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	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a baseline care plan to properly care for 1 of 3 residents (R2) reviewed for baseline care plan. Additionally, the facility failed to provide a summary of the baseline care plan to 1 of 3 residents (R2). Findings include: R2's admission Data Collection (nursing assessment) dated 2/16/26 at 12:50 p.m., indicated R2 had pain frequently over the past five days that made it hard to sleep at night and limited day-to-day activities. Pain was rated as moderate pain as a five (5) on a scale of 0-10. Nursing assessment indicated R2 had a wound on the coccyx described as, right butt has opening. R2's progress notes indicated on 2/16/26 at 3:18 p.m., R2 was admitted with a chronic stage IV (4) (full-thickness tissue loss with exposure of muscle, tendon, ligament, or bone) sacral ulcer. R2's Physical Therapy (PT) Evaluation and Plan of Treatment dated 2/17/26 (no time), indicated R2 had pain which interfered with functional activity and sleep. Nursing would address the pain. R2's provider progress note dated 2/17/26 (no time), indicated R2 rated pain at 5/10 on 2/16/26 at 1:31 p.m. R2's pain ratings included the following:2/16/26 at 1:31 p.m., pain rated as 5/102/18/26 at 7:17 a.m., pain rated as 6/102/18/26 at 3:29 p.m., pain rated as 8/102/18/26 at 3:31 p.m., pain rated as 8/10 R2's 48-Hour Care Plan (baseline care plan) dated 2/18/26, indicated R2 admitted [DATE]. R2's care plan indicated R2 experienced pain but failed to include interventions to relieve pain. The 48-Hour care plan indicated R2 was on Enhance Barrier Precautions (EBP) related to wounds but failed to include R2 had skin issues or interventions to treat the wounds. The 48-hour care plan failed to indicate if R2, or R2's family/representative was offered a copy of the 48-hour care plan or the opportunity to sign the 48-hour care plan. R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 admitted with pain that interfered occasionally with sleep, therapy, and day-to-day activities, with pain rated as 5/10 and a Stage III (full-thickness skin injury that extends into the subcutaneous fat but does not expose muscle, tendon or bone) pressure ulcer (PU). During an interview on 3/17/26 at 3:43 p.m., employee (E)- A stated if a resident had pain or pneumonia on admission, they should be addressed on the baseline care plan and there should be a plan for staff to follow to provide care. The resident should be offered a copy and an opportunity to sign the care plan. During an interview on 3/17/26 at 4:30 p.m., E-B stated a care plan was developed right away after admission, and should include pain, pressure ulcers, and skin checks with interventions that match the orders sent by the hospital. The residents should sign the care plan and is offered a copy. During an interview on 3/17/26 at 5:25 p.m., the director of nursing stated if a resident was admitted with pain and/or a pressure ulcer, inventions should be on the resident's 48-Hour care plan and the resident should be provided with a copy. Facility provided document, The Care Plans - Baseline policy dated 7/21/23, indicated the baseline care plan is used until staff can conduct a comprehensive assessment and develop an interdisciplinary person-centered care plan and should include any services and treatments to be administered by the facility.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and document review the facility failed to comprehensively develop and implement care plan interventions for 1 of 3 residents (R4) when R4 had poor nutritional intake with a diagnosis of malnutrition. Findings include:R4's admission Minimum Data Sheet (MDS) dated [DATE], indicated R4 admitted to the facility on [DATE], with intact cognition, required set-up assistance for meals, and diagnoses included pneumonia and malnutrition. R4's care plan dated 2/2/26, indicated a potential nutritional problem related to moderate malnutrition with interventions to assist with meal set-up, record nutritional intakes, take orders at meals and offer alternatives. The care plan failed to include interventions for when R4 did not eat meals as well as direction when to offer nutritional supplement that was ordered. During an observation and interview on 3/13/26 at 12:56 p.m., R4 independently drank fluids from her glass, drank her fruit cup instead of using utensils, and ate a few bites of the fish from her plate with her fingers. R4 did not eat the rest of her meal that included pasta and a vegetable. R4 stated she did not like her meal, it was fish but didn't taste like fish. During an observation and interview on 3/13/26 at 1:21 p.m., E-G entered R4's room, asked if R4 was done eating. R4 replied she was done. Employee G removed R4's tray. E-G stated R4 ate about 10% of her noon meal. E-G was aware R4 disliked the facility food. E-G stated when residents didn't eat, staff should offer an alternative food choice or ask if the resident required assistance