

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 06/18/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to notify a resident's physician of the deterioration of a non-pressure related skin wound for 1 of 3 residents (R3) reviewed for non-pressure related skin wounds.</p> <p>Findings include:</p> <p>R3's annual Minimum Data Set (MDS) assessment dated [DATE], indicated he admitted to the facility with 6/7/24 and had diagnoses including non-pressure chronic ulcer of left heel and midfoot, morbid obesity, chronic respiratory failure, difficulty in walking, and diabetes mellitus (type 2 diabetes). R3 had diabetic foot ulcer(s) and treatments included application of dressings to feet.</p> <p>R3's care plan dated 6/7/25, identified he had diabetes. Interventions included check all of body for breaks in skin per protocol and treat promptly as ordered by doctor. The care plan identified an actual impairment in skin integrity related to diabetes with left heel diabetic ulcer. Interventions included follow facility protocols for treatment of injury, wedge pillow to offload heel, encourage good nutrition and hydration in order to promote healthier skin, and obtain blood work and labs of any open wounds as ordered by physician.</p> <p>R3's wound care provider note dated 5/15/25, identified a left heel diabetic ulcer measuring 3.1 cm long by 1.8 cm wide by 0.2 cm deep with total area of 5.58 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions noted: clean with Vashe (brand of wound cleanser containing hypochlorous acid), pat dry, skin prep, apply Santyl (brand of collagenase ointment used to break down dead tissue in a wound) and calcium alginate (alginate dressing), ABD (ABD pad) and wrap, change three times weekly and as needed.</p> <p>R3's corresponding Skin and Wound Evaluation dated 5/15/25, identified the wound's measurements and the progress was stable.</p> <p>R3's progress note dated 5/16/25, indicated the IDT met and reviewed R3's skin. He had a diabetic [ulcer] to left heel noted to be stable. He was followed weekly by the wound care provider. Treatment orders changed from Medihoney to Santyl and calcium alginate. Plan of care reviewed and up to date.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's physician order with start date 5/17/25 and end date 5/23/25, was for diabetic left heel ulcer treatment and directed clean with wound cleanser, pat dry, Santyl, calcium alginate, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday.</p> <p>R3's wound care provider note dated 6/12/25, identified a left heel diabetic ulcer measuring 7.3 cm long by 2 cm wide by 0.2 cm deep with total area of 14.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged. Notification section indicated R2's primary care physician, medical doctor (MD)-A, was notified, though did not specify what MD-A was notified about.</p> <p>R3's corresponding Skin and Wound Evaluation dated 6/12/25, identified the wound's measurements and the progress was stable. There was 100% granulation tissue, no evidence of infection, moderate serosanguineous drainage, no odor, periwound erythema with normal temperature, no pain, intact dressing, cleansing solution of Vashe, enzymatic debridement, primary dressing of calcium alginate and other (collagen particles, Santyl, ABD pad), and secondary dressing of compression wrap.</p> <p>R3's progress note dated 6/13/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound care provider continued to follow with current treatment to continue. Plan of care was up to date.</p> <p>R3's physician order with start date 6/17/25, was for diabetic ulcer left heel treatment with the same treatment directions as order dated 5/24/25. The order directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday.</p> <p>During an interview on 6/18/25 at 8:25 a.m., licensed practical nurse (LPN)-C was a nurse manager. LPN-C stated nurse managers did wound rounds with the wound care provider and she was part of wound rounds for R3. R3 had a diabetic ulcer on his heel. LPN-C reviewed R3's Skin and Wound Evaluations and corresponding wound photos. LPN-C noted the 6/12/25 photo showed three open areas on R3's heel as compared to one open area in photo dated 5/15/25. R3's skin appeared to be cracking and two more areas had opened up since 5/15/25. LPN-C stated the wound looks like it is deteriorating. She identified the wound was no longer improving and from evaluations and photos from 5/8/25 through 6/12/25 the wound had increased in size, the periwound area looked worse, and there were more open areas. LPN-C explained she was not an expert, but the wound was not looking good and looked worse than it did last week. LPN-C was not aware of R3's physician, MD-A, having been notified of the deteriorating wound, but thought she may have mentioned it to the nurse practitioner but did not have documentation reflecting this notification. LPN-C confirmed that though the Wound Evaluation dated 6/12/25 indicated MD-A had been notified (of unspecified details), she had not notified MD-A of the wound's deterioration. LPN-C stated for a deteriorating wound the primary provider and wound care providers should be notified and updated treatments orders obtained and entered. LPN-C confirmed she did not see any documentation that R3's primary providers were updated about the wound's deterioration and did not see any indication the treatment or plan of care had changed since the new orders from the wound care provider a month ago.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 6/18/25 at 9:29 a.m., LPN-C removed the dressing dated 6/17/25 from R3's left foot. The ABD pad had serosanguinous drainage present that had gone through the alginate dressing underneath it. Three open areas were observed on R3's foot. LPN-C noted the largest and original open area looked worse and bigger than it had last week and it had grown in length and was almost connected to the newer smaller open area present beneath it. LPN-C stated she was going to call and notify the provider and see what they wanted to do for treatment because maybe the current treatment wasn't working.</p> <p>During an interview on 6/18/25 at 11:05 a.m., nurse manager registered nurse (RN)-C stated she would wait roughly a week or two weeks to determine if a treatment was working or a wound was deteriorating. If a wound was worsening in progress, the primary provider and wound care providers should be notified.</p> <p>During an interview on 6/18/25 at 11:05 a.m., the director of nursing (DON) stated for a wound that was deteriorating both the wound care provider and primary care provider should be updated. If a wound was deteriorating staff needed to have a conversation with the provider and try to do a root cause analysis to see why it was deteriorating.</p> <p>During an interview on 6/18/25 at 10:14 a.m., nurse practitioner (NP)-B stated she was covering for MD-A's usual nurse practitioner. NP-B stated she had not been notified of R3's worsening diabetic left foot ulcer wound and would review documentation for indication that MD-A or the other nurse practitioner had been notified. In a continued interview at 12:38 p.m., NP-B stated she did not see any documentation that the facility had notified R3's primary care team of his wound deteriorating. NP-B confirmed she would expect the primary care team to be notified of a wound increasing in size or new open areas. NP-B stated this was important because they may want to draw labs, make sure there was no osteomyelitis (bone infection), see what could be precipitating the issue of wound healing, or see what else they could do. NP-B stated notification should be made and documented.