DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 8, 2026

Administrator
VILLAS AT BRYN MAWR LLC
275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

RE: CCN:245203

Cycle Start Date: June 17, 2026

Dear Administrator:

On June 17, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 17, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 17, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Administrator
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275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

Re: State Nursing Home Licensing Orders
Event ID: 231C8B-H1

Dear Administrator:

The above facility survey was completed on June 17, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS AT BRYN MAWR LLC	275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 6/14/26-6/17/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/29/2026
F0000	INITIAL COMMENTS On 6/14/26-6/17/26, a standard recertification survey (S5203038-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H#: H52032936C / iQies: 3043755 H#: H52032861C / iQies: 3020799 H#: H52032862C / iQies: 2992528 H#: H52032863C / iQies: 2981125 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		07/29/2026

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 reverse for further 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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F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to immediately report incidents of potential resident-to-resident abuse to the state agency (SA) within two hours, as required for 2 of 2 residents (R64, R116) reviewed for abuse. In addition, the facility failed to ensure allegations of potential abuse were reported to the state agency (SA), within 2 hours, for an injury of unknown cause resulting in a fracture for 1 of 1 residents (R80) whose allegations were reviewed. Further, the facility failed to ensure timely reporting of self-neglect for a missing resident for 1 of 1 resident (R7) reviewed who left the building and did not return and whose whereabouts were unknown. Findings include: R64 R64's quarterly Minimum Data Set (MDS) dated	F0609	F609: Reporting of Alleged Violations Immediate Corrective Action: Resident to resident altercation between R64 and R116 was reported to the state agency and 5-day investigation was completed. On call management educated on timely reporting regarding fracture of unknown origin. MAARC report filed for Resident 7 on 6/17/26. Corrective Action as it applies to others: Abuse policy education completed with all staff regarding reporting timelines. Education to social services and nursing regarding filing a missing person report after no contact with the resident for 24 hours. Education to social services and nursing leadership regarding filing a MAARC report within 24 hours of discharge date. If the family member/guardian/next of kin requests a missing person report earlier, that request will be accommodated. Recurrence will be prevented by: Admin and/or DON will audit progress notes daily for potential reportable incidents, missing persons, and AMA discharges. RDO/RNC will audit Admin/DON to ensure proper timelines are reported for any state agency reports weekly x 4 weeks. Admin/DON will audit all LOAs daily to ensure missing person reports are filed timely and MAARC reports filed timely if needed.	07/29/2026

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F0609 SS = E	Continued from page 2 4/21/26, indicated R64 had intact cognition, was diagnosed with depression and bipolar disorder, and was independent with all activities of daily living (ADLs). R64's email communication to the administrator dated 6/13/26 at 1:22 p.m., indicated R64 wrote to the administrator and the substance use disorder services director (SD) that R116 had come up to his unit and was telling other residents that he (R116) intended to fight him (R64). R64 then wrote that given the physical threats made against him, he was "increasingly concerned" about his safety. The administrator responded at 1:27 p.m. and indicated they would call the nurse back and let them know what was happening. At 2:19 p.m., the administrator advised R64 to stay on his current unit and not go to the substance use disorder unit and let staff at his current unit know if he had any issues. R64's medical record was reviewed and lacked an indication that R64's allegations of resident-to-resident abuse was reported to the SA. R116's admission MDS dated 6/8/26, indicated R116 had intact cognition, was diagnosed with depression, and was independent with transferring and walking. R116's progress note dated 6/15/26 at 4:50 p.m., indicated R116 was on 15-minute safety checks related to a "verbal altercation" with another resident. R116's medical record was reviewed and lacked an indication that R64's allegation of abuse involving R116 was reported to the SA. During an interview on 6/15/26 at 2:43 p.m., R64 stated that he had a verbal altercation with R116 last Friday. R64 stated that R116 had threatened him and called him vulgar names, but he did not believe any staff had seen the incident. R64 stated that on Friday he had also moved from the substance use disorder unit to a different unit. R64 stated he had then heard that R116 intended to fight him, so he had emailed the administrator because he feared for his safety. R64 stated that although other residents had talked with R116 over the weekend, he had not seen R116 since Friday. During an interview on 6/15/26 at 3:24 p.m., the administrator stated that the allegation that R64 had emailed her on 6/13/26 had not been reported as R64 was very "grandiose," but she had put interventions in place to ensure his safety. During an interview on 6/16/26 at 10:35 a.m., licensed practical nurse (LPN)-C stated that he had	F0609	Continued from page 2 Quiz 5 staff members weekly x4 weeks regarding reporting timelines, reportable incidents. LOAs/missing persons and AMA discharges. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee and/or DON/designee Date of Compliance: 7/29/26	07/29/2026

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F0609 SS = E	Continued from page 3 been working the substance use disorder unit, that R64 had previously resided in and R116 currently resided in, this Saturday. LPN-C stated R64 was moved off the substance use disorder unit when R64 had been the aggressor in a resident-to-resident verbal altercation. LPN-C stated that as a precaution after the incident, facility staff were to assure R64 and R116 stayed on their respective units. LPN-C stated that if the resident reported abuse or he witnessed it, he would report this to the director of nursing (DON), administrator, or the manager on duty, and they would be in charge of reporting it. LPN-C stated that the administrator had been aware of this altercation between R64 and R116. R80 A submitted SA incident report, dated 6/14/26 at 6:30 a.m., identified an allegation of “unexplained injury” and “self-neglect” was being submitted for R80. An incident dated 6/13/26 at 7:00 a.m. was listed, which identified “resident was in pain and sent out to the hospital and returned with fracture.” Further in the report, it identified R80 called 911 himself on 6/12/26 complaining of pain and was sent to the hospital about 1 p.m. R80’s admission Minimum Data Set (MDS) assessment dated 3/29/26, identified R80 had intact cognition with no hallucinations or delusion, and was dependent on staff for all activities of daily living (ADLs) including bed mobility and transfers. R80’s care plan, printed 6/17/26, identified R80 transferred with assist of full lift (Hoyer lift-mechanical lift used for people who cannot bear weight) and assist of 2 staff. In addition, R80 was identified as a vulnerable adult while residing at the nursing facility and at risk for decreased cognitive and physical ability related to diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis and muscle weakness affecting the left side of the body following a stroke-blood clod in the brain) and aphasia (impairs ability to speak, write and understand both spoken and written language). R80’s progress notes, 6/12/26 to 6/13/26, were reviewed and identified the following. -6/12/26 at 1:34 p.m.: R80 called 911 due to leg pain and requested transportation to hospital	F0609		07/29/2026

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F0609 SS = E	Continued from page 4 -6/13/26 at 7:01 a.m.: R80 was sent to the hospital on 6/12/26. The note included a diagnosis of closed fracture of proximal end of the left fibula, unspecified fractur morphology and “the fibular head is noted to have a fracture.” R80 was to wear immobilizer for 6-8 weeks with recommended follow up with ortho in 2 weeks. -6/13/26 at 7:02 a.m.: addendum to the note above: R80 returned from the hospital on 6/12/26 at 7:00 p.m. -6/13/26 at 2:24 p.m.: R80 returned with documentation that reported a fracture. R80 denied any recent fall, injury or abuse. R80 reported pain to his left leg but “denies any injury.” Administrator notified. The progress notes lacked an entry of when R80 returned from the hospital and who was notified upon return. During an interview on 6/16/26 at 12:50 p.m., registered nurse (RN)-F stated they had been working the day after R80 returned from hospital (6/13/26) and had questioned the paperwork the facility had received when he returned from the hospital. RN-F stated she called the hospital to get additional information and was sent the x-ray results. RN-F stated the paperwork from the hospital had been reviewed upon from the hospital as it had passed on in report. Surveyor attempted to reach licensed practical nurse (LPN)-E on called 6/17/26 at 8:28 a.m. but unable to reach to follow up if they had notified management of fracture of unknown origin upon R80 returning from the hospital. Did not return call. During an interview on 6/17/26 at 9:12 a.m., licensed practical nurse (LPN)-D stated if a resident returned from the hospital with a fracture with unknown cause would be something that should be reported to the supervisor right away. LPN-D stated they would have to investigate what happened and report it to the state. On 6/17/26 at 10:18 a.m., director of nursing (DON) stated fractures of unknown causes would be reportable to the state agency. During an interview on 6/17/26 at 11:12 a.m.,	F0609		07/29/2026

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F0609 SS = E	Continued from page 5 administrator reviewed the timelines of the incident and the report. Administrator verified she should have reported the incident to the SA within 2 hours. A facility policy titled Abuse Prohibition/Vulnerable Adult Policy, dated 11/25/, identified the following: -Incidents to be Reported; section e. “Injuries of unknown source - an injury should be classified as an "injury of unknown source." When both of the following conditions are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and, b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is in an area not generally vulnerable to trauma), or the number of injuries observed at one point in time or the incidence of injuries overtime.” Furthermore, the policy indicated: “How and when to report to the Minnesota Department of Health (MOH)/ Office of Health Facility Complaints (OHFC) 1. Suspected Abuse shall be reported to OHFC online reporting process not later than 2 hours after forming the suspicion of abuse. 2. Suspicion of Neglect, Exploitation, or Misappropriation of resident property must be reported to OHFC online reporting process not later than 2 hours if the incident resulted in serious bodily injury.” R7 R7’s quarterly Minimum Data Set (MDS) assessment dated 5/5/26, identified R7 had intact cognition and had impaired on both upper and lower extremities on one side. The MDS indicated R7 was independent with eating, hygiene, dressing, toileting, and ambulated using a cane or wheelchair. The MDS indicated active discharge planning for return to	F0609		07/29/2026

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VILLAS AT BRYN MAWR LLC	275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405

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F0609 SS = E	Continued from page 6 community was not occurring, and R7 did not have a history of wandering. R7's Medical Diagnosis list reviewed 6/17/26, included stroke affecting the left side, schizophrenia, post-traumatic stress disorder, opioid abuse, depression, alcohol dependence, and difficulty swallowing. R7's care plan interventions dated 1/20/26, identified R7 needed 1 assist with toilet use for BM (bowel movement) and assist of 1 with ambulation with left side weakness. Interventions dated 1/21/26, included assist of 1 with grooming, bathing and dressing. In addition, a care plan focus dated 5/6/26, included R7 will have an appropriate discharge plan and R7 was working to move into an assisted living facility or group home. R7's May 2026 Medication/Treatment Administration Record indicated on 5/19/26 - 5/31/26, medications and treatments were marked with a "3" which indicated "absent from home." MAR included orders for the following: -escitalopram (antidepressant) 10 milligrams (mg)-give 1 tablet by mouth in the morning for major depressive symptoms -nifedipine (medication used to treat high blood pressure) 90 mg tablet – give 1 tablet by mouth daily in the morning for hypertension (high blood pressure) -Eliquis (anticoagulant) 2.5 mg – give 2.5 mg by mouth two times a day related to hemiplegia and hemiparesis following cerebral infarction affecting dominate side -seroquel (antipsychotic medication) – give 25 mg by mouth tow times a day for schizophrenia -suboxone (buprenorphine-naloxone –2-part medication used to treat opioid use disorder) 4.1 mg sublingual film – give 1 film sublingually two times a day related to opioid abuse. -propranolol 10 mg – give 1 table by mouth three times a day for hypertension No medications were documented as administered during this time. R7's progress notes included:	F0609		07/29/2026

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F0609 SS = E	Continued from page 7 -5/18/26 at 9:32 p.m.: “resident not seen in the facility at the start of this shift. Writer called resident’s phone number not in service. Writer called resident’s mom and left a voice message.” -5/26/26 at 1:58 p.m.: “writer filed missing person report for resident.” -6/1/26 at 4:17 p.m.: “writer called resident’s phone number to see when resident’s plan on returning to facility. Resident’s phone number was not working. Writer called family who did not answer. Writer left voicemail.” -6/4/26 at 9:12 a.m.: “res’ 18-day bed hold is up and res’ bed was released.” -6/17/26 at 10:08 a.m.: “SSD filled out a MAARC report” The progress notes showed many entries for “LOA” (leave of absence) and absent from home throughout the time frame that were coded under “default PN type for eMAR.” A Notice of Resident/Patient Transfer or Discharge indicated the notice was mailed to R7 on 6/4/26 as R7’s 18-day bed hold expired. The progress notes lacked indicated of a missing person report filed after 24 hours of no contact with resident. Furthermore, the progress notes indicated a MAARC report was not filed until 6/17/26 which was almost a month since last contact with R7. During an interview on 6/17/26 at 9:12 a.m., licensed practical nurse (LPN)-D stated when a resident doesn’t return, they should then notify the supervisor or administrator after searching for the resident. LPN-D stated the local hospitals should be called, and all this was documented in the progress notes. During an interview on 6/17/26 at 9:28 a.m., social services designee (SS)-D stated if a resident was gone from the facility with no contact, then a missing person’s report was filed. SS-D stated if a resident didn’t return to the facility, they would hold the resident’s bed for 18 days after last contact along with filing a Minnesota Adult Abuse Reporting Center (MAARC) report. SS-D stated R7 was in and out of the facility and sometimes went to his	F0609		07/29/2026