to eat. E-G acknowledged she did not do either. E-G stated she should look at the care plan for how a resident eats, or for their food preferences, but had not done this for R4 and stated the nurse managers were responsible to update the care plans. During an interview on 3/13/26 at 2:20 p.m., E-H stated R4 ate about 50% of her noon meal and she charted it in R4's medical record. E-H acknowledged she had not removed the tray from R4's room and had not seen R4 eat, but 50-75% was what R4 typically ate. E-H further acknowledged charting R4 ate 50% of the noon meal was not accurate, the amount R4 actually ate was about 25%. E-H stated typically staff would offer to help a resident eat or offered an alternative food choice if the resident did not eat well. E-H acknowledged she had not done this. On 3/17/26 at 9:00 a.m., upon review of R4's care plan, the care plan was not updated with interventions for what to do if R4 did not want to eat, nor with food preferences. During interview on 3/17/26 at 3:01 p.m., R4 stated she didn't think staff had ever asked her about her food preferences. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated R4's noon meal charted on 3/13/26, indicated R4 ate 50-75% of her meal. The DON stated if a resident does not eat well, staff should ask the resident if they didn't like the meal, offer something else and if the appetite has declined, notify the nurse, dietician, and provider. In addition, DON expected more monitoring was put place for the resident. DON acknowledged this was not done for R4. DON expected interventions were in the care plan. The Care Planning Policy dated 11/2024 indicated the comprehensive care plan was used to develop the resident's daily care routines and was utilized by staff for the purposes of providing care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure pressure ulcer prevention interventions were utilized as ordered for residents at risk of developing pressure ulcers for 2 of 3 residents (R1, R4) reviewed who were at risk for pressure ulcers.Findings include: R1 R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 was severely cognitively impaired, at risk for pressure ulcers and used pressure reducing devices for her chair and bed. R1's diagnoses included a brain tumor, difficulty speaking, diabetes, and paralysis on the right, dominant side. R1's care plan dated 11/6/25, directed to float heels with pillow and turn and reposition every two-to-three hours and as needed (PRN). R1's care plan lacked an update or mention of precautions to prevent friction and sheer, although the progress notes indicated that risk. R1's provider orders dated 11/10/25 indicated weekly skin inspection by licensed nurse. R1's progress notes indicated the following:11/20/25 at 2:47 p.m., makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Friction and Shear is a potential problem.12/2/25 at 2:15 p.m., order placed for air mattress to prevent skin breakdown. R1's hospice progress notes indicated the following:11/28/26 at 4:16 p.m., poor skin turgor (reduced elasticity in skin making it more vulnerable to damage) and anasarca (severe, total-body swelling that severely compromises skin integrity and potential breakdown)12/1/25 at 11:11 a.m., patient's son had nurse speak to facility about making sure they reposition and place patient on their side, checked coccyx to ensure there is no skin breakdown; there is none During an interview on 3/18/26 at 8:30 a.m., family member (FM)-A, who returned a call that was placed on 313/26 at 10:08 a.m., stated staff's version of turning R1 was putting a towel under the shoulder, and when hospice staff came, they [hospice] turned R1 correctly. During an interview on 3/17/26 at 3:43 p.m., Employee (E)-E stated a resident could not be positioned properly with a towel, but instead staff used pillows. A resident would not stay in position with only the support of a towel. R4 R4's admission MDS dated [DATE], indicated intact cognition, risk for pressure ulcers and used pressure reducing devices for her chair and bed. R4's diagnoses included malnutrition, pneumonia, and respiratory failure. R4's provider orders dated 2/24/26, indicated apply TED hose (Thrombo-Embolism-Deterrent compression stockings used to reduce swelling in the legs in the presence of edema), every day shift for edema. Provider orders dated 3/6/26, indicated apply ACE wraps on in the morning and off at bedtime to help manage swelling. R4's provider note dated 3/17/26, indicated 3+ (three-plus- a clinical grading of pitting edema) (moderate-to-severe pitting edema, where significant fluid retention leaves a deep, prolonged indentation after pressure is applied) edema in lower extremities. R4's progress notes indicated the following:3/10/26 at 1:57 p.m., indicated a 10 pound weight gain over a month, with legs that looked quite edematous, and wearing compression stockings.3/17/26 at 10:46 a.m., discussion with daughter related to weight gain, and new order for compression to bilateral lower