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	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed revise the fall care plan to include individualized intervention (fall mat) for 1 of 3 residents (R4), who was reviewed for quality of care/treatment.Findings include:R4's face sheet identified diagnoses of downs syndrome (genetic disorder), dislocation of right shoulder, Alzheimer's and dementia, intellectual disabilities, and epilepsy (seizure disorder).R4's admission Minimum Data Set (MDS) dated [DATE], identified R4 had limited ability to make self understood or respond to others, had poor cognition, had no behaviors. R4 was dependent on staff for activities of daily living. R4 had a fall prior to admission.R4's care plan dated 9/15/25, identified R4 was a fall risk due to dislocation of right shoulder, epilepsy, Alzheimer's, and Down Syndrome. Interventions included follow therapy instructions for mobility function. Monitor and document on safety. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Remove any potential causes if possible.During an observation on 11/6/25 at 10:23 a.m., R4 was sitting up in bed with the head of bed elevated. R4 had a fall mat on the floor next to the bed.Review of R4's care plan did not identify interventions of a fall mat by bed to reduce the risk of injury from falls.During an interview on 11/6/25 at 10:30 a.m., nursing assistant (NA)-B stated R4 had the mat on the floor because she rolls out of bed. R4 had not rolled out of bed since being at the facility but better safe than sorry.During an interview on 11/6/25 at 1:47 p.m., registered nurse (RN)-I stated the floor mat for R4 is in case she fell. R4 had not fallen while at the facility. RN-I was not able to locate the intervention of the floor mat in R4's care plan.During an interview on 11/7/25 at 9:23 a.m., RN-J stated there was not a fall mat listed as an intervention in R4's care plan. Any member of the interdisciplinary team (IDT) could add interventions to the care plan, but the floor nurses were not able to add interventions to the care plan.The facility care planning policy revised 11/2024, identified each resident will have a person-centered care plan developed by IDT for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs

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

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	12/11/2025

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The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 3 residents (R3) was free from a significant medication error. This resulted in an Immediate Jeopardy (IJ) for R3 who was given the wrong dose of medication that resulted in hospitalization in the intensive care unit. The IJ began on 11/4/25 at 7:07 a.m. when R3 was administered the incorrect amount of 40 milligrams (mg) of methadone (a long-acting opioid pain medication) which was 16 times the prescribed amount of 2.5 mg. The administrator and director of nursing (DON) were notified of the IJ on 11/7/2025 at 1:50 p.m. The IJ was removed on 11/5/25 prior to the start of the survey and was therefore past noncompliance Findings include:The package insert for Methadone Hydrochloride informed while serious, life-threatening, or fatal respiratory depression can occur at any time during the use of Methadone Hydrochloride Tablets, the risk is greatest during the initiation of therapy or following a dosage increase. The peak respiratory depressant effect of methadone occurs later and persists longer than the peak analgesic (pain relieving) effect, especially during the initial dosing period. To reduce the risk of respiratory depression, proper dosing and titration (process of gradually adjusting the dose of a medication to find the optimal amount that provides the maximum benefit with the fewest side effects for an individual patient) of Methadone Hydrochloride Tablets are essential. Respiratory depression from opioid use, if not immediately recognized and treated, may lead to respiratory arrest and death. Management of respiratory depression may include close observation, supportive measures, and use of opioid overdose reversal agents. R3's admission Minimum Data Set (MDS) dated [DATE] indicated R3 did not have cognitive impairment. R3 was dependent on staff for activities of daily living (ADLs) and diagnoses including fracture of neck of right femur and Chronic obstructive pulmonary disease (COPD). R3's handwritten order dated 11/3/25 instructed: methadone 10mg/mL give 2.5mg (.4ml) via g-tube once daily Dx. [diagnosis] Pain. This order was written by registered nurse (RN)-F who was a hospice nurse. RN-F did not identify the correct number of mL for administration; the conversation 0.4 mL is equal to 4.0 mg of medication; 0.25 mL is the correct measurement to administer 2.5 mg of Methadone. In addition, the order was not written according to requirements by the Board of Pharmacy. The Minnesota board of Pharmacy undated document Requirements for a Valid Prescription instructed to use leading zeros for doses less than 1 measurement unit (example 0.3 mg never .3mg).During a phone interview on 11/7/25 at 8:48 a.m., RN-F stated on 11/3/25, when she arrived at facility, she was instructed to change all of R3's medication orders from tablets to liquid dosages. RN-F hand wrote all R3's medication orders on a facility order sheet and gave the orders to LPN-D. LPN-D handed the orders to RN-A around 2:00 p.m. on 11/3/25. RN-F stated the nurses' station at the facility was busy at the time and staff were doing change of shift report. Typically, RN-F would hand write all orders for the facility, transcribe all orders in an online system for her facility medical provider, and send the orders to the pharmacy. Since the transcription error on 11/3/25, RN-F's company changed the order writing process to include taking a screenshot of all handwritten orders and sending them to the medical provider, and education on transcribing orders.R3's transcribed order that was entered into the electronic health record on 11/3/25 at 3:11 pm by (RN)-A instructed: methadone oral concentrate 10mg/mL Give 4. ml via g-tube one time a day for pain. This was a difference of 3.6 ml of medication and equivalent to 40 mg of Methadone. R3's medication bottle sent from pharmacy instructed: Methadone bottle 10mg/mL Give one half (0.5) ml (5mg) per g-tube once daily. During an interview on 11/5/2025 at 1:57 p.m., pharmacist (Pharm)-A confirmed the order received from the provider that was escribed-that order was placed on the medication bottle: Methadone concentrate 10mg/mL Give one half (0.5) ml (5mg) per g-tube once daily. Pharm-A stated side effects from methadone could include sedation, drowsiness, respiratory depression, hypotension, and syncope. The half-life (the time it takes for the amount of the medication to decrease by half in the body) was 96 hours. R3's medication administration record (MAR) indicated LPN-A administered 4.0 ml of methadone 10mg/ml (40 mg) on 11/4/25 at 7:07 a.m.During an interview on 11/5/2025 at 12:45 p.m., LPN-A stated when she was getting ready to administer R3's medications on 11/4/25 around 7:00 a.m. she noticed the order in the MAR did not match the medication bottle. She administered the dose that was in the MAR (4 mL) because normally the orders in the MAR are the most current. LPN-A stated she should not have administered the medication and should have contacted the provider for clarification.During an interview on 11/5/2025 at 12:26 p.m., Hospice registered nurse supervisor (HRNS) stated a hospice nurse was at the facility on 11/4/25 around noon to see R3. She noticed he was sleepy and lethargic, which