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F0609 SS = E	Continued from page 8 apartment. SS-D was unsure if R7 had signed out of the facility on 5/19/26. SS-D stated social services was responsible for ensuring the MAARC report was filed for R7. Surveyor requested copy of sign out sheet for residents for 5/19/26 along with copy of the MAARC report. A MAARC report was provided for R7 and indicated it had been filed on 6/17/26 at 10:06 a.m. No copy of the resident sign-out sheet was provided. During an interview on 6/17/26 at 10:18 a.m., director of nursing (DON) stated if a resident didn't return when they indicated they would be back, the staff should be calling the resident/family and would be expected to put in progress notes regarding this. DON stated social services would follow up if the resident hadn't returned within 24 hours and nursing would provide information needed. During an interview on 6/17/26 at 11:09 a.m., administrator stated the report was filed late as it should have been filed 24 hours after resident didn't return. Administrator verified it appears the last contact facility had with R7 was on 5/18/26. Administrator stated a MAARC report and a missing person report should have been filed so adult protection could get involved and verified that it had not been done until today 6/17/26. A facility policy titled Leave of Absence and Discharging Against Medical Advice Process and Acknowledgement Form, updated 10/24, indicated under the leave of absence process: "6. If you do not return to the facility within 24 hours from your expected time back and you fail to call the facility to let the staff know when you will be returning, a missing person report will be completed with the local law enforcement. 7. If you call the facility and inform the staff that you will not be returning, you will be discharged Against Medical Advice (AMA). The facility protocol for discharges Against Medical Advice will be implemented including contacting adult protective services (MAARC). "	F0609		07/29/2026

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F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to maintain the resident room in a safe, clean, and comfortable condition for 2 of 2 residents (R30, R64) by failing to repair or otherwise seal a broken resident room window, leaving an opening to the outside environment that allowed pests to enter the facility. In addition, the facility failed to ensure condition of wall corner trim pieces and baseboards on the second-floor hallways were in a safe condition. Also, the facility further failed to ensure 2 of 2 residents (R10, R100) rooms were maintained in good repair by failing to address missing drawer fronts, missing mirrors, broken wallboard, hanging curtains off their hooks. Findings include: R30's quarterly Minimum Data Set (MDS) assessment dated 5/14/26 indicated R30 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and was independent with activities of daily living (ADLs). R64's quarterly MDS assessment dated 4/21/26 indicated R64 was cognitively intact with a BIMS score of 15 and was independent with ADLs. During an interview and observation on 6/16/26 at 8:12 a.m., R64 stated he had moved into the room the previous week. R64 stated his roommate (R30) had told him the window had been broken for at least four months. Observation revealed an approximately a one-inch gap between the window frame and the windowsill that allowed bugs to enter the room and R64 reported seeing flies in the room over the previous several days. During an interview on 6/16/26 at 8:04 a.m., the Regional Maintenance Director confirmed the window was broken and there was a gap between the window and the frame. He stated the facility had identified an additional issue with the window the previous week and acknowledged there are methods to cover gaps such as this and they should have been implemented. He stated he would have the	F0921	F921: Safe/Functional/Sanitary/Comfortable Environment Immediate Corrective Action: Resident 30 & Resident 64 (room 110) AC unit was repaired in the window and does not have any gaps. Window for 110 has been ordered and will be replaced when it is available. Wall corner time pieces and baseboards on unit 2 hallway were repaired. The drawers, mirrors, wallboards, and curtains were all repaired in room 205 and 207. Baseboard section across from nursing station repaired. Broken corner piece of resident door repaired. Corrective Action as it applies to others: Full house audit completed of all resident rooms and hallways to identify maintenance issues and items found entered into TELs system for maintenance to repair. TELs education to all staff regarding broken items, missing drawers, missing mirrors, curtains hanging improperly, wallboards missing, wall chipping, corners needing repair, etc. Recurrence will be prevented by: Admin will audit 5 resident rooms weekly x4 weeks to ensure homelike environment. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.	07/29/2026

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F0921 SS = E	Continued from page 10 issue corrected immediately. During an interview on 6/16/26 at 12:06 p.m., the Director of Nursing (DON) agreed with the concern and stated the window should not have been open to the outside environment allowing pests or bugs to enter the facility. R10 R10's admissions Minimum Data Set (MDS) dated 4/22/26, identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, viral hepatitis, arthritis, osteoporosis, hip fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice. During observation and interview with R10 on 6/14/26 at 11:10 a.m., R10 was lying in bed. There was an empty drawer with a missing drawer front for R10 and a blank space on the wall above the dresser with a silhouette of a mirror. R10 stated she had been in current room since admission to the facility in April of 2026 and the room had always had a missing drawer front and no mirror on the wall. "it bothers me" and "my room looks really bad." During interview with R10's family member (FM)-A on 6/15/26 at 4:14 p.m., in R10's room, FM-B stated, "condition of the room is not what I expected. I want to move her". RM-B stated missing drawer fronts and cracked wallboard next to the head of her bed was "bad" and needed repair. "I would never live in a place like this". During interview with R10's hospice nurse (RN)-B on 6/16/26 at 1:06 p.m., RN-B stated she visited R10 twice per week and stated, "Condition of [R10's] room is filthy. Missing mirror and front drawer." RN-B stated, "[R10] deserves better". R100 During observation and interview with R100 on 6/14/26 at 11:00 a.m., a hole in the wallboard was noted near head of bed which was placed twelve inches from the wall. Also, the entire wall had peeling paint with most of it near the head of his bed. R100 stated, "[condition of room] looks awful but no one here does anything about it". During observation and interview with nursing	F0921	Continued from page 10 Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

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F0921 SS = E	Continued from page 11 assistant (NA)-A on 6/15/26 at 4:30 p.m., NA-A observed R100's window curtain hanging off the hooks on one corner, and missing drawer fronts to the dresser. "I don't like the way those drawers look. I would like them fixed" and "looks like crap". NA-A stated expectation of staff to notify maintenance of repair requests by using the electronic work order (TELS) report. NA-A said she had not submitted a TELS report for maintenance repairs. At 4:32 p.m., NA-A walked into R10's room and pointed to missing drawer front and verified the drawer front was missing. Also, "I do not like the condition of the curtains, walls and outlet there. Missing mirror or something (pointing to blank wall with silhouette of mirror). I would hate that in my house." During observation on 6/14/26 at 9:17 a.m., on the second floor of facility a wall corner trim outside elevator was cracked and missing a piece leaving sharp edges. A corner piece on the wall alcove outside the janitor closet across from the elevator and nursing desk was also cracked. A baseboard section across from nursing desk was missing and several cracks were observed. In addition, a broken corner piece of resident door was observed leaving wood visible behind it. During observation and interview with the regional maintenance director (RM)-D and the maintenance operation director (MO)-D on 6/15/26 at 5:26 p.m., MO-D stated expectation of staff to submit an TELS report for anything that is need of repair. Both RM-D and MO-D stated there were no records from staff to repair or replace drawer fronts, mirrors, curtains, holes in walls or corner trim pieces. RM-D and MO-D viewed R10 and R100's rooms and MO-D stated, "Definitely not homelike here." MO-D viewed broken corner pieces and stated, "it is not safe [for residents] walking by". During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated expectation of staff to submit a TELS report for any maintenance issues or concerns. LPN-B stated she had not submitted any TELS reports in recent memory. During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated, "when you hear about or see anything that needs fixing or replacing, we have to let maintenance know by using TELS". TMA-A stated she had not submitted any TELS reports in recent memory. During interview with registered nurse (RN)-C on	F0921		07/29/2026

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F0921 SS = E	Continued from page 12 6/17/26 at 9:13 a.m., RN-C stated expectation of all staff to submit a TELS report for any maintenance issues or concerns. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated resident dresser drawers, mirrors, curtains, and holes in the wall “are not appealing and should be in good repair”. Facility policy on safe homelike environment was requested and not received.	F0921		07/29/2026
F0924 SS = E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure handrails on the second floor were securely attached to the wall. This had the potential to affect all residents, staff, and visitors who had access to the handrails. Findings include: During observation on 6/14/26 at 9:17 a.m., second floor hallway handrails were loosely attached to wall across from the elevator, across from the dining room and nursing desk, between two resident rooms. In addition, one handrail was unattached at one end pulling away from the wall outside a resident room. During review of April, May, and June 2026 electronic work orders (TELS) reports, there was no report of loose handrails. During observation and interview on 6/15/26 at 5:26 p.m., the regional maintenance director (RM)-D and the maintenance operation director (MO)-D reviewed and verified the loose and unattached handrails on the second floor. MO-D stated expectation of staff to submit an electronic work order (TELS) report for anything that is need of repair or replacement including loose and unattached handrails. MO-D and RM-D stated they had reviewed TELS reports for January through June 2026 and they failed to identify any work order report for the loose and unattached handrails. During interview with trained medication aide	F0924	F924: Corridors have Firmly Secured Handrails Immediate Corrective Action: All handrails fixed and secured to wall. Corrective Action as it applies to others: Whole house audit of all handrails to ensure they are secured to the wall. Education to all staff regarding entering a TELS order if seeing/noting any loose handrails. Recurrence will be prevented by: Audit one unit weekly x4 weeks to ensure that handrails are secured to wall. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

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F0924 SS = E	Continued from page 13 (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated, “when you hear about or see anything that needs fixing or replacing, we have to let maintenance know by using TELS”. TMA-A stated she had not submitted any TELS reports in recent memory. During interview with registered nurse (RN)-C on 6/17/26 at 9:13 a.m., RN-C stated unattached and loose handrails “are a safety concern”. RN-C stated expectation of all staff to submit a TELS report for any maintenance issues or concerns. During interview with director of nursing (DON) on 6/17/26 at 10:35 a.m., DON stated unattached and loose handrails, “are not safe”. DON stated expectation of all staff to submit a TELS report for any maintenance issues or concerns. Undated facility policy titled Safety stated the facility was “to provide a safe environment by encouraging and empowering residents/employees to live and work in a manner that fosters personal safety.	F0924		07/29/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F0550	F550: Resident Rights/Exercise of Rights Immediate Corrective Action: Dining room serving process established for facility. Corrective Action as it applies to others: Education to all staff regarding new serving process. Recurrence will be prevented by: Culinary director/designee to audit 5 meals a week x4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee	07/29/2026

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F0550 SS = D	Continued from page 14 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 3 of 3 residents (R11, R40, R53) who were seated at the dining room table with other residents who were served meals without being served meals themselves resulting in them waiting for their meals while tablemates dined. Findings include: R11's quarterly Minimum Data Set (MDS) assessment dated 5/21/26, identified R11 had intact cognition and required set up or clean-up assistance from staff for eating. R40's annual MDS assessment dated 4/30/26, identified R40's short term and long term memory appeared "OK" and a Brief Interview for Mental Status (BIMS) was not completed indicating R40 was rarely/never understood. Further, the assessment identified R40 was independent with eating. R53's significant change MDS assessment dated 6/9/26, identified R53 had moderately impaired cognition and required set up or clean-up assistance from staff for eating. On 6/14/26 at 12:09 p.m., the lunch meal service was observed on 2nd floor main dining room. There were residents in the dining room waiting for lunch. The meal cart came up to the floor at 12:13 p.m., and the food was transferred to the steam table. It was observed that R11 and R20 were seated next to each other at the same table on opposite side of the dining room than the steam table along with two other unidentified residents. At 12:30 p.m., R11 was observed to be eating his lunch. At 12:35 p.m., R11 expressed frustration as R11 was "still waiting" for	F0550	Continued from page 14 Date of Compliance: 7/29/26	07/29/2026