</p> <p>Facility policy titled Notification of Changes Policy dated 3/2024, included It is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician) . The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment and preferences to address the changes.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure professional standards of practice for treatment orders were followed for 2 of 3 residents (R1, R2) reviewed for non-pressure related skin wounds who had wound care orders which were not transcribed.</p> <p>Findings include:</p> <p>R1</p> <p>R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated she admitted to the facility on [DATE] with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R1 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment.</p> <p>R1's Skin Evaluation and Skin Risk Factors assessment dated [DATE], identified she had a surgical incision on her coccyx (tail bone) with treatment of a wound vacuum-assisted closure (VAC, a negative pressure wound therapy (NPWT) that applies suction via Granufoam, a foam dressing, applied to the wound bed connected to a portable vacuum pump with a drainage tube that removes fluid draining from the wound).</p> <p>R1's care plan dated 5/14/25, identified she had an alteration in skin integrity with right gluteal surgical wound with a wound VAC. Interventions included treatment to open areas per order.</p> <p>R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness.</p> <p>R1's hospital consult note from wound, ostomy, and continence (WOC) nursing services dated 5/27/25, indicated WOC was consulted for right buttock wound. The note identified a surgical wound to right buttock with negative pressure wound therapy. The note also identified a suction injury wound to right buttock towards hip with contributing factor of Granufoam to good tissue without drape [a transparent adhesive film-like acrylic and silicone dressing] placed. The note identified R1 admitted to the hospital on [DATE] with the wound VAC remaining in place since her admission. It was removed revealing significant suction burn from Granufoam bridge being in direct contact with good tissue.</p> <p>R1's hospital consult note from WOC nursing services dated 5/30/25, indicated the periwound area had mild improvement and the wound VAC could be resumed upon R1's discharge from the hospital. The nurse discussed importance of protecting periwound from black sponge and placed discharge order.</p> <p>R1's hospital progress nursing note dated 5/30/25, indicated the nurse gave report to a registered nurse (RN) at the facility and updated the RN on the wound vac orders.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's hospital Discharge summary dated [DATE], included discharge procedure orders for wound care. The orders noted a wound VAC was in place on the right gluteal area. A wound care order for the right buttock included Daily dressing changes with Vashe (a wound cleanser) packing done inpatient due to periwound damage from black foam being placed directly to skin prior to admission. OK to resume NPWT at discharge. Please protect periwound skin with transparent drape under any foam when bridging [using extra pieces of foam to create a connection point to the VAC device other than to the foam applied directly to the wound, often to adjust positioning of the drainage tube] SensaTRAC pad [pad on the end of the drainage tube that connects from the VAC device to the foam dressing to provide drainage and suction]. This was followed by specific wound VAC dressing change orders for Mondays, Wednesdays, and Fridays of Wash hands and apply non-sterile gloves. To prevent reflux from tubing, close clamp. Turn off VAC pump. Remove old dressing. If adhered to wound base, moisten old foam with normal saline for 5-10 minutes. Cleanse wound bed with wound cleanser to remove debris. Ensure all foam is removed. Examine wound bed: drainage, tunneling, undermining, size. Check condition of periwound skin. Cleanse periwound skin with wound cleanser and pat dry. Prep wound margins with skin protectant. Add window paining to wound edges with transparent drape. Apply alginate AG [alginate dressing, an absorbent wicking antimicrobial pad] to periwound wound bed. Add strip of transparent drape where bridging will be applied. This will hold alginate AG in place. Cut and shape black granulofoam to fit the size and shape of the wound. Do not cut over wound bed. Place shaped foam into wound bed. Cut strip of black granulofoam for bridging onto hip and apply over top of existing transparent drape. The 2 pieces of foam need to touch. Cut and apply transparent drape material to cover all the foam and wound. The drape material should extend out onto the periwound about a half inch all around. When working with the KCI drape [brand of drape dressing], follow the numbers for ease of application. Start with removing layer #1. Cut 2 cm [centimeter] (quarter) sized hole in drape above foam at end of bridge. Apply over the hole in the drape the SensaTRAC pad with tubing arranged in a direction and position that is comfortable for the patient and avoids excessive pressure against skin. Connect tubing from dressing to tubing coming from VAC suction canister. The connectors lock together. Activate VAC suction unit and check for airleak. Set therapy to physician's prescription. When suction is applied, the foam will contract to a raisin-like appearance. Label dressing with date, time, initial, and number of foam pieces placed in wound.</p> <p>R1's progress note dated 5/30/25, indicated R1 returned to the facility from the hospital.</p> <p>R1's physician orders with start date 5/30/25, in the electronic health record (EHR) included: monitor the wound VAC's collection canister every shift and change as needed; treatment to right buttock surgical wound of continue wound VAC, change Monday and Thursday, suction on 125 mm HG; monitor wound VAC for signs and symptoms of infection around wound VAC site and update provider as needed; and monitor function of wound VAC every shift and update provider as needed.</p> <p>R1's orders did not include the specific discharge procedure wound care orders, including step-by-step instructions for dressing changes on Mondays/Wednesdays/Fridays and application of alginate dressing, placed upon her discharge from the hospital. R1's record lacked evidence the hospital wound care orders were transcribed into the facility's EHR physician orders.</p> <p>During an interview on 6/16/25 at 1:54 p.m., licensed practical nurse (LPN)-A stated orders were usually faxed to the facility prior to a resident admitting, entered ahead of time, and confirmed by the nurse admitting the resident. The admitting nurse would look to make sure all the medications and treatments were correct based on the transfer orders that arrived with the resident, orders were double checked by another nurse, and checked again the next day by a nurse manager.