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	05/15/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a developed skin rash was assessed and treatment initiated timely to promote healing for 1 of 4 residents (R4) reviewed for non-pressure skin conditions. Findings include: A Vulnerable Adult Maltreatment Report, dated 4/2026, identified multiple concerns with the care provided to R4 while at the care center. This included, [R4] has diaper rash that is not being treated and 'it is so bad. R4's admission Minimum Data Set (MDS), dated [DATE], identified R4 had severe cognitive impairment and several medical conditions including diabetes mellitus. Further, the MDS outlined R4 demonstrated no rejection of care behaviors and had no current skin issues (i.e., wounds, incisions). R4's Care Plan Report, dated 4/10/26, identified R4 had diabetes, malnutrition, used a Foley catheter, and was at risk for skin alterations. The care plan listed a goal for his skin to remain free of breakdown along with interventions which included positioning him with pillows to protect his bony prominences, using pressure-reducing mattress and cushions, keeping the skin clean and dry, and inspecting the skin daily with routine cares. R4's MHM (Monarch Healthcare Management) Weekly Skin Inspection V-6, dated 4/10/26, identified R4 had a shower. A section labeled, Skin Summary, identified R4 allowed the skin check to be completed, along with recorded findings that read, . has GT [g-tube] site to LLQ [left lower quadrant], no other skin issues noted. R4's MHM Weekly Skin Inspection V-6, dated 4/17/26, identified R4 again had a shower and allowed a skin check. The summary recorded, . has a rash to left buttock and groin area. provider [sic] updated. There was no additional assessment of this developed skin condition or evidence of what, if any, treatment was done for the site at the time. R4's MHM Weekly Skin Inspection V-6, dated 4/24/26, identified R4 again had a shower and allowed the skin check. The summary recorded, . has mild rash to left buttock area. Provider notified. However, again, the form lacked any additional assessment of this developed skin condition or evidence of what, if any, treatment was done for the site at the time. R4's entire medical record, which included progress notes and Treatment Administration Record (TAR), lacked evidence that the developed skin rash identified on the weekly inspections was assessed to determine potential causative factors, nor evidence any treatment for it was ever implemented. R4 then discharged from the care center on 4/26/26 to the acute care hospital for elevated blood glucose levels. On 5/15/26, a telephone call was attempted with R4's family member (FM) to discuss his care while admitted to the care center. However, they were unable to be reached. When interviewed on 5/15/26 at 9:47 a.m., nursing assistant (NA)-A stated they recalled working with R4 and described him as needing total care for most activities of daily living (ADL) and had episodes of bowel incontinence but was able to use the commode with assistance. NA-A stated the NA staff will usually check skin on all residents when they do morning cares and then report concerns to the nurses. They did not recall R4 ever having a skin issue or rash and thought they had applied some barrier cream (skincare products designed to help support the skin's natural moisture barrier) to his bottom at times because they do that for most residents. NA-A stated these applications of the cream would not be documented as we use it on almost all residents.When interviewed on 5/15/26 at 10:17 a.m., registered nurse (RN)-A explained the nurses' do a weekly skin check on each resident and record it on the Weekly Skin Inspection form in the record. If a new rash is (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified, then it should be documented and the nurse manager and medical provider updated. The nurse manager or leadership would then address it further. RN-A stated they recalled working with R4 and described him as being diabetic and using a tube feeding. RN-A did not recall R4 ever having a skin issue or rash though adding aloud, I'm not sure about that. RN-A stated any performed skin treatments, including use of barrier cream, should be recorded on the TAR or in the progress notes. RN-A added, You chart it. On 5/15/26 at 11:18 a.m., the director of nursing (DON) was interviewed and verified they had reviewed R4's medical record. DON explained if a new skin issue, such as a rash, was identified then it should be measured, documented in the record, and the medical provider updated, along with ongoing monitoring placed on the MAR/TAR. DON verified they were unable to locate evidence the provider ever wrote any treatment orders for R4's skin rash, including in the outside Med Line application. DON acknowledged the lack of an assessment related to the developed rash, and subsequent treatment in the medical record. The DON expressed it seemed to be a breakdown in the system. DON stated they would start some education with the nurses about the process for a newly identified skin impairment, as it was important to ensure skin issues were identified and acted upon quickly so we can heal the skin issue, and it doesn't get worse. The facility Skin Assessment & Wound Management policy, dated 2/2025, identified a section labeled, Non-Pressure Wounds and Altered Skin Integrity, along with directions that when a significant alteration in skin integrity was identified to notify the provider, complete education with the resident/family, initiate a skin and wound evaluation, place referrals if needed, and review/update the care plan.