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F0550 SS = D	Continued from page 15 his lunch. R11 stated it “pisses me off” as “happens all the time” [referring to tablemates being served before him]. It was observed that the 2 unidentified residents had finished eating and left the table and R20 was almost done with lunch. At 12:48 p.m. R11 was served lunch (18 minutes after tablemates had been observed eating). At 12:52 p.m., staff delivered desserts to some residents while other residents had not yet been served lunch. On 6/16/26 at 8:14 a.m., the breakfast meal service was observed on the 2nd floor main dining room. There was a table with 2 residents (R82 and R40). At 8:18 a.m., R82 was served a bowl of cold cereal and milk. At 8:30 a.m., R40 was served breakfast (12 minutes after tablemate was served breakfast and eating). During the same observation during the breakfast meal service, another table had 4 residents seated and R53 was seated at the end of the table. Other residents had been served cold cereal in front of them at the start of the observation at 8:14 a.m. At 8:22 a.m., R53 was observed to request oatmeal for breakfast as he did not have any food in front of him despite tablemates having been served. At 8:35 a.m., R53 requested, again, to have some oatmeal which was then provided at 8:37 a.m. (23 minutes after tablemates had been served) During an interview on 6/16/26 at 8:51 a.m., R53 stated he had to wait for breakfast this morning after asking couple of times for oatmeal. During an interview on 6/16/26 at 8:58 am., R40 stated that “it happens all the time” and stated she frequently had to wait for meals after others at the table are served and added “I am used to it.” During an interview on 6/16/26 at 10:26 a.m., nursing assistant (NA)-A stated they assist serving residents in the dining room. NA-A stated they served residents as they came into the dining room. NA-A stated if the residents were already in the dining room, they served them as the trays were prepared. NA-A stated they did not serve residents by table. During an interview on 6/17/26 at 9:04 a.m., NA-B stated residents were served by how the trays were prepared and that was determined by the order of the meal tickets. NA-B stated residents were served on a first come first served basis and not by table. During an interview on 6/17/26 at 10:18 a.m., director of nursing (DON) stated that every unit’s	F0550		07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

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VILLAS AT BRYN MAWR LLC	275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0550 SS = D	Continued from page 16 process for serving food was a little different. DON stated meals should be served table by table. During an interview on 6/17/26 at 11:12 a.m., administrator stated the process for the order of serving residents in the dining room was as the tickets came up from dietary, the residents are served. Administrator verified residents seated at the same table should be served at the same time. A facility policy on dignified dining was requested but not received.	F0550		07/29/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is	F0582	F582: Medicaid/Medicare Coverage/Liability Notice Immediate Corrective Action: Educational moment given to the business office manager regarding NOMNCs and giving the form at least 48 hours prior to the last covered day. Corrective Action as it applies to others: Education regarding NOMNC policy to the IDT. Recurrence will be prevented by: Admin to audit all NOMNCs weekly x4 weeks to ensure proper notice period was given. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

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F0582 SS = D	Continued from page 17 transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the required Notice of Medicare Non-Coverage (NOMNC) was provided timely to 1 of 3 residents (R39) reviewed for beneficiary notices. Findings include: R39's admission Minimum Data Set (MDS) dated 5/18/26, indicated R39 had intact cognition. R39's SNF Beneficiary Protection Notification Review form dated 5/28/26, indicated R39's last covered day of Medicare Part A service was on 5/28/26, and the termination was provider-initiated when Part A benefit days were not exhausted. R39's NOMNC form dated 5/28/26, indicated R39's last covered day of Medicare Part A service was on 5/28/26 and was signed by the resident on 5/27/26. R39's medical record was reviewed, and no indication that facility staff had attempted to give R39 the NOMNC form before 5/27/26 was found. During an interview with the administrator on 6/17/26 at 8:12 a.m., the administrator confirmed that she could not find an indication that the NOMNC form was given to R39 before 5/27/26 in R39's medical record. The administrator stated she would have expected this form to be given at least	F0582		07/29/2026

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F0582 SS = D	Continued from page 18 48 hours before the service end date. The facility's NOMNC policy dated 2/20/23 indicated the NOMNC must be delivered at least two days before Medicare-covered services end.	F0582		07/29/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F0584	F584: Safe/Clean/Comfortable/Homelike Environment Immediate Corrective Action: R10 has discharged at this time. Prior to discharge, R10s nightgowns and glasses were found. R15's MDS was modified to include his glasses in the CAA and his glasses were replaced and given to him. R15 had a new hearing/vision assessment completed. Corrective Action as it applies to others: Education to all staff regarding the missing item process and where to find a missing item form. Education to clinical management the accuracy of hearing/vision assessments. Recurrence will be prevented by: Admin to audit missing item reports weekly x4 weeks Quiz 4 residents per week regarding missing items x4 weeks. Whole house audit for hearing/vision assessments DON to audit 5 resident's hearing/vision assessments and accuracy weekly x4 weeks	07/29/2026

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F0584 SS = D	Continued from page 19 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: During observation, interview and record review, the facility failed to ensure protection of resident property for 2 of 2 residents (R10, R15) reviewed for missing items. Findings include: R10 R10's admissions Minimum Data Set (MDS) dated 4/22/26, identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, vital hepatitis, arthritis, osteoporosis, hip fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice. R10's admissions Care Area Assessment (CAA) with assessment review date (ARD) of 4/28/26 identified vision problems indicated by "Moderately impaired" and "ability to see in adequate light (with glasses or other visual appliances)". R10's MN Admission packet dated 4/22/26, identified a Personal Belongings Inventory form with and "X" marked next to Glasses. The form failed to identify any clothing that was brought in by resident or family at admission. During observation and interview with R10 on 6/14/26 at 11:10 a.m., R10 was lying in bed wearing a nightgown. R10 stated she was missing several nightgowns and a pair of eyeglasses. R10 stated the facility was aware of the missing items and had not investigated. During interview with R10's family member (FM)-A on 6/15/26 at 4:10 p.m., FM-A stated she visited R10 daily and R10 was now missing five nightgowns which were labeled and "[R10] is on her third pair of glasses". FM-A stated facility staff were aware but no one from the facility investigated. During interview with hospice nurse (RN)-B on 6/16/26 at 1:06 p.m., RN-B stated she visited R10 twice per week and experienced difficulty working with facility. RN-B stated R10's eyeglasses were missing and had notified facility but nothing was	F0584	Continued from page 19 The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee and DON/designee Date of Compliance: 7/29/26	07/29/2026

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F0584 SS = D	Continued from page 20 done. RN-B stated R10's nightgowns were missing, "Literally everything is missing from [R10's] room". R15 R15's admissions MDS dated 4/7/26 identified R15 with inability to determine cognition, adequate vision with no corrective lenses, impaired function of one side of upper extremity, utilized a wheelchair for mobility, required substantial assistance with dressing and personal hygiene. In addition, R15 with Encephalopathy (malfunction in the brain causing mental status changes), blood clots, kidney disease, anxiety, depression, and rhabdomyolysis (breakdown of muscle causing kidney damage). R15's MN Admission Packet dated 3/19/26 identified a Personal Belongings Inventory" form with an "X" next to Glasses. R15's admissions CAA with assessment review date (ARD) of 4/7/26 identified "03. Visual Function" as "Not Triggered". R15's orders, care plan and kardex failed to identify visual impairment. R15's Admissions Data Collection Assessment dated 3/19/26 identified R15 as having no to "Corrective lenses (contacts, glasses, or magnifying glass)" R15's Hearing/Vision Assessment Form dated 3/20/26 and 4/2/26, the forms identified R15 with "adequate vision. No corrective lenses." During record review of R15's Hospital DC interagency transfer form dated 4/1/26, identified R15 with "uses glasses" when prompted regarding "any visual impairments". During interview with R15's FM-B on 6/16/26 at 9:23 a.m., FM-B stated R15 wore prescription eyeglasses and when she visited him on 4/9/26 they were bent and dirty and were tucked away in his bedside table. She stated R15 was supposed to have them on. FM-B stated he was missing them entirely on two subsequent visits and staff were unable to locate them. FM-B stated no one from the facility contacted her about the missing eyeglasses. FM-B stated she had to replace R15's eyeglasses. Facility Grievance logs with dates from 1/21/26 to 6/14/26 failed to identify missing items for R10 and R15.	F0584		07/29/2026

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F0584 SS = D	Continued from page 21 During interview with nursing assistant (NA)-A on 6/15/26 at 4:32 p.m., NA-A stated expectation of staff to fill out a grievance form for reported missing items. NA-A stated she was aware of R10's missing eyeglasses and nightgowns yet did not file a grievance because she thought "someone else did". During interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of all staff to fill out a grievance form for reported missing items and the social services department would conduct a formal investigation. During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated resident belongings were documented on a "personal inventory form" which was attached to the admission packet. LPN-B was unaware of who documented it and where it would be located in the electronic medical record (EMR). LPN-B stated social services department was responsible for investigating missing items once staff identify and fill out a grievance form. During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated the facility had a "personal inventory form" to identify all belonging that are brought in by the resident at admissions but was unaware of where to locate the document or determine if there was one completed for R10 and R15. During interview with social services designee (SS)-D on 6/17/26 at 8:33 a.m., SS-D stated she was responsible for investigating missing items once the staff fill out a grievance form. SS-D stated she was unaware of R10 and R15's missing items. SS-D reviewed the grievance logs and verified they were not reported missing. SS-D stated she believed the mental health technician (MH)-T was responsible for documenting personal inventory of all residents upon admission to the facility. SS-D was unable to locate the form in the EMR for both R10 and R15. During interview with MH-T on 6/17/26 at 8:34 a.m., MH-T stated he was assigned to review personal inventory for all residents upon admission. MH-T stated his role was to complete the personal belonging inventory form electronically which was attached to the admission forms. MH-T verified both R10 and R15 were located in their EMRs with their admissions packets with eyeglasses documented as present on admission. During interview with RN-C on 6/17/26 at 9:31 a.m., RN-C verified she had completed the 3/20/26	F0584		07/29/2026

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F0584 SS = D	Continued from page 22 Hearing/Vision Assessment form for R15. RN-C stated, “I know he wears glasses and do not know why I documented that he did not wear them.” RN-C verified the incorrect information she documented failed to trigger a Care Area Assessment (CAA) R15’s admissions MDS which failed to create a care plan and kardex for R15 with regard to eyeglasses. During interview with the facility’s MDS Coordinator (M)-C on 6/17/26 at 9:59 a.m., M-C stated she was responsible for submitting all MDS information to Centers of Medicare and Medicaid. M-C reviewed the vision section of R15’s admissions MDS and stated it was not filled out correctly. “I think he wears eyeglasses.” M-C stated R15’s inaccurate MDS resulted in the CAA section to not be triggered for vision therefore causing R15’s care plan and kardex to not include his prescription eyeglasses. M-C stated, “the ball got dropped”. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of staff to fill out a “personal inventory form” for anything that the resident brought with them upon admission. DON was unaware of who was assigned to complete the form and download it in the EMR. For missing items, the DON stated expectation of staff to fill out a grievance form and social services department could then investigate. DON verified the grievance logs failed to identify missing eyeglasses for R10 and R15. DON stated the staff had failed to document and follow up on missing items. Facility policy on missing items was requested and not received.	F0584		07/29/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0605	F605: Right to be Free from Chemical Restraints Immediate Corrective Action: R15’s antidepressant side monitoring order was entered. R15’s target behavior monitoring order was entered. R15 discharged on 7/20/26. Corrective Action as it applies to others: Whole house audit completed for target behaviors	07/29/2026

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F0605 SS = D	Continued from page 23 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which	F0605	Continued from page 23 and psychotropic medication monitoring orders. Psychotropic medication and target behavior section added to morning meeting form Education to all nurses to ensure psychotropic medication side effect monitoring orders and target behavior orders are entered in PCC. Recurrence will be prevented by: DON to audit all new psychotropic orders weekly x4 weeks to ensure side effect monitoring and target behaviors orders are entered The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/designee Date of Compliance: 7/29/26	07/29/2026

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F0605 SS = D	Continued from page 24 indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure ongoing, adequate monitoring for side effects with psychotropic medication use to promote continuity of care for 1 of 5 residents (R15) reviewed for unnecessary medication use. In addition, the facility failed to ensure psychotropic	F0605		07/29/2026

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F0605 SS = D	Continued from page 25 medication had identified target behaviors/symptoms, and therefore failed to monitor for target behavior/symptoms for 1 of 5 residents (R15) reviewed for unnecessary medication use. Findings include: R15's admission Minimum Data Set (MDS) dated 4/7/26, indicated R15 had some difficulty making decisions regarding tasks in daily life in new situations and demonstrated no delusional thinking during the review period. The MDS indicated R15 used antidepressant medication and was diagnosed with depression and anxiety. R15's care plan dated 5/20/26, indicated R15 had an alteration in mood and behavior related to anxiety, depression, ADHD (attention deficit/ hyperactivity disorder), and mild cognitive impairment and was enrolled in mental health services per recommendation. The care plan did not include target behaviors or side effect monitoring for duloxetine. R15's order summary dated 6/13/26, included an order dated 5/22/26 for 60 milligrams (mg) of duloxetine (an antidepressant medication) daily for depression. R15's medical record, including the treatment administration record, was reviewed and did not indicate that duloxetine target behaviors were identified or being monitored. Side effect monitoring for duloxetine use was also not found after reviewing R15's medical record. During an interview on 6/17/26 at 9:11 a.m., licensed practical nurse (LPN)-C stated R15 received duloxetine for depression. LPN-C stated that usually target behavior monitoring and side effect monitoring were added to the treatment administration record (TAR), but he did not see that it had been added. LPN-C stated he was unsure what target behaviors related to his duloxetine but did not think R15 had been having any side effects from the medication. During an interview on 6/17/26 at 9:17 a.m., LPN-A, the nurse manager for the unit, confirmed she had reviewed R15's medical record and stated that she	F0605		07/29/2026

