

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 09/17/2024
NAME OF PROVIDER OR SUPPLIER The Villas at Brookview		STREET ADDRESS, CITY, STATE, ZIP CODE 7505 Country Club Drive Golden Valley, MN 55427	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35992</p> <p>Based on observation, interview and document review, the facility failed to ensure physician orders were followed to promote good nutritional intake for 1 of 1 residents, (R1), with the diagnoses of end stage renal disease and diabetes.</p> <p>Findings include:</p> <p>R1's annual Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact. R1's medical diagnoses identified R1 was medically complex, and his diagnoses included anemia, peripheral vascular disease, renal disease and diabetes.</p> <p>R1's physician orders dated 6/11/24, indicated R1 was to receive a regular diet, regular texture, and regular (thin) consistency. In addition, the order indicated R1 was to receive double meat/protein for nutrition.</p> <p>R1's care plan, initiated on 12/26/17, identified R1 had diabetes mellitus II (adult onset). The care plan directed staff to monitor for breaks in skin, and, if noted, to treat promptly as ordered by the doctor. The care plan directed staff to check skin when assisting with activities of daily living (personal cares). The care plan also identified R1 was at potential national risk related to anxiety problems with end stage renal disease with dialysis. The care plan directed staff to serve diet as ordered, explain the prescribed diet and the need for adequate nutritional intake.</p> <p>The care plan identified R1 was to receive double meat portions. In addition to concerns related to renal disease and diabetes, the care plan also identified R1 had impairment to skin integrity related to vascular disease (a disease related to impaired circulation), had surgical interventions on more than one occasion, had a history of venous ulcers (ulcers related to poor circulation), and a history of pressure ulcers.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/17/24, at 6:50 p.m., R1 was observed in the dining room during the evening. R1 had been served a pulled pork sandwich on two pieces of bread. In addition to the sandwich, there were noted to be a sugar cookie, and two beverages. When asked how his evening meal was, R1 commented I'm a big guy. I should have two sandwiches. There was nothing else served. No chips. Nothing. When they serve corn dogs, I get one corn dog! That's not enough for a big guy like me! R1 went on to state when he had asked for a second sandwich, he was told he had to wait until the dietary staff was sure there was an adequate amount of sandwiches for those not served yet. R1's ticket was on the table and identified his order for a sandwich. R1's ticket lacked direction to staff to indicate he was to receive double meat/protein. R1 stated he often ordered in food items, or purchased food items to heat up in the microwave, using his own finances, to eat when he did not receive enough food with meals. R1 stated I shouldn't have to do this.</p> <p>On 9/17/24, at 10:00 a.m., the nutritional consultant (NC) stated resident's may receive a double portion of meal item served if it was requested when meal order was placed the day prior. If a request was received at the time of the meal, the resident was provided a second serving of the requested item after the staff assured there was adequate food for all residents. NC did state if the resident had orders for double meat/protein, the staff would automatically serve them a double portion. In the case of a sandwich, the resident would receive two sandwiches.</p> <p>On 9/17/24, at 2:56 p.m., registered nurse (RN)-A, clinical manager, stated if a resident was to receive double meat/protein, it was listed on the tray ticket. RN-A stated if the resident was to receive double meat/protein and sandwiches were being served, they should have received either a double portion of meat in the sandwich, or a second sandwich. RN-A reviewed the care plan at that time and stated it was not identified in there.</p> <p>On 9/17/24, at 3:22 p.m., an interview was held with licensed practical nurse (LPN)-A, ADON (assistant director of nursing) regarding physician orders for double meat/protein. LPN-A verified the order for double meat/protein was in place on R1's orders, and should have been identified on his tray ticket to alert staff of the order. LPN-A stated education was needed regarding the importance of placing this information on the ticket, to ensure the order was followed and resident was receiving double meat/protein servings.</p> <p>On 9/17/24, at 3:40 p.m., the registered dietitian, (RD), stated R1 had a history of skin and wound concerns, including ulcerations, and subsequent amputations. RD stated she had just amended R1's tray ticket to reflect double meat/protein servings after having been contacted by ADON. RD acknowledged R1 frequently ordered in food items independently from other sources and indicated R1 was not always following his recommended dietary limitations when obtaining/consuming outside food. RD stated R1's labs and weight are stable.</p> <p>A facility policy, undated, titled Diet Manual and Diet Orders, identified it was the facility policy to provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily, nutritional, and special dietary needs. The policy directed staff when changes were received for a dietary order, the person who accepted the order was to make the changes in the patient ' s medical record. The person would then ensure the culinary services department received a written notice.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35992</p> <p>Based on interview and document review the agency failed to maintain current certification for the Clinical Laboratory Improvement Amendments (CLIA) waiver, which is required for agencies performing blood testing. This had the potential to affect patients who received blood testing by the agency, including those residents who had received routine glucose testing (check of blood sugar). This included R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, and R35.</p> <p>On [DATE], at 10:00 a.m. a review of the facility certifications was completed upon entrance to the facility. At this time, a document dated [DATE], indicated the CLIA waiver became effective [DATE] and expired on [DATE].</p> <p>On [DATE], at 2:00 p.m. inquired of administrator if there had been a CLIA certificate received following the date of expiration on [DATE]. An email was received in follow up at 2:50 p.m. and indicated there was not an updated CLIA waiver in house, however, identified they were in the process of renewal. Additionally, correspondence was received at 3:34 p.m. to indicate the facility lacked documentation of the application for renewal.</p> <p>A review of the current resident population via the electronic medication administration record indicated the following residents had orders for blood glucose monitoring at the below listed frequency for the identified diagnosis:</p> <p>R9 had blood glucose monitoring three times a day for Diabetes Mellitus Type II.</p> <p>R10 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R11 had blood glucose monitoring four times a day for Diabetes Mellitus.</p> <p>R12 had blood glucose monitoring twice daily for Diabetes Mellitus Type II.</p> <p>R13 had blood glucose monitoring four times a day for Diabetes Mellitus.</p> <p>R14 had blood glucose monitoring three times a day for Diabetes Mellitus Type II.</p> <p>R15 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R16 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R17 had blood glucose monitoring three times a day for Diabetes Mellitus Type II.</p> <p>R18 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R19 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R20 had blood glucose monitoring daily for Diabetes Mellitus Type II.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R21 had blood glucose monitoring four times a day for Diabetes due to underlying condition.</p> <p>R22 had blood glucose monitoring three times a day for Diabetes due to underlying condition.</p> <p>R23 had blood glucose monitoring three times a day for Diabetes Mellitus Type II.</p> <p>R24 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R25 had blood glucose monitoring four times a day for Diabetes due to underlying condition.</p> <p>R26 had blood glucose monitoring three times a day for Diabetes Mellitus Type II.</p> <p>R27 had blood glucose monitoring three times a week for Diabetes Type II.</p> <p>R28 had blood glucose monitoring three times a day for Diabetes Mellitus Type II.</p> <p>R29 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R30 had blood glucose monitoring daily for Diabetes due to underlying condition.</p> <p>R31 had blood glucose monitoring daily for Diabetes Mellitus Type II.</p> <p>R32 had blood glucose monitoring four times a day for Diabetes Mellitus Type II.</p> <p>R33 had blood glucose monitoring three times a day for Diabetes Mellitus.</p> <p>R34 had continuous blood glucose monitoring for Diabetes Mellitus Type II.</p> <p>and R35 had blood glucose monitoring twice daily for Diabetes Mellitus Type II.</p> <p>A policy was requested for maintenance of the CLIA waiver was requested, however, was not available per the administrator.</p>