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/16/25 at 2:37 p.m., R1 was observed in her bed. LPN-A identified R1's wound on her right buttock/hip with dressing she had changed earlier that day. R1's surgical wound had foam inside of it and a piece of bridge foam extending from the foam in the wound off to the right side which was connected to the drainage tubing and wound VAC. On the upper right side of the surgical wound there was an area of redness extending diagonally approximately three inches identified as LPN-A as the area where it looked like bridge foam had been previously placed without a drape underneath it. LPN-A confirmed the dressing did not include notation of the date or time it was changed, her initials as the person who changed it, or indicate how many pieces of foam were used to fill the wound bed in accordance with the hospital wound care orders. In a follow-up interview at 3:44 p.m., LPN-A confirmed she had not been applying and had not applied an alginate dressing underneath the bridge foam and did not see any present during the earlier observation of R1's dressing.</p> <p>During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound care orders came from her hospital discharge paperwork and the current order dated 5/30/25 was to change the wound VAC dressing Mondays and Thursdays with suction at 125 mm Hg. RN-C was unaware of the detailed wound care orders from R1's hospital discharge on [DATE]. She noted the orders had been faxed to the facility prior to R1's arrival and uploaded in her EHR, but RN-C had never seen them before. RN-C had talked to the hospital who said they would send specific orders on how to protect R1's periwound area, but the orders R1 arrived with from the hospital did not include this. RN-C was not aware of any follow-up done regarding the orders. RN-C confirmed the orders were not transcribed into the EHR, R1's wound care had not been in accordance with the physician orders, and she would expect the detailed wound care orders to be followed.</p> <p>During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated treatment orders from the hospital should be followed for any alterations in skin integrity when a resident is admitted . The DON confirmed treatments should be in accordance with provider orders which should be transcribed into residents' EHRs after review by two nurses. The DON stated orders should be transcribed and not doing so might lead to the wrong treatment being done or deterioration of a wound. If orders were absent from the medical record, then the continuous plan of care for a resident would be disrupted.</p> <p>During an interview on 6/18/25 at 9:41 a.m., nurse practitioner (NP)-A stated she worked with the surgical team and had seen R1 for a follow-up appointment on 5/22/25 with another follow-up appointment next week. NP-A stated members of the surgical team had seen R1 during her recent hospitalization from 5/24/25 through 5/30/25 and placed the discharge wound care orders. NP-A stated she would expect orders that are included in discharge instructions to be transcribed and followed. NP-A stated the surgical team's intention was for R1's discharge wound care orders to be followed until she came back in for her follow-up appointment. NP-A noted potential outcomes of not following the orders included maceration and worsening of the suction burn injury, denuding and erosion of the periwound area, a delay in healing, or worsening of the wound.</p> <p>R2</p> <p>R2's MDS assessment dated [DATE], indicated she admitted to the facility on [DATE] with recent re-entry on 6/2/25 from the hospital. R2 had diagnoses including other fracture and mechanical complication of internal right hip prosthesis (problem with an artificial hip joint). R2 had orthopedic surgery to repair a fracture of the pelvis, hip, leg, knee, or ankle during the prior inpatient hospital stay requiring active care at the facility and a surgical wound.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's care plan dated 5/23/25, identified she had an alteration in skin integrity related to surgical intervention with surgical wound to hip. Interventions included treatment to open areas per order.</p> <p>R2's physician orders dated 6/2/24, included: monitor surgical incision site for signs and symptoms of infection and healing every shift; and do not apply creams, lotions, powder, or hydrogen peroxide to the incision.</p> <p>R2's progress note dated 6/4/25, indicated a call was received from R2's orthopedic clinic who would be at the facility that day to see R2. The provider ordered an x-ray to be done at the facility prior to the appointment.</p> <p>R2's Orthopedic Progress Note and Provider Orders document dated 6/4/25, indicated R2 was seen that day for three to five week post-operative visit following a right femur fracture with revision femoral implant (fracture of the thigh bone near a hip replacement implant requiring revision surgery to replace the original implant). Orders included Wound care: incision looks good, sutures were removed. Steri Strips to fall off on their own. Ok for incision to get wet in the shower.</p> <p>R2's progress note dated 6/6/25, indicated the interdisciplinary team (IDT) met to review R2's skin and wound, she admitted with a surgical incision to right hip. The surgical non-removable dressing was removed by orthopedics with Steri-Strips (brand of thin adhesive bandages used to close incisions) in place. Incision clean, dry, and intact with treatment orders in place. The care plan was reviewed and up to date.</p> <p>R2's physician orders did not include the wound care order from R2's orthopedic follow-up appointment on 6/4/25.</p> <p>On 6/17/25 at 9:48 a.m., R2's right hip surgical incision was observed while she was lying in bed. The incision extended down R2's outer thigh from her hip and had Steri-Strips in place near the middle portion of the incision line. Nurse manager, RN-C, stated the incision appeared approximately 16 inches long and there were four Steri-Strips present across the incision line which appeared to be closed.</p> <p>During an interview on 6/17/25 at 10:00 a.m., nurse manager RN-C stated R2 had admitted with a right hip surgical incision. RN-C stated R2's current wound care orders were just the monitoring. RN-C noted orthopedics came out to see R2 on 6/4/25 at the facility. Upon review of the Orthopedic Progress Note and Provider Orders document dated 6/4/25, RN-C stated the wound care orders were that Steri-Strips had been placed, okay for Steri-Strips to fall off on their own, and okay for incision to get wet in the shower. RN-C confirmed these wound care orders were not present in the physician orders in R2's EHR and should have been transcribed. RN-C stated the note was in R2's paper chart, but the orders had not been transcribed into the EHR. During a follow-up interview on 6/18/25 at 10:41 a.m., RN-C noted that if the order was not transcribed there was the potential for staff to remove the Steri-Strips which could result in wound dehiscence. RN-C confirmed the standard of practice was to transcribe physician orders and provide treatment accordingly.</p> <p>(continued on next page)</p>		

