

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  02/14/2025
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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649</b></p> <p>Based on interview and record review the facility failed to develop and implement discharge plans that addressed all the needs for 1 of 3 (R2) residents reviewed for discharge. R2 was discharged before a waiver evaluation was completed at the facility resulting in discharging to home without a personal care assistant (PCA). In addition, incorrect orders were transcribed as R2 was ordered to have a skilled nurse (SN) from the home care agency, the facility ordered a home health aide instead and R2's medications and dialysis were not ordered correctly.</p> <p>Findings include:</p> <p>Email correspondence on [DATE] at 10:21 a.m. sent by R2's community case manager (CM) to the facility social worker (SW) indicated the CM was asking the SW if she had contacted R2's waiver provider to resume services for his discharge on [DATE].</p> <p>Email correspondence on [DATE] at 6:57 a.m. sent by R2's CM to the facility SW indicated she was again following up on R2's discharge plans and services.</p> <p>R2's providers discharge summary dated [DATE] indicated R2 was to be discharged home on [DATE] and continue PT/OT/RN (physical therapy, occupational therapy, and registered nurse) after discharge. Medications would be called into his pharmacy. The summary indicated R2 required the medically necessary services of PT/OT/RN in the home due to the patient's complicated condition and comorbidities that required continued care in the home. R2 was considered homebound.</p> <p>R2's discharge MDS dated [DATE] indicated R2 had a BIMS score of 15 indicating R2 was cognitively intact. R2 was discharged from the facility to his home. R2 required moderate assistance for bathing and lower body dressing. For transferring he required supervision or touching assistance. R2 was occasionally incontinent or urine and frequently incontinent of bowels. R2's pertinent diagnoses were acute onset of chronic diastolic congestive heart failure, mobility obesity, muscle weakness, lack of coordination, morbid obesity, and cognitive communication deficit (difficulty with language comprehension and expression).</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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's facility discharge instructions and summary dated [DATE] at 8:59 a.m. indicated a 30-day supply of all medications were called into a hospital pharmacy. No medications were listed on the discharge summary, there was a note to see the medication summary. R2 was to have occupational therapy (OT) and physical therapy (PT) from a home care agency. Under the heading name of home health agency listed a name with orders for PT/OT/HHA (home health aide) and the name of the agency. R2's primary physician was listed with a phone number. Resident consent to share information was left blank. Items provided included, advance directive, copy of recent laboratory/radiology results, most recent consultation, most recent MDS, comprehensive care plan including goals and most recent H &amp; P (history and physical) were all left blank. No other documents were attached. The discharge summary asked for signature of the responsible party, the nurse and the provider, all signature lines were all left blank.</p> <p>A facility spreadsheet dated [DATE] made by the SW indicated R2 had a dialysis appointment, but at a different location than he usually went to in the community.</p> <p>Email correspondence on [DATE] at 10:01 a.m. sent by R2's CM to the facility SW indicated she just spoken with R2, and he had no services in place. He reported no medications were ordered for him upon discharge, and he had no medications over the weekend. R2 reached out to dialysis regarding his schedule and was told they were not notified of his discharge, so no dialysis had been scheduled. The CM sent requests to the waiver worker to contact her. The CM requested the SW to contact her ASAP via phone to discuss the needs/services missed.</p> <p>Upon interview on [DATE] at 9:12 a.m. R2's community care manager, (CM) stated R2 was discharged from the facility on [DATE] which was a Friday, and the CM reached out to him on [DATE] a Monday when R2 told her that he did not receive any medications from the facility and missed his medications all weekend. The CM followed-up with the pharmacy the facility stated they had faxed medications to and there were no orders for R2. She stated R2 had called the facility, and the facility stated they had refaxed the medications on [DATE]. R2 worked with his community primary care physician (PCP) to re-order his medications. The CM picked-up his medications on [DATE] and she reported to his PCP that he had missed 6 days of medications. The CM stated she mentioned at R2's facility care conference on [DATE] that the facility needed to have the CADI waiver assessment completed at the facility prior to his discharge as the waiver had expired and R2 would need the PCA services. She stated R2 missed a dialysis appointment on [DATE] because the facility did not set it up and he missed an appointment with his PCP because R2 was unable to dress himself to go the appointment.</p> <p>Upon interview on [DATE] at 9:40 a.m. R2 stated the facility did not fax or call in his prescriptions to the pharmacy. R2 had his CM assist him with him PCP to get the medications sent to the pharmacy he used prior in the community. He stated he had never worked with the pharmacy the facility stated they faxed the medications to. R2 had an appointment set-up with his PCP where the missed medications were going to be reviewed, but he missed the appointment because he was unable to fully dress himself since he did not have a PCA. He stated in his home he could transfer himself from his wheelchair to the toilet and his chair to his bed. He had difficult cleaning himself after moving his bowels. The inability to clean himself caused him anxiety because of his diabetes he was aware if he got a pressure ulcer he would have a difficult time with healing. He stated he called his daughter to assist him with cleaning himself until his services got settled.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Upon interview on [DATE] at 10:11 a.m. registered nurse (RN)-B nurse manager stated the social worker (SW) completed the discharges. RN-B was not aware if R2's dialysis was set up or not, what the home care orders were and how the medications were ordered from the community pharmacy. RN-B stated she did not know anything about waiver services for discharging residents.</p> <p>Upon interview on [DATE] at 9:45 a.m. the SW stated on [DATE] she faxed the medications to the pharmacy that R2 had picked out. She stated she did receive a call from R2, and she refaxed the medications on [DATE]. She denied any follow-up after refaxing the medications. She stated she did set-up dialysis, but it was at another site, she believed she told R2, but did not have any documentation of the site change. The SW stated she did not know if R2's CADI waiver had closed while he was at the facility. She stated she ordered homecare for OT/PT/HHA stating he needed a home health aide he did not need a nurse. She believed the Nurse Practitioner (NP) had an error when she transcribed the order for skilled nursing. The SW did not follow-up with the NP regarding the discrepancy.</p> <p>Upon interview on [DATE] the NP stated she did intend R2 to have skilled nursing services in the home because of his complicated medication conditions of diabetes, dialysis, congestive heart failure and weakness. She was not aware that a home health aide was ordered instead of a skilled nurse. The NP was aware that R2 received PCA services prior and would have PCA again through the county, so she was confused why the facility wanted a home health aide as well.</p> <p>Upon interview on [DATE] at 1:16 p.m. the DON stated the facility was not to discharge a resident who was waiver eligible or had a prior waiver to discharge without it. In addition, the services should be included on the discharge summary.</p> <p>Upon interview on [DATE] at 1:25 p.m. the Administrator stated she believed R2's CM was notified of the discharge date . She stated R2 should not have gone home without the waiver in place no matter whose fault it was. She stated if the NP orders skilled nursing services, then the facility must follow the NP's orders.</p> <p>A facility policy titled Discharge Planning process dated ,d+[DATE] indicated the facility to identify each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the residents stay to ensure a successful discharge. The discharge coordinator is to involve the intradisciplinary team.</p>		