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F0605 SS = D	Continued from page 26 did not see that target behaviors were identified or monitoring was in place for his duloxetine. LPN-A stated that she also did not see that side effect monitoring for the duloxetine was in place and would have to add it. During an interview on 6/17/26 at 9:22 a.m. with the director of nursing (DON) and regional nurse consultant (RNC)-A (a registered nurse), RNC-A stated that residents taking psychotropic medications should have target behavior monitoring and side effect monitoring in place. The DON stated this monitoring would be documented in the TAR. The facility's Psychotropic Medication Use policy dated 5/2025, indicated that identified target behaviors would be monitored along with individualized interventions as well as supporting documentation in the clinical record. The policy indicated that ongoing documentation must include behavioral indicators or symptoms, monitoring for effectiveness, and potential for adverse consequences.	F0605		07/29/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F0628	F628: Discharge Process Immediate Corrective Action: Bed hold policy reviewed and remains current. Corrective Action as it applies to others: Education to all nurses and IDT regarding bed hold forms. Recurrence will be prevented by: Admin and/or DON to review progress notes daily Admin and/or DON to audit transfers to hospitals and ensure a bed hold form is completed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.	07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS AT BRYN MAWR LLC	275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0628 SS = D	Continued from page 27 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F0628	Continued from page 27 Corrections will be monitored by: Administrator/designee and/or DON/designee Date of Compliance: 7/29/26	07/29/2026

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F0628 SS = D	Continued from page 28 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is	F0628		07/29/2026

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F0628 SS = D	Continued from page 29 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to	F0628		07/29/2026

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F0628 SS = D	Continued from page 30 authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide a written bed hold (BH) for 3 of 3 residents (R9, R15, R100) reviewed for hospitalization. Findings Include: R15 R15's admissions MDS dated 4/7/26 identified R15 with inability to determine cognition, adequate vision with no corrective lenses, impaired function of one side of upper extremity, utilized a wheelchair for mobility, required substantial assistance with dressing and personal hygiene. In addition, R15 had diagnoses of Encephalopathy (malfunction in the brain causing mental status changes), blood clots, ischemic colitis requiring colostomy (bag outside body to collect stool), kidney disease, anxiety, depression, and rhabdomyolysis (breakdown of muscle causing kidney damage). R15's progress notes for 3/19/26 and 3/20/26 identified R15 with admission to facility on 3/19/26 and suffered a fall with head strike on 3/20/26 with return to the hospital. R15's progress note dated 4/1/26, stated R15 had readmitted to the facility. Also, R15's progress note dated 5/23/26 identified hospitalization and subsequent return on that date. R15's Care Conference form dated 4/8/26 identified R15 had admitted to facility on 3/19/26 and had a fall with a head strike and was admitted to the hospital. Also, R15 was readmitted to facility on 4/1/26. R15's Hospital Transfer form dated 5/23/26 documented by registered nurse (RN)-A identified R15 had another fall with a head strike and was sent to the hospital. The assessment form failed to mark section of "7. Bed hold form" with indication of sending a signed bedhold form with R15 to the hospital. Form stated daughter, family member (FM)-B was notified. During interview with R15's FM-B on 6/16/26 at 9:23 a.m., FM-B stated she and the rest of R15's	F0628		07/29/2026

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F0628 SS = D	Continued from page 31 family were never notified or informed regarding a bedhold or transfer form with both hospitalizations on 3/19/26 and 5/23/26. FM-B stated she called the facility on 3/19/26 to follow up on R15's hospitalization because the hospital contacted her and not the facility. During interview with social services designee (SS)-D on 6/14/26 at 1:14 p.m., SS-D stated R15 was competent to make his own decision and reviewed R15's electronic medical record (EMR) and verified hospitalizations on 3/20/26 with return to facility on 4/1/26, and 5/23/26. SS-D stated nursing was responsible for ensuring a written and signed bedhold form was completed and scanned into the EMR. If form was not signed then a progress note would have to be done in the EMR and social services would have to follow up. SS-D stated this was not done for R15 for both his hospitalizations on 3/19/26 and 5/23/26. R100 R100's quarterly MDS dated 4/15/26 identified R100 with intact cognition, substantial assistance needed for dressing, and toileting hygiene and had diagnoses of schizoaffective disorder, cancer, heart disease, diabetes, seizures, anxiety, depression, bipolar, and lung disease. R100's EMR identified hospitalizations on 1/28/26, 2/25/26, 3/15/26, 5/19/26, 5/22/26, and 6/11/26 from the Hospital Transfer form assessments. All assessments failed to identify a signed bedhold form was offered and signed. During interview on 6/14/26 at 3:14 p.m., R100 stated he had never been asked to sign a bedhold form prior to any of his hospitalizations. Review of Ombudsman notices from facility to the Office of the State Long-Term Care Ombudsman for January to May 2026 failed to identify R4, R15, and R100's hospital transfers. During interview with social services director (S)-D on 6/17/26 at 11:15 a.m., S-D stated there was staff turnover and verified notices to the Office of the State Long-Term Care Ombudsman failed to include residents who transferred to the hospital and that bedholds were not documented in the EMR and should be. During interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of staff to start a Hospital	F0628		07/29/2026

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F0628 SS = D	Continued from page 32 Transfer form in the EMR for every incident of transferring a resident to the hospital. RN-A verified he documented R15's 5/23/26 Hospital Transfer form and also R100's 1/28/26, 2/25/26, 3/15/26, 5/19/26 ,5/22/26,and 6/11/26 Hospital Transfer forms. RN-A stated, "I do not know anything about a bedhold form. I have never been told that I have to have a resident sign [that]. I only fill out the hospital transfer form in the EMR and mark the sections that I complete." During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated expectation of nursing staff to document bed hold conversations in the Hospital Transfer form when sending resident to the hospital. Also, staff were supposed to document whether they obtained the signed form or not and to inform social services to follow up if form was not signed. During interview with RN-C on 6/17/26 at 9:05 a.m., RN-C stated expectation of nursing staff to create a document in the EMR titled Hospital Transfer form for each episode of transferring a resident to the hospital. RN-C stated the form identified what paperwork needed to accompany resident to the hospital and a signed bedhold form was included. RN-C reviewed R15's EMR and verified he was admitted to hospital on 3/19/26 with no Hospital Transfer form documented and no indication or scanned bed hold in the EMR. She also verified R15 was sent to the hospital on 5/23/26 and the EMR identified a Hospital Transfer form but no bed hold was offered or signed. RN-C reviewed R100's EMR and verified hospitalizations on 1/28/26, 2/25/26, 3/15/26, 5/19/26, 5/22/26, and 6/11/26. RN-C also verified bedhold were never offered and signed. RN-C stated, the EMR "does not have bedholds uploaded and not done, it should be.". During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of nursing staff to create a Hospital Transfer form in the EMR for each resident sent to the hospital. DON also stated expectation of staff to offer and have resident or guardian sign the form and if they were unable to, then document that in the EMR and have social services follow up. DON verified the process was not being done and "it is on the radar to educate [staff] further for the bedhold process". R9's quarterly Minimum Data Set (MDS) dated 4/14/26 indicated R9 was cognitively intact, had no delusions, and did not refuse personal cares. R9's MDS indicated diagnoses of hypertension, diabetes,	F0628		07/29/2026

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F0628 SS = D	Continued from page 33 bipolar disorder, anxiety disorder, and chronic pulmonary disease. R9's progress notes indicated he was hospitalized on 1/7/26 and 1/30/26. R9's progress notes lacked evidence of a BH being discussed with the resident or representative at time of transfer for the 1/7/26 or the 1/30/26 hospitalizations or during either hospitalization. Facility's forms titled Hospital Transfer forms dated 1/7/26 and 1/30/26 lacked documentation about the BH. During review of R9's entire electronic medical record (EMR) lacked documentation whether a written BH form was sent to the hospital during R9's hospital stays on 1/7/26 and/or 1/30/26. During interview on 6/14/26 at 12:04 p.m., R9 stated he was very sick and was hospitalized twice in January. R9 said he was very sick with pneumonia at the beginning of January and later in the same month he returned to the hospital due to increase weakness in his right arm. During interview on 6/15/26 at 4:11 p.m., registered nurse (RN)-D stated when a resident was sick the nurse assessed the resident, updated the primary doctor, and the doctor decided if a sick resident needed to be sent to the hospital. RN-D stated the nurse sent a copy of the resident's face sheet, POLST (code status) form, medication record, treatment record, and hospital transfer form. When asked about the BH form, RN-D stated, sometimes the residents could sign the BH form before they are transferred to the hospital. RN-D stated there was a section on the Hospital Transfer form where the nurse would check if a BH form was sent with the resident or not. RN-D added they also wrote a progress note indicating what forms were sent to the hospital and whether a resident wanted to hold their bed or not. RN-D stated if a resident was unable to sign the BH before leaving the facility or the family/guardian could not be contacted, then the nurse working the following shift needed to follow up. RN-D verified there were no BH forms in R9's EMR for his two hospitalizations in the month of January. During interview on 6/16/26 at 10:45 a.m., the medical records manager (MRM) verified R9's EMR did not contain any BH forms. MRM stated the BHs were scanned into the miscellaneous section, and if they were not scanned, the forms were never	F0628		07/29/2026

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F0628 SS = D	Continued from page 34 completed or signed. Facility's policy titled Bed-Holds and Returns dated 2/2026, indicated prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. The policy also indicated: Prior to the transfer, written information will be given to the residents and the residents' representatives that explains in detail: The rights and limitations of the resident regarding bed holds. The reserve bed payment policy as indicated by the state plan (Medicaid residents). The facility per diem rate requires to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and The details of the transfer (per the Notice of Transfer).	F0628		07/29/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641	F641: Accuracy of Assessments Immediate Corrective Action: R15's MDS was modified to include his glasses in the CAA and his glasses were replaced and given to him. R15 had new hearing/vision completed. Corrective Action as it applies to others: Education to clinical management the accuracy of hearing/vision assessments. Recurrence will be prevented by: Whole house audit for hearing/vision assessments	07/29/2026

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F0641 SS = D	Continued from page 35 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect vision status for 1 of 1 residents (R15) reviewed for MDS accuracy. Findings include: R15's Admissions Minimum Data Set (MDS) dated 4/7/26, identified R15 with adequate vision and no corrective lenses. In addition, R15 required assistance with hygiene and had an ostomy (abdominal opening for stool to drain out of). Also, diagnoses include encephalopathy (brain disorder which can lead to mental status issues, memory loss, personality changes and in some cases, coma), kidney disease, anxiety, depression, blood clots, and rhabdomyolysis (muscle breakdown). The Care Area Assessment (CAA) for "Visual Function" was not triggered. R15's Hospital DC Interagency Transfer form dated 4/1/26 identified R15 with "uses glasses". R15's ADMISSION CONTRACT dated 3/19/26 with a form titled Personal Belongings Inventory identified R15 with eyeglasses. R15's care plan and kardex failed to indicate R15 wore eyeglasses. R15's Hearing/Vision Form Assessment dated 3/20/26 completed by registered nurse (RN)-C identified R15 with adequate vision and no corrective lenses. During observation on 6/14/26 at 2:00 p.m., R15 sat	F0641	Continued from page 35 DON to audit 5 resident's hearing/vision assessments and accuracy weekly x4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee and DON/designee Date of Compliance: 7/29/26	07/29/2026