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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>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** Based on observation, interview, and document review, the facility failed to comprehensively assess non-pressure related skin wounds for 2 of 3 residents (R1, R2) reviewed for non-pressure related skin wounds. In addition, the facility failed to administer non-pressure related skin wound treatments in accordance with physician orders for 1 of 3 residents (R1) and failed to identify deterioration of a non-pressure related skin wound for 1 of 3 residents (R3) reviewed for non-pressure related skin wounds.</p> <p>Findings include:</p> <p>R1</p> <p>R1's Minimum Data Set (MDS) assessment dated [DATE], indicated she admitted to the facility on [DATE] with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R3 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment. R3 was cognitively intact.</p> <p>R1's Skin Evaluation and Skin Risk Factors assessment dated [DATE], identified she had a surgical incision on her coccyx (tail bone) with treatment of a wound vacuum-assisted closure (VAC, a negative pressure wound therapy (NPWT) that applies suction via Granufoam, a foam dressing, applied to the wound bed connected to a portable vacuum pump with a drainage tube that removes fluid draining from the wound).</p> <p>R1's care plan dated 5/14/25, identified she had an alteration in skin integrity with right gluteal surgical wound with a wound VAC. Interventions included treatment to open areas per order, weekly measurement and assessment of wound, monitor for skin breakdown and signs/symptoms of infection and report to providers, document on skin condition and keep providers informed of changes.</p> <p>R1's physician order with start date 5/14/25 and end date 5/15/25, directed to continue large wound VAC and dressing on right buttock wound, change Monday Wednesday and Friday, suction at 125 millimeters of mercury (mm Hg).</p> <p>R1's medication administration record (MAR) progress note dated 5/14/25, indicated the wound VAC was not changed as staff were waiting for the wound VAC.</p> <p>R1's progress note dated 5/15/25, indicated the wound VAC arrived and was placed on the right gluteal wound, wound provider present and assessed wound at that time.</p> <p>R1's physician order with start date 5/19/25, directed to continue wound VAC on right buttock wound, change Monday and Thursday, suction on 125 mm Hg.</p> <p>R1's surgical clinic follow-up visit note by nurse practitioner (NP)-A dated 5/22/25, indicated R1's wound vac was removed but not able to be replaced as supplies were not sent with her. NP-A placed a wet-to-dry dressing and covered with an abdominal pad (ABD pad, an absorbent gauze dressing). Orders included change wound vac dressing on Monday, Wednesday, and Friday, do not place sponge on top of healthy skin, cut foam to fit inside wound, and call if questions.</p> <p>(continued on next page)</p>		

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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>R1's MAR dated 5/1/25 through 5/31/25, indicated wound VAC dressing changes were completed on 5/19/25 and 5/22/25.</p> <p>R1's progress note dated 5/23/25 at 10:50 a.m., indicated the wound VAC alarm went off at 6:30 a.m. Licensed practical nurse (LPN)-A found that the wound VAC device had failed and was unable to be reset, called the facility's medical supply company to obtain a replacement wound VAC, and was awaiting delivery. LPN-A removed the wound VAC dressing and replaced it with a wet-to-dry dressing until the new wound VAC could be applied, updated the resident, and updated the nurse manager. The progress note did not indicate the provider was contacted to notify of the wound VAC failure or obtain a new order for a wet-to-dry dressing.</p> <p>R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness.</p> <p>R1's hospital consult note from wound, ostomy, and continence (WOC) nursing services dated 5/27/25, indicated WOC was consulted for right buttock wound. The note identified a surgical wound to right buttock with negative pressure wound therapy (wound VAC). The note also identified a suction injury wound to right buttock towards hip with contributing factor of Granufoam to good tissue without drape [a transparent adhesive film-like acrylic and silicone dressing] placed. The note identified R1 admitted to the hospital on [DATE] with the wound VAC remaining in place since her admission. It was removed revealing significant suction burn from Granufoam bridge being in direct contact with good tissue. R1 experienced significant pain with the dressing change and the plan was to take a break from the wound VAC to allow the periwound area (skin surrounding a wound, where the suction burn was located) to heal.</p> <p>R1's hospital consult note from WOC nursing services dated 5/30/25, indicated the periwound area had mild improvement and the wound VAC could be resumed upon R1's discharge from the hospital. The nurse discussed importance of protecting periwound from black sponge and placed discharge order. The suction injury wound was not measured, had a red wound base, moderate sanguineous (bloody) drainage, with periwound skin erythema (redness), maceration (breakdown and softening of skin due to exposure to excessive moisture), and fragile/thin.</p> <p>R1's hospital Discharge summary dated [DATE], included discharge procedure orders for wound care. The orders noted a wound VAC was in place on the right gluteal area. A wound care order for the right buttock included Daily dressing changes with Vashe (a wound cleanser) packing done inpatient due to periwound damage from black foam being placed directly to skin prior to admission. OK to resume NPWT at discharge. Please protect periwound skin with transparent drape under any foam when bridging [using extra pieces of foam to create a connection point to the VAC device other than to the foam applied directly to the wound, often to adjust positioning of the drainage tube] SensaTRAC pad [pad on the end of the drainage tube that connects from the VAC device to the foam dressing to provide drainage and suction]. This was followed by wound VAC dressing change orders to change Mondays, Wednesdays, and Fridays with step-by-step instructions including: Apply alginate AG [alginate dressing, an absorbent wicking antimicrobial pad] to periwound wound bed; add strip of transparent drape where bridging will be applied to hold alginate AG in place; and label dressing with date, time, initial, and number of foam pieces placed in wound.</p> <p>R1's progress note dated 5/30/25, indicated R1 returned to the facility from the hospital.</p> <p>(continued on next page)</p>		