extremities to assist with edema.3/17/26 at 4:42 p.m., weight remains elevated due to edema and fluid retention R4's care plan dated 2/2/26, indicated turn and reposition and offload (reduction or redistribution of pressure on a specific area) every 2-3 (two-to-three) hours and as needed. During continuous observation and interview on 3/13/26 from 11:52 a.m., to 2:20 p.m., R4 was lying in bed on her back, with the head of bed raised, feet resting on a pillow, and a pillow resting on top of her feet at the base of the bed. At 2:20 p.m., staff entered the room to assist R4 to reposition. R4 was not wearing TED hose or ACE wraps as ordered. During an interview on 3/13/26 at 2:14 p.m., E-K stated R4 required assistance to reposition and to move up in bed, and staff was supposed to do that every two hours as R4 could turn a little bit on her own, but needed help. At 1:55 p.m., R4 stated her feet were still on the pillow and she didn't know why there was a pillow laying on her legs, but it felt heavy on them. During an observation and interview on 3/13/26 at 2:20 p.m., E-H, a licensed nurse, acknowledged R4's feet and legs had a lot of swelling, and the top R4's socks were making indentations in R4's feet. E-H stated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4 was at risk to get sores from the socks being too tight. R4's heels were directly on a pillow instead of floated off the bed, and the E-H acknowledged R4's heels were on the pillow instead of floated, and was not wearing TED hose but should have been. The Employee E stated she put the pillow on R4's feet when she repositioned R4 in the morning and forgot to remove it. E-H did not reposition R4's lower extremities to float the heels, did not remove the socks or apply the TED stockings before leaving the room. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated pressure ulcer prevention included a turning and repositioning program, incontinence care, floating heels, padding bony prominences and using an air mattress. The DON stated offloading pressure from heels meant putting a pillow under the legs, with the heels off the pillow so the heels were floating. The Skin Assessment and Wound policy dated 2/2025, indicated the facility would implement appropriate preventative skin measures including a mobility and repositioning plan and pressure redistribution plan. The facility would update the care plan to identify risks for skin breakdown.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide safe transfers for 1 of 3 residents (R5) when one staff transferred R5 with an EZ Stand (mechanical lift used to move a person who can bear weight from one surface to another) but required assistance of two staff with an EZ Stand for safe transfers. Findings include: R5's annual Minimum Data Set (MDS) dated [DATE] indicated intact cognition, dependence on staff for all transfers, and diagnoses that included heart failure and morbid obesity. R5's care plan dated 6/3/24, indicated R5 required assistance of two staff transfers with the EZ Stand and was at risk for falls related to impaired mobility. The care plan dated 9/3/24, indicated care in pairs. R5's orders dated 2/10/26 indicated care in pairs. R5's provider notes dated 3/11/26, with no time, indicated R5 weighed 543 pounds. During an observation on 3/13/26 at 11:47 a.m., R5 ?s door was closed, and then opened by nursing assistant (NA)-A who was in the room alone with R5. R5 thanked NA-A for helping her out of bed, and NA-A exited the room with an EZ Stand. No other staff left R5's room or was in the area of R5's room. During an interview on 3/13/26 at 11:49 a.m., R5 stated only NA-A helped her up with the EZ Stand, and stated staff used one person instead of two when staff couldn't find another person to assist with the two-person transfer. During an interview on 3/13/26 at 12:41 p.m., Employee (E)-J stated R5 transferred with an EZ Stand with two staff for safety. E-J stated all residents who transferred with any mechanical lift required two staff for transfers. During an interview on 3/13/26 at 2:14 p.m., NA-A acknowledged she transferred R5 without assistance from another staff with the EZ Stand even though she was supposed to use two staff for safety. The NA-A stated she could not find another staff to help her with the transfer but should have waited until another staff was available and was aware R5 was supposed to have care in pairs due to past allegations against staff. Further, NA-A stated she could get in trouble for using one staff, and the resident or she could be injured without another staff to assist with R5's transfers with the EZ Stand. During an interview on 3/17/26 at 4:30 p.m., E-D stated R5 transferred with an EZ Stand, and always with two staff for safety. E-D stated if only one was staff assisted R5 with the EZ Stand transfer, R5 could fall, break their legs, or break their necks, or the staff could be injured. E-D stated if she witnessed staff doing an EZ Stand transfer independently with R5, E-D would educate that staff about how to do the transfer safely. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated all mechanical lifts in the facility required two staff for safe transfers, and a NA or other trained employee, can ask a nurse, nurse manager, call the DON, or can wait for help when the NA needs another person to help with safe transfers. The Fall Prevention and Management policy dated 11/2025 indicated staff would identify and implement relevant interventions to try to minimize serios consequences of falling.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to sufficiently manage pain or offer non-medication pain management interventions for 1 of 3 residents (R2) reviewed for pain management. R2's admission Data Collection (nursing assessment) dated 2/16/26 at 12:50 p.m., indicated R2 had pain frequently over the past five days that made it hard to sleep at night, limited day-to-day activities, and affected sleep, rated as moderate pain at five (5) on a scale of 0-10. R2 received scheduled and as needed (PRN) pain medication and non-medicine interventions to relieve pain. R2's Physical Therapy (PT) Evaluation and Plan of Treatment dated 2/17/26, (no time) indicated R2 had pain that interfered with functional activity and sleep, and nursing would address the pain. R2's provider progress notes dated 2/17/26, (no time) indicated R2 rated pain at 5/10 (five out of ten) on 2/16/26 at 1:31 p.m. R2's provider orders indicated the following:Lidocaine external patch 4%, apply to painful site topically one time a day for pain starting 2/21/26Oxycodone-acetaminophen (Percocet - a narcotic pain medication used to treat moderate to severe pain) oral tablet 10-325 milligrams (mg), give one tablet by mouth every six hours as needed for pain, ordered 2/18/26 at 6:00 a.m. R2's pain ratings included the following:2/16/26 at 1:31 p.m., pain rated as 5/102/18/26 at 7:17 a.m., pain rated as 6/102/18/26 at 3:29 p.m., pain rated as 8/102/18/26 at 3:31 p.m., pain rated as 8/102/19/26 at 2:25 a.m., pain rated as 8/102/19/26 at 10:13 a.m., pain rated as 7/102/19/26 at 2:42 p.m., pain rated as 5/102/20/26 at 3:33 p.m., pain rated as 6/102/20/26 at 11:37 p.m., pain rated as 9/102/21/26 at 8:02 a.m., pain rated as 5/102/21/26 at 2:11 p.m., pain rated as 5/102/22/26 at 9:35 a.m., pain rated as 5/102/22/26 at 6:42 p.m., pain rated as 6/102/23/26 at 7:27 a.m., pain rated as 6/10 R2's nursing progress notes and February 2026 Medication Administration Record (MAR) indicated the following:2/16/26 at 3:31 p.m., R2 admitted and indicated pain was rated as 5/10. The note lacked mention of what pain interventions were provided.2/17/26 at 9:45 am., R2 requested pain medications as she was on long-term opioids but came with no orders for pain medications. Pain provider updated and awaiting new orders.2/18/26 at 7:17 a.m., first dose of Percocet was administered.2/19/26 at 4:57 a.m., the medication was noted as effective, but lacked mention of other non-medication pain interventions tried before use of opioid.2/20/26 at 3:33 p.m., Percocet was administered for pain rated as 6/10 per the MAR; the progress notes lacked mention of non-medication pain relief interventions tried.On 2/20/26 at 11:37 p.m., Percocet was administered for pain rated as 9/10 per the MAR; the progress notes lacked mention of non-medication pain relief interventions tried.The progress notes lacked mention of non-medication interventions for pain with any of the administration of Percocet doses. R2's 48-Hour Care Plan (Baseline Care Plan) dated 2/18/26, indicated R2 admitted [DATE], with pain but lacked interventions to relieve pain. R2's care plan dated 2/18/26, indicated an alteration in comfort with interventions that included provide non-medicinal forms of pain relief such as positioning, rest, and massage. R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had intact cognition and admitted with pain that interfered occasionally with sleep, therapy, and day-to-day activities, with pain rated as 5/10. During an interview on 3/13/26 at 10:53 a.m., R2 stated when she arrived she was told, by nursing, she didn't have an order for her usual pain medication, Percocet. R2 stated she had a history of seizures when her pain wasn't managed. R2 stated her pain wasn't greater than it was before but was afraid it could be without the Percocet and she was typically in a lot of pain related to her diagnosis of transverse myelitis (a neurological disorder caused by inflammation around the spinal cord resulting in pain, muscle weakness, paralysis, sensory alterations and bowel and bladder dysfunction). During an interview on 3/17/26 at 4:20 p.m., Employee (E)-C stated when residents arrived from the hospital, the care plan was developed, and pain interventions should be on the care plan. E-C stated if a resident reported pain, the nurse would do an assessment, determine the location of the pain, check vital signs, inform the provider immediately, and the nurse would chart the assessment in the progress