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F0641 SS = D	Continued from page 36 in wheelchair out at dining room and was wearing eyeglasses. During interview with family member (FM)-B on 6/16/26 at 9:23 a.m., FM-B stated R15 “wear[s] prescription eyeglasses”. During interview with mental health technician (MH)-T on 6/17/26 at 8:34 a.m., MH-T stated he was the staff responsible for filling out the Personal Belongings Inventory section of the Admissions Packet. MH-T stated the admissions packet was electronic and he reviewed with resident and family the personal items that were brought in. This form was then filled out and imbedded into the admissions packet and downloaded into the electronic medical record (EMR). During interview with registered nurse (RN)-C on 6/17/26 at 9:28 a.m., RN-C verified she was the nurse manager on R15's unit and was familiar with R15. RN-C looked at the 4/1/26 Hospital DC Interagency Transfer form and verified it stated R15 had eyeglasses. RN-C then reviewed the Hearing/Vision Form Assessment dated 3/20/26 completed by her and stated, “I know he wears glasses and do not know why I documented that he did not wear them”. RN-C reviewed R15’s 4/7/26 MDS and verified it was coded incorrectly and the CAA did not trigger a care plan or kardex section regarding visual function. During interview with facility coordinator (M)-C on 6/17/26 at 9:59 a.m., M-C stated she was responsible for submitting the MDS information to Centers for Medicare and Medicaid (CMS) when the nurse managers complete the assessments. M-C stated, “I think [R15] wears glasses” and observed the EMR banner for R15 which had a photo of him wearing eyeglasses. M-C agreed R15’s MDS was incorrectly filled out and “the ball got dropped”. M-C verified the CAA was not triggered which meant his care plan and kardex were not triggered. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of MDS’s to be completed accurately. DON stated R15 did wear eyeglasses and verified the EMR failed to have a care plan and kardex mentioning visual function. In addition, DON verified the 4/7/26 MDS did not trigger a CAA for visual function. Facility policy on MDS accuracy requested and not received.	F0641		07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

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F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure timeliness of person-centered care conferences for 1 of 1 residents (R100) and to include periodic review and revision by an interdisciplinary team along with the resident in adjusting their care plan and making decisions about their care. Findings include: R100's quarterly MDS dated 4/15/26 identified R100 with intact cognition, substantial assistance needed for dressing, and toileting hygiene and had diagnoses of schizoaffective disorder, cancer, heart disease, diabetes, seizures, anxiety, depression, bipolar, and lung disease.	F0657	F657: Care Plan Timing and Revision Immediate Corrective Action: R100 is expired. Care conference protocol established. Corrective Action as it applies to others: Whole house audit completed of all care conferences and ensuring care conference form is prepared and care conference was set up in the last 3 months. Education to social services and clinical management regarding timing of care conferences. Recurrence will be prevented by: Weekly audit all scheduled comprehensive/annual, significant change, and quarterly MDS schedule to ensure that care conference is scheduled timely x4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee and DON/designee Date of Compliance: 7/29/26	07/29/2026

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F0657 SS = D	Continued from page 38 Additional MDS assessments were completed as follows: 7/15/25 Quarterly, 8/5/25 Annual, 10/22/25 Quarterly, 1/15/26 Quarterly R100's MHM IDT Care Conference Forms dated 10/6/25, and 3/26/26, indicated R100 had a guardian and family was involved in care, but did not include whether R100 was invited or attended. Review of R100 electronic medical record (EMR) revealed no other care conference forms to coincide with the MDS assessment schedule, including the most recent MDS dated 4/16/26. During interview on 6/15/26 at 4:57 p.m., R100 stated, "I do not remember having a meeting to talk about my care here." During interview with social services designee (SS)-D on 6/17/26 at 8:24 a.m., SS-D stated she was responsible for scheduling and documenting care conferences in the EMR. SS-D stated the facility had originally scheduled and documented care conferences every three months regardless of the MDS cycle. SS-D reviewed R100's care conferences and MDS cycle and stated the care conferences were not done for the 7/15/25, 8/5/25, and 1/15/26 MDS cycle. During interview with registered nurse (RN)-C on 6/17/26 at 9:12 a.m., RN-C stated expectation of care conferences to be performed "around the MDS schedule" and the social services designee was responsible for scheduling and documenting them in the resident EMR. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of care conferences to be completed "with the MDS cycle" by the SS-D. DON verified R100's MDS assessments were completed for 7/15/25, 8/5/25, and 1/15/26 and facility failed to conduct care conferences for R100 at those times. Facility policy on care conferences was requested and not received.	F0657		07/29/2026

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F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to consistently and comprehensively assess a non-pressure skin condition to ensure skin condition changes could be adequately monitored and acted upon promptly to promote healing and reduce the risk of complications (i.e., infection, worsening) for 1 of 2 residents (R22) reviewed who had skin impairments. In addition the facility failed to ensure services were coordinated with the hospice agency of 1 of 1 residents (R10) reviewed who received hospice services. Findings include: R22’s annual Minimum Data Set (MDS) dated 4/15/26, indicated R51 had moderately impaired cognition and was diagnosed with dementia and schizophrenia. The MDS indicated R22 was independent with toileting hygiene, required supervision or touching assistance with bathing/showering, and set up or clean up assistance for lower body dressing. R22’s Weekly Skin Inspection dated 3/11/26, indicated R22 had ongoing "red rashes" on the perineal area, that a cream was applied per order, and included no further description such as if open areas were present on the skin. R22’s provider note dated 3/16/26 at 12 a.m., indicated R22 had “fungal dermatitis” to her buttocks that was unresolved, open areas to her bottom, and the provider was ordering a new treatment. R22’s Weekly Skin Inspection dated 3/18/26, indicated R22 had “ongoing fungal rashes on the groin/ perineal area”, that R22 was receiving an oral medication, and included no further description such	F0684	F684: Quality of Care Immediate Corrective Action: LPN care coordinator assessed R22s skin and entered a progress note on 6/16/26 regarding the condition of her skin. R10’s hospice binder and calendar was received and placed on the unit. R10 has since discharged from facility. Corrective Action as it applies to others: Education to nurses regarding weekly skin assessments and how to document on ongoing skin concerns. Education to clinical managers, social services, and all nurses regarding hospice binders and calendars. Recurrence will be prevented by: Whole house audit completed for skin conditions such as rashes, dermatitis, MASD Weekly audit of documentation of all skin conditions such as rashes, dermatitis, MASD to ensure detailed descriptions of skin condition x4 weeks Whole house audit completed for current hospice residents and ensuring the hospice binder and calendars are located at the nurse’s station. Weekly audit of hospice binder x4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/designee	07/29/2026

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F0684 SS = D	Continued from page 40 as if open areas were present on the skin. R22's order summary dated 4/29/26, indicated R22 had an order dated 4/29/26 for Nystatin-Triamcinolone (a combination antifungal/steroid) cream twice a day to her bilateral legs, back, abdomen, and perineal area for "skin condition". R22's care plan dated 5/1/26, indicated R22 had a risk for alteration in skin integrity related to dementia and schizophrenia. The care plan indicated R22 had a history of picking at skin and had a rash on the "trunk/buttock/groin area" with a goal of the rash resolving by the review date of 7/30/26. The care plan indicated staff were to monitor skin integrity daily during care, and the nurse was to complete weekly skin inspections. The care plan indicated nursing staff were to document on R22's skin condition and keep the provider informed of changes. R22's progress notes dated 5/15/26 to 6/14/26 were reviewed with the following referencing skin status: - 5/15/26 at 12 a.m., the provider note indicated that on exam of R22, the rash to her bottom continued to improve and was nearly healed with one small scab to her right buttock, no open areas noted, and mild redness to her bottom and groin. - Dated 6/12/26 at 12 a.m., the provider note indicated that on exam of R22's "rash to bottom", it was stable with a few light scratch marks, no open areas, and mild redness to the groin and bottom. - No further progress notes indicating R22's skin status during this period were found. R22's Weekly Skin Inspection dated: - 5/20/26, indicated a cream was applied to R22's fungal rashes on her perineal area, abdomen, lower back, and bilateral legs. - 5/27/26, indicated a cream was applied to R22's fungal rashes on her perineal area, abdomen, buttocks, and bilateral upper legs. - 6/3/26, indicated a cream was applied to R22's fungal rashes on her perineal area, lower back, buttocks, and bilateral upper legs. - 6/10/26, indicated a cream was applied to R22's	F0684	Continued from page 40 Date of Compliance: 7/29/26	07/29/2026

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F0684 SS = D	Continued from page 41 fungal rashes on her lower back and legs, perineal area, and buttocks. - The inspections did not include further description of the skin alteration, such as if open areas were present or what color the skin alteration was. During an observation and interview on 6/16/26 at 7:47 a.m., licensed practical nurse (LPN)-B was observed entering R22's room and escorting her to the bathroom. A small, thin (slightly thicker than a fingernail) scab that was about an inch long on her right buttock, with dark pink skin observed in the gluteal cleft expanding out to her bilateral buttocks. Slight redness was observed extending down a couple inches down the inner thighs. The skin was observed with no open areas. LPN-B stated that nursing staff were supposed to document on R22's skin alteration on her shower days in the weekly skin checks. LPN-B stated they were supposed to document whether the alteration was healing, "moist or dried", if there was any odor or not, what the color of the wound was, and if it was open or closed. LPN-B was observed reviewing the 6/10/26 Weekly Skin Inspection and stated she did not see that nursing staff were including these things in their assessment, so she was unsure if the wound had changed since then or not based on this assessment. During an interview on 6/16/26 at 10:47 a.m., LPN-A, the nurse manager for the unit, stated that all residents had a weekly skin check after their shower to ensure their skin was intact. LPN-A stated that if the resident had a skin alteration, she would expect nursing staff to document a description of this alteration, including the color, if the area had any open areas or if it was closed, and if the wound was improving or not. LPN-A stated that R22 had a fungal rash that nursing staff applied a cream to as treatment. LPN-A stated she would expect assessments of this rash to be completed in the weekly skin checks. During an interview on 6/16/26 at 12:32 p.m., the director of nursing (DON) stated that nursing staff would complete weekly skin assessments that would be documented in the weekly skin assessment form. The DON stated she wouldn't expect staff to document if a rash was closed or its color, but would expect staff to document if the area had changed or if the rash had opened up. During an interview on 6/16/26 at 12:52 p.m., nurse practitioner (NP)-A stated R15 had a fungal rash	F0684		07/29/2026

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F0684 SS = D	Continued from page 42 since around February, and they had tried a variety of treatments, but the wound now seemed to be improving. NP-A stated there had been scabs from R22 itching the area in the past. NP-A stated she would expect nursing staff to document if there were any open areas or not, any worsening redness, or if the patient reported worsening symptoms. The facility's Skin Assessment and Wound Management policy dated 2/2025, indicated that staff would perform daily skin inspections with daily care, and a weekly skin inspection would be completed by licensed staff. The policy indicated if a "significant alteration," that is "When large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers" occurred, staff would notify the provider and the resident representative, complete education, initiate skin and wound evaluation, notify the nurse manager/wound nurse, refer to dietary and therapies as appropriate, review and update the care plan and resident care lists, and update the care plan to identify risks for skin break down. R10's R10's admissions Minimum Data Set (MDS) dated 4/22/26, identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, viral hepatitis, arthritis, osteoporosis, hip fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice. During review and interview of R10's hospice binder at nursing desk on 6/14/26 at 1:14 p.m., with social services designee (SS)-D the binder contained no calendar of visits and no home health aide visit notes. SS-D stated, "looks like we do not have [them]" and missing information from the binder was necessary for all staff to provide "needed care". During observation and interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of R10's hospice binder should have updated calendar for who is coming and when from hospice. "If it is not in there then we will not know who is doing what and when for [R10]". RN-A pointed to R10's hospice binder at the nursing station and stated, "it did not have a calendar in it before today so we could not find out when the aide comes. Communication is not ideal if we do not know who is coming and when".	F0684		07/29/2026

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F0684 SS = D	Continued from page 43 During interview with hospice nurse (RN)-B at 6/16/26 at 1:06 p.m., RN-B stated she was R10's case manager and visited twice per week. RN-B stated the hospice binder was supposed to have the visit monthly calendar and the written visit notes by each hospice service including home health aides, nursing, social worker, and chaplain. RN-B stated working with the facility "has not been easy" and "communication is a problem". RN-B stated, "I have had to replace that binder several times because [facility] keep losing it, although I do not know how." RN-B stated the facility did not have information needed to provide care for R10 with missing visit notes and calendars. In addition, RN-B stated facility did not reach out to her with concerns about missing calendars and visit notes. During interview with nursing assistant (NA)-A on 6/16/26 at 11:05 a.m., NA-A stated expectation of facility staff to review R10's hospice binder to receive "needed information" which included visit notes from all services. "if no calendar or visit notes [then] we do not know who is coming out and when and what happened". During interview with staffing coordinator (S)-C on 6/16/26 at 11:09 a.m., S-C stated she also filled in as nursing assistant and trained medication aide "when staffing is needed". S-C stated expectation of facility staff to review R10's hospice binder to determine when hospice staff were visiting and what happened at each visit. "It is important to have a streamlined system in place to have us, hospice and family on the same page". During interview with family member (FM)-A on 6/15/26 at 4:14 p.m., FM-A stated she was primary emergency contact and daughter for R10. FM-A stated the hospice provider communicated frequently with changes and updates, however communication and updates from the facility were "lacking" and was not happy with facility. During interview with registered nurse (RN)-C on 6/17/26 at 9:13 a.m., RN-C stated expectation of facility staff to review R10's hospice binder to determine when hospice staff were visiting and what happened at each visit. RN-C stated she was unaware of facility reaching out to R10's hospice provider to communicate or collaborate on visits and updates. RN-C stated, "there is a failure to communicate with us and hospice. If the calendar and visit notes are missing then we are unable to know what is going on and when. The process [here] is not therapeutic at this time for [R10]".	F0684		07/29/2026