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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>R1's physician orders with start date 5/30/25, in the electronic health record (EHR) included: monitor the wound VAC's collection canister every shift and change as needed; treatment to right buttock surgical wound of continue wound VAC, change Monday and Thursday, suction on 125 mm HG; monitor wound VAC for signs and symptoms of infection around wound VAC site and update provider as needed; and monitor function of wound VAC every shift and update provider as needed. R1's orders did not include the hospital discharge wound care orders, including step-by-step instructions for dressing changes on Mondays/Wednesdays/Fridays and application of alginate dressing.</p> <p>R1's MAR dated 5/30/25 through 6/16/25, indicated the treatment order for right buttock surgical wound to continue wound VAC, change Monday and Thursday, suction on 125 mm HG</p> <p>was completed on 6/2/25, 6/5/25, 6/9/25, 6/12/25, and 6/16/25. R1's MAR lacked evidence that wound treatment was completed in accordance with the hospital discharge wound care orders dated 5/30/25.</p> <p>R1's Admission/Initial Data Collection assessment dated [DATE], included a skin section with area to identify alterations in skin integrity and the associated site, type, length, width, depth, and stage (if alteration was pressure-related). No alterations in skin integrity were identified. Comments included healing skin alteration on right hip and wound on right buttock with dressing dry and intact. The assessment lacked any further information about the new suction injury wound and did not include a comprehensive assessment of the injury.</p> <p>R1's Skin Evaluation and Skin Risk Factors assessment dated [DATE], included a current skin issues section including description of wound bed for each site, description of drainage amount and odor, description of periwound area, and current treatment. This section was blank. Question are there any new wound[s] prompting assessment? was marked no. The risk factors and interventions sections were blank. The summary noted she readmitted with new skin to periwound of buttock wound, wound VAC placed, skin prep to periwound, and wound provider to see resident next week. The assessment lacked any further information about the new suction injury wound and did not include a comprehensive assessment of the injury.</p> <p>R1's Weekly Skin Inspection assessment dated [DATE], included a summary of current skin condition with note that wound VAC was on.</p> <p>R1's Wound Care note dated 6/5/25, indicated R1 was seen by the wound care provider regarding surgical wound to right gluteal area. The note indicated the wound was improving with no new area of concern. One wound was identified, a surgical right gluteal wound 7.7 cm long x 4.4 cm wide x 5.3 cm deep with moderate serosanguineous (mix of bloody and clear) exudate (drainage), identification of tissue type, periwound area positive for erythema, and note moderate erythema. Treatment plan was continue wound VAC as ordered. The note did not identify the presence of a second wound, the suction burn injury, or include a comprehensive assessment of the wound.</p> <p>R1's Wound Evaluation dated 6/5/25, identified a surgical wound to right gluteus with healing ridge, other closure method, and stable progress with measurements identified in the Wound Care note from the same day. The wound bed, periwound, and treatments sections were blank. It did not identify or include a comprehensive assessment of the suction burn injury wound.</p> <p>R1's Weekly Skin Inspection dated 6/12/25, included a summary of current skin condition with note no new skin issues noted.</p> <p>(continued on next page)</p>		

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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>R1's Wound Care note dated 6/12/25, indicated R1 was seen by the wound care provider regarding surgical wound to right gluteal area. The note indicated the wound was improving with no new area of concern. One wound was identified, a surgical right gluteal wound 4.9 cm long x 3 cm wide x 4.5 cm deep with moderate serosanguineous (mix of bloody and clear) exudate (drainage), identification of tissue type, periwound area positive for erythema, and note mild erythema. Treatment plan was continue wound VAC as ordered. The note did not identify the presence of a second wound, the suction burn injury, or include a comprehensive assessment of the wound.</p> <p>R1's Wound Evaluation dated 6/12/25, identified a surgical wound to right gluteus with healing ridge, other closure method, and improving progress with the measurements identified in the Wound Care note from the same day. Wound bed section identified tissue types and no evidence of infection. Periwound surrounding tissue was erythema with normal temperature. Pain level was zero. Treatment was intact dressing with generic wound cleanser and primary dressing of NPWT. It did not identify or include a comprehensive assessment of the suction burn injury wound.</p> <p>R1's record did not include a comprehensive assessment of the suction burn injury wound on her right gluteus/hip after she re-admitted to the facility on [DATE].</p> <p>During an interview on 6/16/25 at 12:38 pm., R1 stated she was at the facility for a wound on her right hip which was connected to a pump (wound VAC) and couldn't go home until it healed up enough that she no longer needed it. R1 stated her dressing was changed every three days. Only a couple of nurses including LPN-A did these dressing changes, and once in a while the dressing would not be right resulting in a leak causing the wound VAC to alarm. R1 noted the wound provider saw her weekly and said the wound was getting better. R1 noted she had to go back to the hospital for a few days after she admitted to the facility, but didn't remember why.</p> <p>During an interview on 6/16/25 at 1:54 p.m., licensed practical nurse (LPN)-A stated she was the charge nurse for R1's unit. LPN-A noted residents had head-to-toe skin assessments completed by a nurse on admission. The next day a nurse manager or charge nurse would do another skin assessment and wound assessments. Wound assessments were then done by the wound care provider during weekly rounds. LPN-A looked in orders to know what to do for a wound including dressings and treatments. If a wound VAC failed there should be an order for an as needed wet-to-dry dressing to use instead. LPN-A noted R1's wound VAC failed on 5/23/25 and she changed the dressing to a wet-to-dry dressing. LPN-A stated she had notified the provider and been instructed to place a wet-to-dry dressing while waiting for a new wound VAC. LPN-A was not sure if R1 had the order for this or if she charted this, but she would have charted the dressing change as an as needed order and charted provider notification in a progress note. LPN-A stated she changed R1's wound VAC a couple of times, always placed a drape down beneath the bridge foam to protect intact skin, and had never seen the bridge foam in direct contact with R1's skin, though knew it had happened because R1 now had a new area of red skin.</p> <p>(continued on next page)</p>		