notes. Staff would use (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-medication interventions, like position change or distraction until the medication came. If the resident didn't admit with a prescription, the nurse would call the provider to get a prescription, and the medication could be obtained from the medication bank as soon as the pharmacist had the prescription. The resident could have the medication as soon as the provider sent the prescription. During an interview on 3/1726 at 4:30 p.m., E-D stated the facility had standing orders for Tylenol that can be offered to a resident for pain, and if the resident required a narcotic medication, the nurse could call a provider to get an order. Staff can try rest, reposition, music, snack, a conversation, and ice for pain relief before using an opioid and would document the interventions that worked. E-D acknowledged she did not see documentation of non-medication interventions attempted for R2. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated if a resident did not have pain medications upon admission, and experienced pain rated as 5/10, staff would offer Tylenol per the standing orders and perform a thorough pain assessment and then contact the pain provider team. The pain team can send an e-prescription to the pharmacy, and then nurses can get a code from pharmacy to get the prescription from the medication bank. The nurses were expected to try non-pharmacological interventions and document them. Further, the DON stated a resident may have overall deterioration in their condition from having pain, the resident may be unhappy, blood pressure and heart rate may elevate, and the resident may not want to eat. The DON expected nurses to document the assessment, interventions, and the resident's response to the interventions, and acknowledged that process was not followed for R2. The Pain Management Protocol dated 3/23/23, indicated residents with pain or at risk of pain have an effective pain management plan in place. The interdisciplinary team performs an assessment of the residents' diagnoses and conditions that commonly predispose to pain and reviews current medications and treatments, including non-pharmacological treatments. The nurse would assess the resident upon admission, and with input from the resident, the provider and staff establish goals of pain treatment. Staff document history of pain and its treatment. If there is a delay in obtaining pain medication, the provider is notified, and alternative medications or interventions would be obtained to meet the resident's pain management needs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure nurses were timely and competently trained on medication administration for 1 of 3 residents (R1) reviewed with specific orders for administration of oral medication. Findings include: R1's diagnoses list dated 11/4/25, indicated diagnoses that included cancer of the frontal lobe of the brain. R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 was significantly cognitively impaired, was dependent upon staff for activities of daily living, had complaints of difficulty or pain with swallowing, and received scheduled and as needed (PRN) pain medications. R1's hospice progress notes indicated the following:12/5/25 at 3:05 a.m., indicated a facility nurse contacted the hospice provider to request all medications be discontinued because R1 was having difficulty swallowing, and indicated R1 had Synthroid and morphine. The hospice provider provided education about lorazepam (medication used to manage anxiety and agitation) and morphine (pain medication used for moderate to severe pain) being comfort medications and advised it was ok to administer morphine.12/5/25 at 9:54 a.m., indicated R1's family requested the facility administer the morphine and lorazepam as a slurry (fluid mixture of medication in water designed for faster absorption)12/5/25 at 10:08 p.m., indicated R1 passed away on 12/5/26 at 8:50 p.m.12/8/25 at 10:20 a.m., documentation for 12/5/25, report from on-call triage and RNCM (registered nurse case manager) that facility staff require education on medication administration. Staff were providing solutab (form of medication which dissolves quickly and absorbs in the mouth without swallowing) comfort medications using applesauce that was draining out of patient's mouth, unable to swallow. Also reported that facility staff called to request to discontinue comfort medications due to inability to swallow, did not know that medications dissolve in mouth without swallowing. Facility nurse managers were updated about the concerns. R2's provider orders indicated the following:12/5/25 at 10:00 a.m. lorazepam soluble, give 0.5 milligrams (mg) every 4 hours PRN12/5/25 at 12:00 p.m. morphine solutab, give 5 mg every 6 hours for pain or shortness of breath12/5/25 at 10:00 p.m., indicated OK to slurry morphine and Ativan solutab in small amount of water and give sublingual. R1's Grievance Form - Medication Issue dated 