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
January 10, 2020

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

RE: CCN: 245186
Cycle Start Date: November 26, 2019

Dear Administrator:

On January 10, 2020, the Minnesota Department(s) of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 4, 2019

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

RE: CCN: 245186
Cycle Start Date: November 26, 2019

Dear Administrator:

On November 26, 2019, a 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

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 February 26, 2020 (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 May 26, 2020 (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

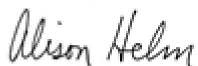
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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.

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 11/26/2019

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 11/25-11/26/19 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5186276C at F609, and complaint H5186277C at F610. 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) §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	F 609		1/2/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/13/2019

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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	245186	A. BUILDING ______ B. WING ______	C 11/26/2019

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F 609	Continued From page 1 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 voiced and documented complaints of potential abuse and/or neglect were reported to the administrator and the state agency (SA) in a timely manner for 1 of 2 residents (R1) with allegations reviewed. Findings include: R1 face sheet dated 11/26/19 indicated diagnoses including muscle weakness, and reduced mobility. R1's admission Minimum Data Set (MDS) dated 10/15/19, indicated intact cognition with a brief inventory of mental status (BIMS) score of 15, verbal behavior directed at others, and extensive assist for transfers and bed mobility. R1's progress note dated 10/23/19, at 11:13 p.m. documented "Pt. (patient) raised concern that	F 609	R1 allegations were reported to the administrator and the state agency while the MDH surveyor was onsite at the facility. All current residents have the potential to be affected by this. DON and Nurse Managers re-educated all current staff on the protocol of reporting voiced or documented allegations of abuse to the Administrator or DON immediately. Administrator and DON were re-educated on immediately reporting all VA allegations to MDH. Administrator and/or designee will audit self reports for proper reporting and timeliness weekly x 4 weeks, then monthly x 3 months.	

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 **11/26/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVIEW A VILLA CENTER	**7505 COUNTRY CLUB DRIVE** **GOLDEN VALLEY, MN 55427**

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F 609	Continued From page 2 NAR (nursing assistant) mishandled him when transferring him to bed. NAR denied allegation. No injury noted." The record had no documentation of notification of the administrator, and no report to the SA. The director of nursing (DON) documented at 7:41 a.m. on 10/24/19 that the administrator interviewed R1 regarding the complaint. The administrator was interviewed on 11/25/19, at approximately 2:30 p.m. and stated there was no investigation of the allegation, and she heard about the allegation the next morning. The adminstrator verified that allegations should be immediately reported to the DON or the administrator. The DON was interviewed on 11/26/19, at 10:45 a.m., and stated she was aware of the allegation when the charting was reviewed in the morning on 10/24/19. The facility policy for abuse, neglect, exploitation,mistreatment and misappropriation of property dated 11/28/17 directed that immediately upon receiving a report of alleged abuse are reported immediately but not more than 2 hours after the allegation is made. The policy further directs that employees must always report any abuse immediately to the administrator.	F 609	Results of these audits will be reviewed by the QAPI committee to ensure compliance. Administrator/DON are responsible for continued compliance.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		1/2/20

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	245186	A. BUILDING ______ B. WING ______	C 11/26/2019

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F 610 Continued From page 3
violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 2 residents (R3) reviewed for physical abuse.

Findings include:

R3 was interviewed on 11/26/19, at 9:00 a..m. he stated he remembered calling the police to report an assault, and stated a nursing assistant (NA) had grabbed both his arms while R3 was seated in his wheelchair. He stated the NA was in front of him, and there was no injury from holding his arms. R3 stated he considered any holding an assault, and called the the police and told a nurse. R3 stated he didn't know what action was taken, he had moved to another unit and was happy with his cares at this time.

R3's Admission Minimum Data Set (MDS) identified R3 was cognitively intact with a brief inventory of mental status (BIMS) score of 15, had verbal behaviors and needed assist of one for transfers. R3's face sheet dated 11/26/19

F 610

R3 allegations of abuse were investigated. R3 has since returned to his home per discharge plan.

All current residents with allegations of abuse have the potential to be affected by this deficiency.

Administrator, DON, NUMs and Social Services have been educated on the new protocol for investigating abuse allegations.

OHFC self report audits will be completed weekly x 4 weeks, then monthly x 3 months to ensure a complete investigation occurred. Facility Corporate Compliance Officer will complete the audits.

Results of these audits will be brought to the QAPI committee to ensure continued compliance.

Administrator and/or designee will be

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 11/26/2019

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F 610	Continued From page 4 indicated diagnoses which included muscle weakness and reduced mobility. The facility investigative file incident (tracking ID 330395) dated 10/20/19, indicated R3 reported to RN-B staff had assaulted him, and later had called the police and reported an assault. The report did not indicate a description of the assault. RN-B was interviewed on 11/26/19, at 9:45 a.m. and stated she had heard R3 yelling at the aide but the door was closed and she had not seen the interaction, she later asked 2 aides to get R3 up and stayed in the room and did not witness any problems with the cares. RN-B stated after this she heard R3 state to the police on the phone he was assaulted, and someone had grabbed his arms. During an interview with the director of nurses (DON) on 11/26/19, at approximately 10:00 a.m. she stated she was responsible for the investigation. She stated R3 would not talk with her, and she was not sure how he was assaulted. She stated she did not interview the police but did have a statement from RN-B. The RN statement (undated and unsigned) indicated R3 reported he was assaulted by the male NA, and soon after she heard R3 on the phone to the police stating he was assaulted and started to describe the situation to the other person on the phone. The statement did not include information that his arms were held by staff. The investigation did not include interviews with other residents on the unit regarding their cares, and no additional interviews were available. On	F 610	responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 5	F 610		

11/26/19 at 10:00 a.m. the adminstrator stated the other interviews had been lost, and provided an interview with the NA (undated) the DON stated she had re-interviewed him yesterday.

The administrator was interviewed on 11/26/19, at 12:00 p.m.. and stated it was her expectation to complete abuse allegation investigations per facility policy. She stated she reviewed, but did not sign off on the investigation done by the DON. She was not aware that R3 had told RN-B his arms had been held, and was not aware that the written statements had been lost. She stated she reviewed the summary sent to the SA, not the complete file.

The facility policy for abuse, neglect, exploitation ,mistreatment and misappropriation of property dated 11/28/17 directed that investigations of abuse by the administrator or designee, will be investigated thoroughly and include resident's statements, other residents, and involved staff. The policy indicated the results of the investigation would be reported to the resident along with corrective action taken.

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
December 4, 2019

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

Re: Event ID: MP7Q11

Dear Administrator:

The above facility survey was completed on November 26, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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.

Sincerely,

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

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 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVIEW A VILLA CENTER	**7505 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427**

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2 000	Initial Comments	2 000		

*****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 November 25 and 26, 2019, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaints:

H5186276C and H5186277C

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 **11/26/2019**

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

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2 000	Continued From page 1 No correction orders were issued. The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		