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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>During an interview on 6/18/25 at 11:50 a.m., registered nurse (RN)-D stated she had changed R1's wound VAC dressing on the morning on 5/24/25 before R1 went to the hospital. RN-D stated R1's wound VAC had failed earlier and she had to take out the wet-to-dry dressing and put the new dressing and wound VAC on that morning. RN-D stated she placed the barrier film (drape) on top of the bridge foam and didn't put a barrier on the bottom, and the hospital said it ate R1's skin. RN-D stated R1 had left for the hospital with the dressing she had applied and new wound VAC in place. RN-D stated she had not been familiar with using a foam bridge with wound VAC dressings and wasn't sure at the time if there was supposed to be a barrier underneath it. She proceeded the way she was trained to do for wound VACs without a bridge piece and had not sought clarification.</p> <p>During an observation and interview on 6/16/25 at 2:37 p.m., R1 was observed in her bed. LPN-A identified R1's wound on her right buttock/hip with dressing she had changed earlier that day. R1's surgical wound had foam inside of it and a piece of bridge foam extending from the foam in the wound off to the right side which was connected to the drainage tubing and wound VAC, all covered with transparent drape dressings. Due to the overlapping nature of the transparent film drape dressing pieces underneath and over the foam, the drape under the bridge foam could not be specifically visualized, though LPN-A stated she had applied it. On the upper right side of the surgical wound was an area of redness extending diagonally approximately three inches identified by LPN-A as the area where the bridge foam had been previously placed without a drape underneath. LPN-A confirmed the dressing did not include initials, date, time, or number of pieces of foam used in accordance with the hospital wound care orders. In a follow-up interview at 3:44 p.m., LPN-A confirmed she did not apply an alginate dressing underneath the bridge foam when she had changed the dressing earlier that day.</p> <p>During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound should be monitored every shift with a monitoring order nurses sign off on. RN-C confirmed wound monitoring orders were in place starting 5/30/25, but there was no order for or documentation of wound monitoring every shift from 5/13/25 to 5/24/25 prior to R1's hospitalization. RN-C noted R1's wound VAC malfunctioned on 5/23/25 and a wet-to-dry dressing applied. She expected the provider to be notified of the failure, new order obtained, and documented in a progress note. RN-C confirmed R1's record lacked an order for the wet-to-dry dressing and documentation of provider notification. RN-C stated there were issues with R1's wound vac dressing when she went to the hospital 5/24/25. The bridge was applied improperly resulting in periwound skin damage. RN-C identified R1's wound care orders came from her hospital discharge paperwork and the current order dated 5/30/25 was to change the wound VAC dressing Mondays and Thursdays with suction at 125 mm Hg. RN-C was unaware of the detailed wound care orders from R1's hospital discharge on [DATE]. She noted the orders had been faxed to the facility prior to R1's arrival, uploaded in her EHR, but RN-C had never seen them before. RN-C stated R1's wound VAC dressing changes were done on Mondays and Thursdays in accordance with direction from the facility's wound care provider but did not see any orders in his notes directing staff to change the treatment from what the hospital ordered. RN-C confirmed R1's wound care had not been in accordance with the physician orders, and she would expect the detailed wound care orders to be followed. During a follow-up interview on 6/17/25 at 10:58 a.m., RN-C stated the suction burn wound was considered part of the peri-wound area of the surgical wound per the wound care provider and confirmed separate wound assessments had not been completed for R1's suction burn wound. RN-C confirmed the surgical wound assessments only identified peri-wound erythema and did not include identification of the suction burn wound's etiology, treatment, measurements, or other details. She did not see assessment of the wound in the wound care provider's weekly notes or photographs that captured the entirety of the wound. RN-C was unable to identify completion of a comprehensive assessment of the suction burn wound.</p> <p>(continued on next page)</p>		

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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>During an interview on 6/16/25 at 1:16 p.m., RN-B stated when residents were admitted nurses did skin assessments immediately and checked for any wounds. Wounds were assessed when doing dressing changes and with weekly skin assessments. Wound care orders were on the MAR and treatments were documented on the MAR. RN-B stated wound VAC dressings had to have a film dressing underneath bridging foam if it was used to avoid skin irritation around the wound. If a wound VAC needed to be changed but supplies were not available, she would call the provider, let them know, and get an order for a different dressing.</p> <p>During an interview on 6/16/25 at 1:00 p.m., RN-A stated nurses did wound care based on physician orders in the MAR, including procedures and dressings. Everything was put in the MAR unless there was a new admit and then you use the discharge orders. Treatments were charted in the MAR. Wound assessments were completed by nurse managers on admission, by nurses when doing dressing changes, and by the wound care provider who came once weekly. RN-A stated for wound VAC dressing changes, you had to put down a protective barrier over the skin before placing the bridging foam to protect the good skin because it could create a new wound from all the moisture passing through the foam. RN-A noted nurse managers performed wound VAC dressing changes. If a dressing change was needed but supplies were unavailable, RN-A would notify the provider and get an order for a different dressing while waiting for supplies.</p> <p>During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated all wounds were to be comprehensively assessed on admission and at least weekly thereafter. A comprehensive assessment included how the wound looks, drainage, wound bed description and size, the treatments, description of the wound bed and periwound area, presence of tunneling or maceration, wound status of improving deteriorating or stable, and pain. He expected all components of the facility's wound assessments to be completed as part of a comprehensive assessment. On admission, treatment orders from the hospital should be followed for any alterations in skin integrity. The DON confirmed treatments should be in accordance with provider orders. Treatments should be documented and if anything was not done per orders or if orders were missing, nurses should notify the provider. He would expect the provider to be called if a wound VAC failed to notify them of the failure and get an order for a new treatment. The DON confirmed R1's wound vac had not been applied properly with a barrier between the bridge foam and intact skin leading to skin breakdown.</p> <p>During an interview on 6/18/25 at 9:41 a.m., NP-A stated she was part of the surgical clinic team and had seen R1 for a surgical follow-up appointment on 5/22/25 with plan to see her again in a month, but she was re-admitted to the hospital where documentation showed a suction burn injury from the wound VAC. NP-A confirmed R1 was discharged with specific orders for how to change the wound vac from the surgical team. NP-A would expect orders that are part of discharge instructions to be transcribed and followed. NP-A stated, our intention was for these to be followed until she came back in and noted she did not see evidence that the surgical team had been contacted regarding wound VAC failure, treatment orders, or consultation regarding management of the wound VAC. NP-A noted not following the orders could lead to maceration with the periwound area eroding or denuding which could delay healing or make the wound potentially worse.</p> <p>R2</p> <p>(continued on next page)</p>		