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F0684 SS = D	Continued from page 44 During interview with director of nursing (DON) on 6/17/26 at 10:36 a.m., DON stated expectation to provide quality care to R10 is for facility staff to review R10's hospice binder to determine when hospice staff were visiting and what happened at each visit. DON stated, "[There] should be better collaboration [with hospice] schedules and visit notes for everyone." Policy on communicating and collaborating with outside providers was requested and not received.	F0684		07/29/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to failed to ensure medications were stored in a secure manner when staff left a medication cart unattended and unlocked, resulting in unauthorized individuals having potential access to medications, including controlled substances. This had the potential to affect medications accessible in that cart by allowing	F0761	F761: Label/Store Drugs and Biologicals Immediate Corrective Action: RN-E was given an educational moment regarding the importance of locking the medication/treatment carts. Corrective Action as it applies to others: Education to all staff regarding locking the medication and/or treatment carts. Recurrence will be prevented by: Weekly audit of 8 medication/treatment carts on various shifts x4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee and DON/designee Date of Compliance: 7/29/26	07/29/2026

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F0761 SS = D	Continued from page 45 unauthorized access and creating the potential for medication diversion or resident harm. Findings include: During continuous observation on 6/16/26 from 9:01 a.m. through 9:21 a.m., an unlocked medication cart remained unattended at the nurses' station while the assigned nurse was away from the cart. During the observation, four ambulatory residents walked past the medication cart, staff members came and went from behind the nurses' station, and the nurse manager also walked past the unattended cart. The cart was out of sight of staff intermittently throughout the observation. Because the medication cart remained unlocked, medications, including controlled substances stored within the cart, were no longer maintained in a double-locked manner. On 6/16/26 at 9:22 a.m., registered nurse (RN)-E acknowledged the medication cart had been left unlocked. RN-E stated, "I always lock it, I should have. Someone was going on break and called me over and I left without locking it." During an interview on 6/17/26 at 11:35 a.m., the Director of Nursing (DON) stated staff were expected to lock the medication cart whenever they walked away from it for resident safety. A facility policy titled Medication Storage in the Facility, dated August 2019, indicated controlled substances were to remain double locked at all times.	F0761		07/29/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F0880	F880: Infection Prevention and Control Immediate Corrective Action: R2 was given new and clean urinal. Corrective Action as it applies to others: Education to all staff regarding dirty urinals. Recurrence will be prevented by: All urinals replaced with clean urinals.	07/29/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 46 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 46 Audit 6 residents weekly to ensure clean urinals x 4weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/designee Date of Compliance: 7/29/26	07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/17/2026

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F0880 SS = D	Continued from page 47 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow infection control standards of practice for cleaning a urinal for 1 of 1 resident (R2) reviewed for infection control. Findings include: R2’s quarterly Minimum Data Set (MDS) dated 5/26/26 indicated, R2 had severe cognitive impairment, didn’t have delusions, didn’t refuse cares, was continent of bladder, was independent with activities of daily living, was independent with transfers, and used a wheelchair for mobility. R2’s MDS indicated diagnoses of anemia, coronary disease, heart failure, hypertension, and chronic lung disease. R2’s care plan indicated he had a risk for alteration in elimination related to impaired mobility. Care plan indicated R2 was continent of bladder, and he kept a plastic urinal on his wheelchair. R2’s care plan also indicated the staff had to clean or replace the urinal as needed. During observation and interview on 6/14/26 at 12:32 p.m., R2 was in his room, and on top of his bedside table there were two plastic urinals with black matter around the rims, numerous black spots inside the vessels, and 6-8 flies standing on the urinals. Additionally, there were little black insects flying throughout the room. R2 stated he used a urinal throughout the day and sometimes the staff emptied the urinals in the room’s bathroom, but he also used the toilet in the spa room to empty his urinals. R2 said the staff never rinsed or washed his urinals, R2 said the staff had not replaced the urinals for a long time. During observation and interview on 6/15/26 at 3:57 p.m., trained medication aide (TMA)-B stated she emptied R2’s urinal once to twice during her shift but has never washed or changed his urinals. During observation on 6/15/26 at 4:00 pm, R2’s	F0880		07/29/2026

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F0880 SS = D	Continued from page 48 urinals were on top of his bedside table and within 20 centimeters there was a mug with water. The urinals were partially filled; one was closed with a lid, and the other had no lid. During interview on 6/15/26 at 4:04 p.m., TMA-B verified the urinals had black matter around the rims and black spots inside the vessel. TMA-B stated they were dirty, and she would replace them. During interview on 6/15/26 at 4:06 p.m., nurse manager/licensed practical nurse (LPN)-A observed the urinal on top of the bedside table and stated, “They [urinals] should not be near food. They need to be emptied. They are dirty, this in an infection control issue.” LPN-A also verified insects were standing in the urinals and flying in the room. During interview on 6/17/26 at 12:36 p.m., director of nursing (DON) stated she was informed about the urinals and said it was an infection control issue. Facility’s policy titled Infection Prevention and Control Program dated 11/2024, indicated the primary mission of Monarch Healthcare Management is to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP is a facility wide effort involving all disciplines and is part of the quality assurance and performance improvement program.	F0880		07/29/2026
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by:	F0919	F919: Resident Call System Immediate Corrective Action: Bathroom call light (room 108) was repaired. Corrective Action as it applies to others: Education to all staff regarding call light lengths and TELs orders if noticed to be too short. Recurrence will be prevented by:	07/29/2026

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F0919 SS = D	Continued from page 49 Based on observation, interview and document review, the facility failed to ensure the emergency call system remained accessible and functional for 4 of 4 residents (R9, R30, R52, and R64) who used the shared bathroom by failing to ensure the bathroom emergency call light pull cord was long enough to be reached by a resident from the floor creating the potential for delayed staff response during an emergency. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated 3/24/26 indicated R9 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, was independent with personal hygiene and toileting, and had experienced one fall with minor injury. R52's quarterly MDS assessment dated 5/19/26 indicated R52 had severe cognitive impairment with a BIMS score of 4 and was independent with activities of daily living. R30's quarterly MDS assessment dated 5/14/26 indicated R30 was cognitively intact with a BIMS score of 15, was independent with activities of daily living, and had diagnoses that included unsteadiness on feet and unspecified dementia. R64's quarterly MDS assessment dated 4/21/26 indicated R64 was cognitively intact with a BIMS score of 15, was independent with activities of daily living, and had a diagnosis that included a history of falling. Observation on 6/14/26 at 9:48 a.m. revealed the emergency bathroom call light pull cord shared by R9, R30, R52, and R64 was broken off, leaving approximately one inch of cord hanging from the wall connection approximately half-way up the wall. The remaining cord was not long enough to be reached by a resident from the bathroom floor in the event of a fall, preventing residents from activating the emergency call system to summon assistance. During an interview on 6/16/26 at 12:06 p.m., the Director of Nursing (DON) confirmed the short emergency pull cord in the bathroom and stated the bathroom emergency pull cords should be long enough to be reached if a resident fell to the floor. The DON stated a maintenance work order would be submitted to repair the call light and add a longer chain to ensure the cord was reachable from the floor.	F0919	Continued from page 49 Whole house audit for all call lights to ensure proper length Admin to audit 6 call lights per week x 4 weeks to ensure proper length The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

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F0919 SS = D	Continued from page 50 A facility policy titled Call Light Policy, dated 5/16/23, indicated, "A nurse call must be provided for each resident bathroom, facility bathroom (if the resident is able to access it), and in all areas used for resident bathing. If a pull cord is provided it must extend to within six inches above the floor, so it is accessible to a resident lying on the floor."	F0919		07/29/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/14/26 -6/17/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed:	20000		07/16/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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20000	Continued from page 1 H#: H52032936C / iQies: 3043755 H#: H52032861C / iQies: 3020799 H#: H52032862C / iQies: 2992528 H#: H52032863C / iQies: 2981125 NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		07/16/2026
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and	20550	corrected	07/29/2026

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20550	Continued from page 2 must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect vision status for 1 of 1 residents (R15) reviewed for MDS accuracy. Findings include: R15's Admissions Minimum Data Set (MDS) dated 4/7/26, identified R15 with adequate vision and no corrective lenses. In addition, R15 required assistance with hygiene and had an ostomy (abdominal opening for stool to drain out of). Also, diagnoses include encephalopathy (brain disorder which can lead to mental status issues, memory loss, personality changes and in some cases, coma), kidney disease, anxiety, depression, blood clots, and rhabdomyolysis (muscle breakdown). The Care Area Assessment (CAA) for "Visual Function" was not triggered. R15's Hospital DC Interagency Transfer form dated 4/1/26 identified R15 with "uses glasses". R15's ADMISSION CONTRACT dated 3/19/26 with a form titled Personal Belongings Inventory identified R15 with eyeglasses. R15's care plan and kardex failed to indicate R15 wore eyeglasses. R15's Hearing/Vision Form Assessment dated 3/20/26 completed by registered nurse (RN)-C identified R15 with adequate vision and no corrective lenses. During observation on 6/14/26 at 2:00 p.m., R15 sat in wheelchair out at dining room and was wearing eyeglasses. During interview with family member (FM)-B on 6/16/26 at 9:23 a.m., FM-B stated R15 "wear[s] prescription eyeglasses". During interview with mental health technician (MH)-T on 6/17/26 at 8:34 a.m., MH-T stated he was the staff responsible for filling out the Personal Belongings Inventory section of the Admissions Packet. MH-T stated the admissions packet was	20550		07/29/2026

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20550	Continued from page 3 electronic and he reviewed with resident and family the personal items that were brought in. This form was then filled out and imbedded into the admissions packet and downloaded into the electronic medical record (EMR). During interview with registered nurse (RN)-C on 6/17/26 at 9:28 a.m., RN-C verified she was the nurse manager on R15's unit and was familiar with R15. RN-C looked at the 4/1/26 Hospital DC Interagency Transfer form and verified it stated R15 had eyeglasses. RN-C then reviewed the Hearing/Vision Form Assessment dated 3/20/26 completed by her and stated, “I know he wears glasses and do not know why I documented that he did not wear them”. RN-C reviewed R15’s 4/7/26 MDS and verified it was coded incorrectly and the CAA did not trigger a care plan or kardex section regarding visual function. During interview with facility coordinator (M)-C on 6/17/26 at 9:59 a.m., M-C stated she was responsible for submitting the MDS information to Centers for Medicare and Medicaid (CMS) when the nurse managers complete the assessments. M-C stated, “I think [R15] wears glasses” and observed the EMR banner for R15 which had a photo of him wearing eyeglasses. M-C agreed R15’s MDS was incorrectly filled out and “the ball got dropped”. M-C verified the CAA was not triggered which meant his care plan and kardex were not triggered. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of MDS’s to be completed accurately. DON stated R15 did wear eyeglasses and verified the EMR failed to have a care plan and kardex mentioning visual function. In addition, DON verified the 4/7/26 MDS did not trigger a CAA for visual function. Facility policy on MDS accuracy requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring.	20550		07/29/2026

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20550	Continued from page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20550		07/29/2026
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure timeliness of person-centered care conferences for 1 of 1 residents (R100) and to include periodic review and revision by an interdisciplinary team along with the resident in adjusting their care plan and making decisions about their care. Findings include: R100’s quarterly MDS dated 4/15/26 identified R100 with intact cognition, substantial assistance needed for dressing, and toileting hygiene and had diagnoses of schizoaffective disorder, cancer, heart disease, diabetes, seizures, anxiety, depression, bipolar, and lung disease. Additional MDS assessments were completed as follows: 7/15/25 Quarterly, 8/5/25 Annual, 10/22/25 Quarterly, 1/15/26 Quarterly R100’s MHM IDT Care Conference Forms dated 10/6/25, and 3/26/26, indicated R100 had a guardian and family was involved in care, but did not include	20570	corrected	07/29/2026

