 was invited to group activities but declined, "...until her shoulder feels better." Further, on 4/9/19, R10 was recorded as again having PRN medication to help with complaints of left shoulder pain. The progress note(s) reviewed since 2/19/19, lacked any recorded evidence of reported or suspected left shoulder pain until 3/18/19.

R10's physician progress note(s) dated 2/20/19 to 4/11/19, were reviewed. On 3/11/19, R10 was recorded by the physician as having, "...some left shoulder pain but cannot describe any further with regards to timing, duration, intensity." The note identified corresponding assessment(s) and

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2 830	Continued From page 5	2 830		

treatment(s) for her condition, which included, "Chronic pain syndrome," and listed a treatment plan, which read, "Multiple medications. PT/OT." The note lacked any specific assessment of R10's reported left shoulder pain. On 3/5/19, and again on 3/25/19, R10 was seen by medical doctor (MD)-A with chief complaints being listed as, "Fibromyalgia and back pain." A section was listed which was used to record the pain location which was completed on both notes as, "multi side, low back." None of the completed physician note(s) had any recorded mention or specific assessment for R10's reported left shoulder pain(s) to determine if they were of new onset, a potential chronic condition or something which had previously been addressed.

R10's medical record was reviewed and lacked evidence R10's left shoulder pain had been assessed to determine if the pain was newly onset or symptom of her chronic fibromyalgia pains, nor did the record reflect any specific interventions developed to address the shoulder pain which was not identified on the original pain assessment the facility completed on 2/19/19.

During interview on 4/11/19, at 9:15 a.m. nursing assistant (NA)-A stated R10 had "recently" started complaining about pain in her left shoulder and in her left side. NA-A explained R10 reported the pain in her shoulder stemmed from a fall prior to her admission to the nursing home, and R10's daughter had recently commented on maybe getting the left shoulder x-rayed due to the complaints of pain. NA-A stated she first heard R10 voice complaints of her left shoulder "last week," which she reported to the nurses.

On 4/11/19, at 9:48 a.m. registered nurse (RN)-A was interviewed. RN-A explained the facility

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2 830	Continued From page 6	2 830		

completed pain assessments on a quarterly basis and with "something significant." R10 had "ongoing" issues with pain and was a long-time opioid user, and RN-A explained she had recently visited with R10's daughter who had requested an x-ray for R10's left shoulder and arm as she was reporting complaints with pain with it. RN-A stated she was unaware R10's reported left shoulder pain was potentially "something different" for R10. RN-A reviewed R10's medical record and verified it lacked any assessment or reassessment of R10's pain since the left shoulder pain was first identified in the provider progress note on 3/11/19. RN-A stated R10's shoulder pain should have been assessed if it was "something new" for her.

During interview on 4/11/19, at 11:56 a.m. MD-A described R10 as being deconditioned and having fibromyalgia which would cause her pain locations and intensity to fluctuate at times. MD-A stated nothing had ever stood out with her reported complaints of pain and he did not see the benefit of completing an x-ray on her left shoulder. MD-A stated he felt R10's left shoulder pain had been assessed and handled appropriately; however, added he was not sure if maybe the facility was lacking some documentation to support this.

R10's subsequent Physician's Orders dated 4/11/19, identified MD-A ordered a left shoulder x-ray with a diagnosis listed, "Left shoulder pain." The note indicated this was discussed with R10's daughter.

A Pain Management policy dated 11/28/17, identified a purpose of ensuring adequate and individualized pain management interventions are identified and implemented to meet an

Minnesota Department of Health

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2 830	Continued From page 7 acceptable level of comfort for a resident. The policy listed several guidelines to be implemented, which included treating reports of pain as highly individual and being "what the resident says it is," and gathering both objective and subjective information for a completed pain observation. A section labeled, "Follow Up," directed each resident would be assessed for pain, "...at a minimum of quarterly or at any time that a significant change of condition occurs." SUGGESTED METHOD OF CORRECTION: The facility administrator and/or designee could review policies for resident comprehensive assessment, in regards to pain management, with responsible facility staff. TIME PERIOD FOR CORRECTION: Fourteen (14) days	2 830		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential	21995	Corrected	5/20/19

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21995	Continued From page 8	21995		

neglect were reported in a timely manner to the state agency (SA) for 1 of 1 residents (R6) whose allegations were reviewed.

Findings include:

R6's 60-day Minimum Data Set (MDS) dated 3/6/19, identified R6 had intact cognition, demonstrated no hallucinations or delusions, and required extensive assistance with bed mobility and transfers. In addition, R6's care plan dated 4/11/19, identified R6 had anxiety, used the call light excessively at times and had potential to make false accusations towards the staff and others.

R6's progress note(s) dated 4/1/19 to 4/11/19, identified the following entries:

On 4/7/19, "[R6] was very mad this [morning], saying she was left in wet linens on the night shift. CNA [nursing assistant] checked her bed, bed was wet, and she was cold. CNA changed her linens right away. No behaviors noted this shift ..."

On 4/9/19, an interdisciplinary team (IDT) note was entered which identified, "IDT met and reviewed patient complaining about night staff not changing her bedding and sitting in wet linens for 8 hours. Investigation to be completed."

During an interview on 4/11/19, at 11:11 a.m. R6 acknowledged a concern recently with her cares on the night shift; however, stated she did not wish to speak about it as it "makes me upset."

R6's medical record was reviewed and lacked any evidence the allegation of potential neglect identified in the recorded progress notes had

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21995	Continued From page 9	21995		

been reported to the SA.

A facility provided Incident Reports listing printed 4/11/19, identified eight allegations of potential abuse or neglect had been reported to the SA in the past 60 days; however, R6's allegation was not listed as being reported.

On 4/11/19, at 11:16 a.m. the administrator and director of nursing (DON) were interviewed. R6's allegation had been reported to them the morning of the incident on 4/7/19, and they started an investigation into the situation as R6 had reported being left soiled and naked in bed all night long. A call was placed to the overnight nursing assistant (NA) who reported they had helped R6, despite her accusations, with cares during the shift. However, the DON stated she had not reviewed any corresponding documentation from R6's medical record to corroborate the NA's care being completed. The DON explained R6 had a tendency to fixate on certain things at times and had reported being "naked and afraid" at other times during her stay at the nursing home. They explained R6's allegation recorded in the progress note(s) was not reported to the SA as R6 had a history of false reporting along with making false allegations, and their immediate investigation into the incident did not reveal any reason to report the matter. The DON stated if they had learned something else about the matter through their investigation, which had more firmly suggested neglect, they would have then reported it to the SA. The administrator acknowledged their policy and process was typically to report potential allegations and then investigate them.

A facility Abuse, Exploitation, Mistreatment and Misappropriation of Resident Property policy dated 11/28/17, identified the nursing home

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVIEW A VILLA CENTER	**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
21995	Continued From page 10 administrator or designee would report abuse to the state agency per State and Federal requirements. A section labeled, "Reporting and Response," directed all alleged violations involving abuse, neglect, exploitation or mistreatment would be reported to the state agency immediately but not later than 24 hours after the allegation is made if the allegation did not involve abuse or result in serious bodily injury. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could review the facility abuse and neglect policy, in regards to reporting to the state agency, with all facility staff. TIME PERIOD FOR CORRECTION: Five (5) days.	21995		