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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>R2's MDS assessment dated [DATE], indicated she admitted to the facility on [DATE] with entry on 6/2/25 from the hospital. R2 had diagnoses including other fracture and mechanical complication of internal right hip prosthesis (problem with an artificial hip joint). R2 had orthopedic surgery to repair a fracture of the pelvis, hip, leg, knee, or ankle during the prior inpatient hospital stay requiring active care at the facility and a surgical wound.</p> <p>R2's progress note dated 6/2/25, indicated she re-admitted to the facility following a hospital stay for abdominal distention secondary to an ileus.</p> <p>R2's care plan dated 5/23/25, identified she had an alteration in skin integrity related to surgical intervention with surgical wound to hip. Interventions included: monitor skin integrity daily during cares and weekly skin inspection by nurse, treatment to open areas per order, weekly measurements and assessment of wound, and document on skin condition and keep provider informed of changes.</p> <p>R2's physician orders dated 6/2/24, included: monitor surgical incision site for signs and symptoms of infection and healing every shift; and do not apply creams, lotions, powder, or hydrogen peroxide to the incision.</p> <p>R2's Skin Evaluation and Skin Risk Factors assessment dated [DATE], identified a surgical incision to right hip with Steri-Strips (brand of thin adhesive bandages used to close incisions) in place. It did not include additional information about the wound or include measurements.</p> <p>R2's Orthopedic Progress Note and Provider Orders document dated 6/4/25, indicated R2 was seen that day for three to five week post-operative visit following a right femur fracture with revision femoral implant (fracture of the thigh bone near a hip replacement implant requiring revision surgery to replace the original implant). Orders included Wound care: incision looks good, sutures were removed. Steri Strips to fall off on their own. Ok for incision to get wet in the shower.</p> <p>R2's Wound Evaluation dated 6/4/25, identified a front right hip surgical incision with Steri-Strips present on admission. There was no evidence of infection in the wound bed, no exudate or odor, the periwound edges were attached with surrounding tissue normal in color, no induration or edema, normal temperature, and intermittent three out of ten pain. There was no dressing present and the wound was improving. The dimensions section for measurements of the wound was blank.</p> <p>R2's Weekly Skin Inspection dated 6/4/25, noted a shower was completed and R2 had an incision to right hip. It did not include additional information about the wound or include measurements.</p> <p>R2's Wound Evaluation dated 6/12/25, identified a front right hip surgical incision with Steri-Strips present on admission. It measured 3.73 centimeters (cm) long by 0.47 cm wide. The wound bed, periwound, and treatment sections were blank. The wound's progress was improving with note that the resident has Steri strips in place healing well staff will continue to monitor wound for changes.</p> <p>On 6/17/25 at 9:48 a.m., R2's right hip surgical incision was observed while she was lying in bed. The incision extended down R2's outer thigh from her hip and had Steri-Strips in place near the middle portion of the incision line. Nurse manager, RN-C, stated the incision appeared approximately 16 inches long, there were four Steri-Strips present across the incision line which appeared to be closed, and the periwound area had dry skin and looked healthy.</p> <p>(continued on next page)</p>		

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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>During an interview on 6/17/25 at 10:00 a.m., nurse manager RN-C stated she completed R2's Wound Evaluation dated 6/4/25. RN-C confirmed the assessment lacked measurements and she would expect a wound assessment to include measurements. RN-C reviewed R2's Wound Evaluation and attached wound photo dated 6/12/25 and stated the measurements were not accurate because the program that calculated measurements from the photo had only picked up on the small scabbed area remaining in the middle of the incision. RN-C stated the assessment did not identify anything in the wound bed section but should have noted the scab and did not identify anything in the periwound section but she would have put dry flaky skin, edges attached or epithelization with new pink sin. Further, it did not identify if there was evidence of infection, exudate, odor, induration, edema, temperature, or pain. RN-C stated a comprehensive assessment of the wound had not been completed, it should have been done, and the 6/4/25 Wound Evaluation should have included measurements to be comprehensive.</p> <p>R3</p> <p>R3's MDS assessment dated [DATE], indicated he admitted to the facility with 6/7/24 and had diagnoses including non-pressure chronic ulcer of left heel and midfoot, morbid obesity, chronic respiratory failure, difficulty in walking, and diabetes mellitus (type 2 diabetes). R3 had diabetic foot ulcer(s) and treatments included application of dressings to feet.</p> <p>R3's care plan dated 6/7/25, identified he had diabetes. Interventions included check all of body for breaks in skin per protocol and treat promptly as ordered by doctor. The care plan identified an actual impairment in skin integrity related to diabetes with left heel diabetic ulcer. Interventions included follow facility protocols for treatment of injury, wedge pillow to offload heel, encourage good nutrition and hydration in order to promote healthier skin, and obtain blood work and labs of any open wounds as ordered by physician.</p> <p>R3's wound care provider note dated 5/15/25, identified a left heel diabetic ulcer measuring 3.1 cm long by 1.8 cm wide by 0.2 cm deep with total area of 5.58 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions noted: clean with Vashe (brand of wound cleanser containing hypochlorous acid), pat dry, skin prep, apply Santyl (brand of collagenase ointment used to break down dead tissue in a wound) and calcium alginate (alginate dressing), ABD (ABD pad) and wrap, change three times weekly and as needed.</p> <p>R3's corresponding Skin and Wound Evaluation dated 5/15/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, wound pain, and treatments sections were blank.</p> <p>R3's progress note dated 5/16/25, indicated the IDT met and reviewed R3's skin. He had a diabetic [ulcer] to left heel noted to be stable. He was followed weekly by the wound care provider. Treatment orders changed from Medihoney to Santyl and calcium alginate. Plan of care reviewed and up to date.</p> <p>R3's physician order with start date 5/17/25 and end date 5/23/25, was for diabetic left heel ulcer treatment and directed clean with wound cleanser, pat dry, Santyl, calcium alginate, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday.</p> <p>(continued on next page)</p>		

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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.			