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20570	Continued from page 5 whether R100 was invited or attended. Review of R100 electronic medical record (EMR) revealed no other care conference forms to coincide with the MDS assessment schedule, including the most recent MDS dated 4/16/26. During interview on 6/15/26 at 4:57 p.m., R100 stated, “I do not remember having a meeting to talk about my care here.” During interview with social services designee (SS)-D on 6/17/26 at 8:24 a.m., SS-D stated she was responsible for scheduling and documenting care conferences in the EMR. SS-D stated the facility had originally scheduled and documented care conferences every three months regardless of the MDS cycle. SS-D reviewed R100’s care conferences and MDS cycle and stated the care conferences were not done for the 7/15/25, 8/5/25, and 1/15/26 MDS cycle. During interview with registered nurse (RN)-C on 6/17/26 at 9:12 a.m., RN-C stated expectation of care conferences to be performed “around the MDS schedule” and the social services designee was responsible for scheduling and documenting them in the resident EMR. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of care conferences to be completed “with the MDS cycle” by the SS-D. DON verified R100’s MDS assessments were completed for 7/15/25, 8/5/25, and 1/15/26 and facility failed to conduct care conferences for R100 at those times. Facility policy on care conferences was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to inviting residents/families/guardians to participate in care planning and care conferences. The director of nursing or designee could develop a system to ensure care conferences are conducted in timely manner and to educate staff and develop a monitoring system to ensure care conferences are conducted as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		07/29/2026

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20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to consistently and comprehensively assess a non-pressure skin condition to ensure skin condition changes could be adequately monitored and acted upon promptly to promote healing and reduce the risk of complications (i.e., infection, worsening) for 1 of 2 residents (R22) reviewed who had skin impairments. In addition the facility failed to ensure services were coordinated with the hospice agency of 1 of 1 residents (R10) reviewed who received hospice services. Findings include: R22’s annual Minimum Data Set (MDS) dated 4/15/26, indicated R51 had moderately impaired cognition and was diagnosed with dementia and schizophrenia. The MDS indicated R22 was independent with toileting hygiene, required supervision or touching assistance with bathing/showering, and set up or clean up assistance for lower body dressing. R22’s Weekly Skin Inspection dated 3/11/26, indicated R22 had ongoing "red rashes" on the perineal area, that a cream was applied per order, and included no further description such as if open areas were present on the skin. R22’s provider note dated 3/16/26 at 12 a.m., indicated R22 had “fungal dermatitis” to her buttocks that was unresolved, open areas to her bottom, and the provider was ordering a new treatment. R22’s Weekly Skin Inspection dated 3/18/26, indicated R22 had “ongoing fungal rashes on the groin/ perineal area”, that R22 was receiving an oral medication, and included no further description such as if open areas were present on the skin.	20875	corrected	07/29/2026

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20875	Continued from page 7 R22's order summary dated 4/29/26, indicated R22 had an order dated 4/29/26 for Nystatin-Triamcinolone (a combination antifungal/steroid) cream twice a day to her bilateral legs, back, abdomen, and perineal area for "skin condition". R22's care plan dated 5/1/26, indicated R22 had a risk for alteration in skin integrity related to dementia and schizophrenia. The care plan indicated R22 had a history of picking at skin and had a rash on the "trunk/buttock/groin area" with a goal of the rash resolving by the review date of 7/30/26. The care plan indicated staff were to monitor skin integrity daily during care, and the nurse was to complete weekly skin inspections. The care plan indicated nursing staff were to document on R22's skin condition and keep the provider informed of changes. R22's progress notes dated 5/15/26 to 6/14/26 were reviewed with the following referencing skin status: - 5/15/26 at 12 a.m., the provider note indicated that on exam of R22, the rash to her bottom continued to improve and was nearly healed with one small scab to her right buttock, no open areas noted, and mild redness to her bottom and groin. - Dated 6/12/26 at 12 a.m., the provider note indicated that on exam of R22's "rash to bottom", it was stable with a few light scratch marks, no open areas, and mild redness to the groin and bottom. - No further progress notes indicating R22's skin status during this period were found. R22's Weekly Skin Inspection dated: - 5/20/26, indicated a cream was applied to R22's fungal rashes on her perineal area, abdomen, lower back, and bilateral legs. - 5/27/26, indicated a cream was applied to R22's fungal rashes on her perineal area, abdomen, buttocks, and bilateral upper legs. - 6/3/26, indicated a cream was applied to R22's fungal rashes on her perineal area, lower back, buttocks, and bilateral upper legs. - 6/10/26, indicated a cream was applied to R22's fungal rashes on her lower back and legs, perineal area, and buttocks.	20875		07/29/2026

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20875	Continued from page 8 - The inspections did not include further description of the skin alteration, such as if open areas were present or what color the skin alteration was. During an observation and interview on 6/16/26 at 7:47 a.m., licensed practical nurse (LPN)-B was observed entering R22's room and escorting her to the bathroom. A small, thin (slightly thicker than a fingernail) scab that was about an inch long on her right buttock, with dark pink skin observed in the gluteal cleft expanding out to her bilateral buttocks. Slight redness was observed extending down a couple inches down the inner thighs. The skin was observed with no open areas. LPN-B stated that nursing staff were supposed to document on R22's skin alteration on her shower days in the weekly skin checks. LPN-B stated they were supposed to document whether the alteration was healing, "moist or dried", if there was any odor or not, what the color of the wound was, and if it was open or closed. LPN-B was observed reviewing the 6/10/26 Weekly Skin Inspection and stated she did not see that nursing staff were including these things in their assessment, so she was unsure if the wound had changed since then or not based on this assessment. During an interview on 6/16/26 at 10:47 a.m., LPN-A, the nurse manager for the unit, stated that all residents had a weekly skin check after their shower to ensure their skin was intact. LPN-A stated that if the resident had a skin alteration, she would expect nursing staff to document a description of this alteration, including the color, if the area had any open areas or if it was closed, and if the wound was improving or not. LPN-A stated that R22 had a fungal rash that nursing staff applied a cream to as treatment. LPN-A stated she would expect assessments of this rash to be completed in the weekly skin checks. During an interview on 6/16/26 at 12:32 p.m., the director of nursing (DON) stated that nursing staff would complete weekly skin assessments that would be documented in the weekly skin assessment form. The DON stated she wouldn't expect staff to document if a rash was closed or its color, but would expect staff to document if the area had changed or if the rash had opened up. During an interview on 6/16/26 at 12:52 p.m., nurse practitioner (NP)-A stated R15 had a fungal rash since around February, and they had tried a variety of treatments, but the wound now seemed to be	20875		07/29/2026

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20875	Continued from page 9 improving. NP-A stated there had been scabs from R22 itching the area in the past. NP-A stated she would expect nursing staff to document if there were any open areas or not, any worsening redness, or if the patient reported worsening symptoms. The facility's Skin Assessment and Wound Management policy dated 2/2025, indicated that staff would perform daily skin inspections with daily care, and a weekly skin inspection would be completed by licensed staff. The policy indicated if a "significant alteration," that is "When large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers" occurred, staff would notify the provider and the resident representative, complete education, initiate skin and wound evaluation, notify the nurse manager/wound nurse, refer to dietary and therapies as appropriate, review and update the care plan and resident care lists, and update the care plan to identify risks for skin break down. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could create policies or review and/or revise existing policies and procedures pertaining to resident skin status. The DON or designee could educate or re-educate nursing staff to those policies and procedures and conduct measurable audits to verify appropriate skin assessments. The DON or designee could bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20875		07/29/2026
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow infection control	21385	corrected	07/29/2026

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21385	Continued from page 10 standards of practice for cleaning a urinal for 1 of 1 resident (R2) reviewed for infection control. Findings include: R2's quarterly Minimum Data Set (MDS) dated 5/26/26 indicated, R2 had severe cognitive impairment, didn't have delusions, didn't refuse cares, was continent of bladder, was independent with activities of daily living, was independent with transfers, and used a wheelchair for mobility. R2's MDS indicated diagnoses of anemia, coronary disease, heart failure, hypertension, and chronic lung disease. R2's care plan indicated he had a risk for alteration in elimination related to impaired mobility. Care plan indicated R2 was continent of bladder, and he kept a plastic urinal on his wheelchair. R2's care plan also indicated the staff had to clean or replace the urinal as needed. During observation and interview on 6/14/26 at 12:32 p.m., R2 was in his room, and on top of his bedside table there were two plastic urinals with black matter around the rims, numerous black spots inside the vessels, and 6-8 flies standing on the urinals. Additionally, there were little black insects flying throughout the room. R2 stated he used a urinal throughout the day and sometimes the staff emptied the urinals in the room's bathroom, but he also used the toilet in the spa room to empty his urinals. R2 said the staff never rinsed or washed his urinals, R2 said the staff had not replaced the urinals for a long time. During observation and interview on 6/15/26 at 3:57 p.m., trained medication aide (TMA)-B stated she emptied R2's urinal once to twice during her shift but has never washed or changed his urinals. During observation on 6/15/26 at 4:00 pm, R2's urinals were on top of his bedside table and within 20 centimeters there was a mug with water. The urinals were partially filled; one was closed with a lid, and the other had no lid. During interview on 6/15/26 at 4:04 p.m., TMA-B verified the urinals had black matter around the rims and black spots inside the vessel. TMA-B stated they were dirty, and she would replace them. During interview on 6/15/26 at 4:06 p.m., nurse manager/licensed practical nurse (LPN)-A observed the urinal on top of the bedside table and stated, "They [urinals] should not be near food. They need	21385		07/29/2026

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21385	Continued from page 11 to be emptied. They are dirty, this in an infection control issue." LPN-A also verified insects were standing in the urinals and flying in the room. During interview on 6/17/26 at 12:36 p.m., director of nursing (DON) stated she was informed about the urinals and said it was an infection control issue. Facility's policy titled Infection Prevention and Control Program dated 11/2024, indicated the primary mission of Monarch Healthcare Management is to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP is a facility wide effort involving all disciplines and is part of the quality assurance and performance improvement program. SUGGESTED METHOD OF CORRECTION: The DON or infection control officer could develop could educate staff on the infection control program along with random audits of staff cares to ensure proper procedures are implemented. The infection control program could be integrated with the quality assurance program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		07/29/2026
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as	21426	21426: Tuberculosis Prevention and Control Immediate Corrective Action: R40's TB screening form has been completed. R64's TB screening form has been completed. R90's TB screening form has been completed. Corrective Action as it applies to others: Whole house audit completed for TB screening forms. TB screening forms section added to morning meeting form.	07/29/2026

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21426	Continued from page 12 evidenced by: Based on interview and record review, the facility failed to ensure required tuberculosis (TB) symptom screening was completed and documented upon admission for 3 of 5 residents (R40, R64, and R90) reviewed for TB screening, despite evidence that TB testing had been completed. Findings include: R40's face sheet, printed 6/17/26, indicated R40 was admitted to the facility on 6/19/24. Electronic medical record (EMR) review indicated TB testing had been completed; however, there was no documented TB symptom screening completed upon admission. R64's face sheet, printed 6/17/26, indicated R64 was admitted to the facility on 10/17/25. EMR review indicated TB testing had been completed; however, there was no documented TB symptom screening completed upon admission. R90's face sheet, printed 6/17/26, indicated R90 was admitted to the facility on 2/2/26. EMR review indicated a chest x-ray to assess for tuberculosis was completed on 2/5/26; however, there was no documented TB symptom screening completed upon admission. During an interview on 6/16/26 at 11:40 a.m., the infection preventionist, who was also the director of nursing and responsible for the TB admission process, stated nurse managers were expected to schedule the two-step Mantoux skin test upon admission and complete the TB symptom screening with the first step of the Mantoux test. The IP stated all residents were expected to be screened and tested for tuberculosis upon admission to the facility. During an interview on 6/17/26 at 9:27 a.m., the IP reviewed the records for R40, R64, and R90 and stated, "I am not seeing the TB screens for these people." A facility policy titled Tuberculosis Screening and Prevention - Resident, dated 11/2025, indicated all residents would receive an admission screening immediately prior or upon admission to identify any symptoms, risk factors, and history of tuberculosis. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing	21426	Continued from page 12 Education to all nurses to ensure TB screening forms are completed for all new admissions. Recurrence will be prevented by: DON to audit all new admissions weekly x4 weeks to ensure TB screening forms are completed. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: DON/designee Date of Compliance: 7/29/26	07/29/2026

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21426	Continued from page 13 (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one- (21) days.	21426		07/29/2026
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure ongoing, adequate monitoring for side effects with psychotropic medication use to	21535	corrected	07/29/2026