12/10/25, indicated the facility received a call from R1's hospice provider who stated R1's son expressed concern about medication administration related to sublingual (medication administered under the tongue to dissolve and enter the bloodstream through the mucous membranes) medication. The Grievance Form indicated the son wanted staff to administer the medication in a slurry, and the order was obtained. Staff attempted to educate the son on sublingual medication, but son still felt medication needed to be given with water. A facility meeting PowerPoint presentation dated 12/15/25, indicated hospice medication administration related to solutabs, liquids, medication directions, and slurry. The content of the education regarding the definition of a slurry and how to make a slurry was not included on the PowerPoint presentation. During an interview on 3/18/26 at 8:30 a.m., (attempted to call 3/13/26 at 10:08 a.m., and 3/17/26 at 8:58 a.m., a call back was received on 3/18/26), family member (FM)-A stated he saw staff attempt to administer the morphine solutabs, and tried to get R1 to swallow the solutabs several times. R1 would cough and gurgle and, Seeing someone choke for 10-15 seconds each time is hard to see. FM-A stated he informed the hospice provider, who, had several conversations with staff about how to give the medication. During an interview on 3/17/26 at 3:43 p.m., Employee (E)-E, a licensed nurse, stated she did not know what a sublingual medication was and stated, That's a liquid, right? E-E further stated she did not know what a medication slurry was. E-E stated sublingual medication, if swallowed, would not harm the resident because the resident would still get pain relief, but just not work as well as it would if it was administered sublingually. During an interview on 3/17/26 at 4:20 p.m., E-F, a licensed nurse, stated she did not know what a slurry was and was not familiar with the term. During an interview on (continued on next page)

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	03/17/2026

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/17/26 at 4:30 p.m., E-D, a licensed nurse, stated she did not know what a slurry was. E-D stated for R1 there was an order to slurry meds and give sublingually, and further stated, I have them swallow it for hospice patients, and further stated if a resident swallowed a sublingual medication, It dissolves. During an interview on 3/17/26 at 5:25 p.m., the director of nursing (DON) stated a slurry was made by mixing a solutab with 5-10 cubic centimeters (cc) of water and is administered by placing it under the tongue; it was not swallowed. The DON stated hospice came to the facility to provide education about that in December, 2025. A policy about pain management was provided, but did not contain information about how to administer sublingual or slurried pain medications.A medication administration policy was requested but not provided.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and document review, the facility failed to ensure medications were stored securely in areas where residents, staff and guests could not access medications in 1 of 1 medication carts observed, potentially affecting one unit, Unit 400, of the facility. Findings include: During observation and interviews on 3/13/26 at 12:27 p.m., Employee (E)-I walked away from the medication cart, leaving it unlocked in the hallway of the 400 unit, stationed between resident rooms. At 12:31 p.m., the Director of Social Services (DSS)-A walked by the cart and pulled on the locked narcotics drawer. The DSS-A stated she was making sure the drawer was locked and then walked away. The cart remained unlocked and unattended until 12:37 p.m., when E-I returned to the cart. From 12:27 p.m. to 12:37 p.m. one resident wheeled by the cart, and two nursing assistants (NA) walked by the unlocked cart. E-I acknowledged the medication cart was unlocked when she left but should have been locked when she stepped away. Further, E-I stated the cart was supposed to be locked to ensure other staff and residents could not take medications from the cart, which could make them sick. During an interview on 3/17/26 at 3:43 p.m., E-E stated if she walked away from a medication cart, it had to be locked. During an observation and interview on 3/13/26 at 2:27 p.m., the medication cart in the hallway of the 400 unit, stationed between resident rooms was found unlocked and unattended. From 2:27 p.m., to 2:47 p.m., NAs walked by the unlocked cart five times. At 2:47 p.m., the director of nursing (DON) walked by the cart and pushed the lock to lock the medication cart and stated it was not good that the cart was unlocked, medications could go missing, and the cart was supposed to be locked when staff walked away from the cart. The Storage of Medications policy dated May 2022 indicated the medication supply was accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. Medication carts were locked when not attended by people with authorized access.