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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>R3's wound care provider note dated 5/22/25, identified a left heel diabetic ulcer measuring 2.6 cm long by 1.6 cm wide by 0.2 cm deep with total area of 4.16 cm squared with progress of improving. Exudate was moderate serosanguineous with 90% granulation and 10% slough tissue and presence of periwound maceration with note mild maceration. Treatment plan was updated and instructions noted: clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate and Santyl, ABD and wrap, change three times weekly and as needed.</p> <p>R3's corresponding Skin and Wound Evaluation dated 5/22/25, identified the wound's measurements and progress was improving. The wound bed, exudate, periwound, wound pain, and treatments sections were blank.</p> <p>R3's progress note dated 5/23/25, indicated the IDT met to review R3's wound. Diabetic ulcer was improving. Wound care provider continued to follow. Current treatment would continue with no new areas of concern. Plan of care was up to date.</p> <p>R3's physician order with start date 5/24/25 and end date 6/16/25, was for diabetic ulcer left heel treatment and directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday.</p> <p>R3's wound care provider note dated 5/29/25, identified a left heel diabetic ulcer measuring 3.5 cm long by 1.6 cm wide by 0.2 cm deep with total area of 5.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and no periwound erythema. Treatment instructions were unchanged.</p> <p>R3's corresponding Skin and Wound Evaluation dated 5/29/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, wound pain, and treatment sections were blank.</p> <p>R3's progress noted ate 5/30/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound care provider continued to follow and current treatment to continue. Plan of care was up to date.</p> <p>R3's wound care provider note dated 6/5/25, identified a left heel diabetic ulcer measuring 6.4 cm long by 1.5 cm wide by 0.2 cm deep with total area of 9.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged.</p> <p>R3's corresponding Skin and Wound Evaluation dated 6/5/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, pain, and treatment sections were blank.</p> <p>R3's progress note dated 6/6/25, indicated the IDT met to review R3's wound. Diabetic ulcer was stable with no signs or symptoms of infection. Wound care provider continued to follow with current treatment to continue. Plan of care was up to date.</p> <p>(continued on next page)</p>		

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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>R3's wound care provider note dated 6/12/25, identified a left heel diabetic ulcer measuring 7.3 cm long by 2 cm wide by 0.2 cm deep with total area of 14.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged.</p> <p>R3's corresponding Skin and Wound Evaluation dated 6/12/25, identified the wound's measurements and progress was stable. There was 100% granulation tissue, no ev[TRUNCATED]</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to maintain complete, accurate, and up-to-date medical records of administered wound care treatments for 1 of 3 residents (R1) reviewed for non-pressure related skin injuries.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) assessment dated [DATE], indicated she admitted to the facility on [DATE] with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R1 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment.</p> <p>R1's physician order with start date 5/14/25 and end date 5/15/25, directed to continue large wound VAC and dressing on right buttock wound, change Monday Wednesday and Friday, suction at 125 millimeters of mercury (mm Hg).</p> <p>R1's medication administration records (MAR) progress note dated 5/14/25, indicated the wound VAC was not changed as staff were waiting for the wound VAC.</p> <p>R1's progress note dated 5/15/25, indicated the wound VAC arrived and was placed on the right gluteal wound, wound provider present and assessed wound at that time.</p> <p>R1's physician order with start date 5/19/25, directed to continue wound VAC on right buttock wound, change Monday and Thursday, suction on 125 mm Hg.</p> <p>R1's progress note dated 5/23/25 at 10:50 a.m., indicated the wound VAC alarm went off at 6:30 a.m. Licensed practical nurse (LPN)-A found that the wound VAC device had failed and was unable to be reset, called the facility's medical supply company to obtain a replacement wound VAC, and was awaiting delivery. LPN-A removed the wound VAC dressing and replaced it with a wet-to-dry dressing until the new wound VAC could be applied.</p> <p>R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness.</p> <p>During an interview on 6/16/25 at 1:54 p.m., LPN-A stated R1's wound VAC failed on 5/23/25 and she changed the dressing to a wet-to-dry dressing and was not sure if there was a physician order to do so. However, had there been an order for the wet to dry dressing she would have documented the treatment as complete under the order on the treatment administration record (TAR). LPN-A stated the new wound VAC had not been delivered by the end of her shift on 6/23/25, so another nurse had changed the wet-to-dry dressing back to the wound VAC after it arrived.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/18/25 at 11:50 a.m., registered nurse (RN)-D stated she had worked with R1 when she went to the hospital on 5/24/25 and confirmed R1 left with her wound VAC dressing in place. RN-D stated R1's wound VAC had failed earlier and she had taken out the wet-to-dry dressing and put the new dressing and new wound VAC on that morning before R1 went to the hospital.</p> <p>R1's medication and treatment administration record (MAR/TAR) dated 5/1/25 through 5/31/25, included documented wound VAC dressing changes on the following dates: 5/19/25 and 5/22/25. R1's MAR/TAR lacked documentation of the following wound care treatments:</p> <ul style="list-style-type: none"> - Wound VAC dressing change on 5/15/25 by wound care provider - Wet-to-dry dressing change on 5/23/25 by LPN-A - Wound VAC dressing change on 5/24/25 by RN-D <p>During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound VAC malfunctioned on 5/23/25 and a wet-to-dry dressing was applied. RN-C confirmed R1's record lacked an order for the wet-to-dry dressing and documentation of the wet-to-dry dressing change on 5/23/25. RN-C stated there were issues with R1's wound vac dressing when she went to the hospital on 5/24/25, but she did not know who had placed the wound VAC dressing because the removal of the wet-to-dry dressing and replacement of the wound VAC dressing was not documented. In a follow-up interview on 6/18/25 at 10:41 a.m., RN-C stated she did not see any documentation that R1's dressing was changed with wound VAC reapplied prior to her hospital transfer on 5/24/25, though remembered R1 leaving with her wound VAC. She would expect this to be documented. RN-C noted that if transferred, a receiving provider would determine when a dressing was last changed based on the MAR/TAR, which wouldn't be correct if the treatments were not documented; medical record accuracy was needed to know what cares had been provided and what needed to be done. RN-C confirmed R1's medical record was not complete or accurate.</p> <p>During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated wound care treatments should be documented in treatment orders (TAR). The DON noted it was important for medical records to be complete and accurate because medical records act as a guide for providing patient care. He absolutely expected medical records to be complete and accurate.</p> <p>Facility policy regarding contents of medical records requested but not received.</p>		