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21535	Continued from page 14 promote continuity of care for 1 of 5 residents (R15) reviewed for unnecessary medication use. In addition, the facility failed to ensure psychotropic medication had identified target behaviors/symptoms, and therefore failed to monitor for target behavior/symptoms for 1 of 5 residents (R15) reviewed for unnecessary medication use. Findings include: R15's admission Minimum Data Set (MDS) dated 4/7/26, indicated R15 had some difficulty making decisions regarding tasks in daily life in new situations and demonstrated no delusional thinking during the review period. The MDS indicated R15 used antidepressant medication and was diagnosed with depression and anxiety. R15's care plan dated 5/20/26, indicated R15 had an alteration in mood and behavior related to anxiety, depression, ADHD (attention deficit/ hyperactivity disorder), and mild cognitive impairment and was enrolled in mental health services per recommendation. The care plan did not include target behaviors or side effect monitoring for duloxetine. R15's order summary dated 6/13/26, included an order dated 5/22/26 for 60 milligrams (mg) of duloxetine (an antidepressant medication) daily for depression. R15's medical record, including the treatment administration record, was reviewed and did not indicate that duloxetine target behaviors were identified or being monitored. Side effect monitoring for duloxetine use was also not found after reviewing R15's medical record. During an interview on 6/17/26 at 9:11 a.m., licensed practical nurse (LPN)-C stated R15 received duloxetine for depression. LPN-C stated that usually target behavior monitoring and side effect monitoring were added to the treatment administration record (TAR), but he did not see that it had been added. LPN-C stated he was unsure what target behaviors related to his duloxetine but did not think R15 had been having any side effects from the medication. During an interview on 6/17/26 at 9:17 a.m., LPN-A, the nurse manager for the unit, confirmed she had reviewed R15's medical record and stated that she did not see that target behaviors were identified or monitoring was in place for his duloxetine. LPN-A stated that she also did not see that side effect	21535		07/29/2026

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21535	Continued from page 15 monitoring for the duloxetine was in place and would have to add it. During an interview on 6/17/26 at 9:22 a.m. with the director of nursing (DON) and regional nurse consultant (RNC)-A (a registered nurse), RNC-A stated that residents taking psychotropic medications should have target behavior monitoring and side effect monitoring in place. The DON stated this monitoring would be documented in the TAR. The facility's Psychotropic Medication Use policy dated 5/2025, indicated that identified target behaviors would be monitored along with individualized interventions as well as supporting documentation in the clinical record. The policy indicated that ongoing documentation must include behavioral indicators or symptoms, monitoring for effectiveness, and potential for adverse consequences. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure psychotropic medications are adequately monitored for side effects and target behaviors. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		07/29/2026
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to failed to ensure medications were stored in a secure manner when staff left a medication cart unattended and unlocked, resulting in unauthorized individuals having potential access to medications, including controlled substances. This had the potential to affect medications accessible in that cart by allowing unauthorized access and creating the potential for	21610	corrected	07/29/2026

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21610	Continued from page 16 medication diversion or resident harm. Findings include: During continuous observation on 6/16/26 from 9:01 a.m. through 9:21 a.m., an unlocked medication cart remained unattended at the nurses' station while the assigned nurse was away from the cart. During the observation, four ambulatory residents walked past the medication cart, staff members came and went from behind the nurses' station, and the nurse manager also walked past the unattended cart. The cart was out of sight of staff intermittently throughout the observation. Because the medication cart remained unlocked, medications, including controlled substances stored within the cart, were no longer maintained in a double-locked manner. On 6/16/26 at 9:22 a.m., registered nurse (RN)-E acknowledged the medication cart had been left unlocked. RN-E stated, "I always lock it, I should have. Someone was going on break and called me over and I left without locking it." During an interview on 6/17/26 at 11:35 a.m., the Director of Nursing (DON) stated staff were expected to lock the medication cart whenever they walked away from it for resident safety. A facility policy titled Medication Storage in the Facility, dated August 2019, indicated controlled substances were to remain double locked at all times. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		07/29/2026
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal	21665	corrected	07/29/2026

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VILLAS AT BRYN MAWR LLC	**275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
21665	Continued from page 17 belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to maintain the resident room in a safe, clean, and comfortable condition for 2 of 2 residents (R30, R64) by failing to repair or otherwise seal a broken resident room window, leaving an opening to the outside environment that allowed pests to enter the facility. In addition, the facility failed to ensure condition of wall corner trim pieces and baseboards on the second-floor hallways were in a safe condition. Also, the facility further failed to ensure 2 of 2 residents (R10, R100) rooms were maintained in good repair by failing to address missing drawer fronts, missing mirrors, broken wallboard, hanging curtains off their hooks. Findings include: R30's quarterly Minimum Data Set (MDS) assessment dated 5/14/26 indicated R30 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and was independent with activities of daily living (ADLs). R64's quarterly MDS assessment dated 4/21/26 indicated R64 was cognitively intact with a BIMS score of 15 and was independent with ADLs. During an interview and observation on 6/16/26 at 8:12 a.m., R64 stated he had moved into the room the previous week. R64 stated his roommate (R30) had told him the window had been broken for at least four months. Observation revealed an approximately a one-inch gap between the window frame and the windowsill that allowed bugs to enter the room and R64 reported seeing flies in the room over the previous several days. During an interview on 6/16/26 at 8:04 a.m., the Regional Maintenance Director confirmed the window was broken and there was a gap between the window and the frame. He stated the facility had identified an additional issue with the window the previous week and acknowledged there are methods to cover gaps such as this and they should have been implemented. He stated he would have the issue corrected immediately. During an interview on 6/16/26 at 12:06 p.m., the Director of Nursing (DON) agreed with the concern and stated the window should not have been open to the outside environment allowing pests or bugs to	21665		07/29/2026

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21665	Continued from page 18 enter the facility. R10 R10's admissions Minimum Data Set (MDS) dated 4/22/26, identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, viral hepatitis, arthritis, osteoporosis, hip fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice. During observation and interview with R10 on 6/14/26 at 11:10 a.m., R10 was lying in bed. There was an empty drawer with a missing drawer front for R10 and a blank space on the wall above the dresser with a silhouette of a mirror. R10 stated she had been in current room since admission to the facility in April of 2026 and the room had always had a missing drawer front and no mirror on the wall. "it bothers me" and "my room looks really bad." During interview with R10's family member (FM)-A on 6/15/26 at 4:14 p.m., in R10's room, FM-B stated, "condition of the room is not what I expected. I want to move her". RM-B stated missing drawer fronts and cracked wallboard next to the head of her bed was "bad" and needed repair. "I would never live in a place like this". During interview with R10's hospice nurse (RN)-B on 6/16/26 at 1:06 p.m., RN-B stated she visited R10 twice per week and stated, "Condition of [R10's] room is filthy. Missing mirror and front drawer." RN-B stated, "[R10] deserves better". R100 During observation and interview with R100 on 6/14/26 at 11:00 a.m., a hole in the wallboard was noted near head of bed which was placed twelve inches from the wall. Also, the entire wall had peeling paint with most of it near the head of his bed. R100 stated, "[condition of room] looks awful but no one here does anything about it". During observation and interview with nursing assistant (NA)-A on 6/15/26 at 4:30 p.m., NA-A observed R100's window curtain hanging off the hooks on one corner, and missing drawer fronts to the dresser. "I don't like the way those drawers look. I would like them fixed" and "looks like crap". NA-A stated expectation of staff to notify	21665		07/29/2026

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21665	Continued from page 19 maintenance of repair requests by using the electronic work order (TELS) report. NA-A said she had not submitted a TELS report for maintenance repairs. At 4:32 p.m., NA-A walked into R10's room and pointed to missing drawer front and verified the drawer front was missing. Also, "I do not like the condition of the curtains, walls and outlet there. Missing mirror or something (pointing to blank wall with silhouette of mirror). I would hate that in my house." During observation on 6/14/26 at 9:17 a.m., on the second floor of facility a wall corner trim outside elevator was cracked and missing a piece leaving sharp edges. A corner piece on the wall alcove outside the janitor closet across from the elevator and nursing desk was also cracked. A baseboard section across from nursing desk was missing and several cracks were observed. In addition, a broken corner piece of resident door was observed leaving wood visible behind it. During observation and interview with the regional maintenance director (RM)-D and the maintenance operation director (MO)-D on 6/15/26 at 5:26 p.m., MO-D stated expectation of staff to submit an TELS report for anything that is need of repair. Both RM-D and MO-D stated there were no records from staff to repair or replace drawer fronts, mirrors, curtains, holes in walls or corner trim pieces. RM-D and MO-D viewed R10 and R100's rooms and MO-D stated, "Definitely not homelike here." MO-D viewed broken corner pieces and stated, "it is not safe [for residents] walking by". During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated expectation of staff to submit a TELS report for any maintenance issues or concerns. LPN-B stated she had not submitted any TELS reports in recent memory. During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated, "when you hear about or see anything that needs fixing or replacing, we have to let maintenance know by using TELS". TMA-A stated she had not submitted any TELS reports in recent memory. During interview with registered nurse (RN)-C on 6/17/26 at 9:13 a.m., RN-C stated expectation of all staff to submit a TELS report for any maintenance issues or concerns. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated resident dresser	21665		07/29/2026

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21665	Continued from page 20 drawers, mirrors, curtains, and holes in the wall “are not appealing and should be in good repair”. Facility policy on safe homelike environment was requested and not received. The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		07/29/2026
21890	Patients & Residents Of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 22 Subd. 22. Personal property. Patients and residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients or residents, and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility must either maintain a central locked depository or provide individual locked storage areas in which residents may store their valuables for safekeeping. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation, interview and record review, the facility failed to ensure protection of resident property for 2 of 2 residents (R10, R15) reviewed for missing items. Findings include: R10 R10’s admissions Minimum Data Set (MDS) dated 4/22/26, identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, vital hepatitis, arthritis, osteoporosis, hip	21890	corrected	07/29/2026

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21890	Continued from page 21 fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice. R10's admissions Care Area Assessment (CAA) with assessment review date (ARD) of 4/28/26 identified vision problems indicated by "Moderately impaired" and "ability to see in adequate light (with glasses or other visual appliances)". R10's MN Admission packet dated 4/22/26, identified a Personal Belongings Inventory form with and "X" marked next to Glasses. The form failed to identify any clothing that was brought in by resident or family at admission. During observation and interview with R10 on 6/14/26 at 11:10 a.m., R10 was lying in bed wearing a nightgown. R10 stated she was missing several nightgowns and a pair of eyeglasses. R10 stated the facility was aware of the missing items and had not investigated. During interview with R10's family member (FM)-A on 6/15/26 at 4:10 p.m., FM-A stated she visited R10 daily and R10 was now missing five nightgowns which were labeled and "[R10] is on her third pair of glasses". FM-A stated facility staff were aware but no one from the facility investigated. During interview with hospice nurse (RN)-B on 6/16/26 at 1:06 p.m., RN-B stated she visited R10 twice per week and experienced difficulty working with facility. RN-B stated R10's eyeglasses were missing and had notified facility but nothing was done. RN-B stated R10's nightgowns were missing, "Literally everything is missing from [R10's] room". R15 R15's admissions MDS dated 4/7/26 identified R15 with inability to determine cognition, adequate vision with no corrective lenses, impaired function of one side of upper extremity, utilized a wheelchair for mobility, required substantial assistance with dressing and personal hygiene. In addition, R15 with Encephalopathy (malfunction in the brain causing mental status changes), blood clots, kidney disease, anxiety, depression, and rhabdomyolysis (breakdown of muscle causing kidney damage). R15's MN Admission Packet dated 3/19/26 identified a Personal Belongings Inventory" form with an "X" next to Glasses. R15's admissions CAA with assessment review date	21890		07/29/2026

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21890	Continued from page 22 (ARD) of 4/7/26 identified “03. Visual Function” as “Not Triggered”. R15’s orders, care plan and kardex failed to identify visual impairment. R15’s Admissions Data Collection Assessment dated 3/19/26 identified R15 as having no to “Corrective lenses (contacts, glasses, or magnifying glass)” R15’s Hearing/Vision Assessment Form dated 3/20/26 and 4/2/26, the forms identified R15 with “adequate vision. No corrective lenses.” During record review of R15’s Hospital DC interagency transfer form dated 4/1/26, identified R15 with “uses glasses” when prompted regarding “any visual impairments”. During interview with R15’s FM-B on 6/16/26 at 9:23 a.m., FM-B stated R15 wore prescription eyeglasses and when she visited him on 4/9/26 they were bent and dirty and were tucked away in his bedside table. She stated R15 was supposed to have them on. FM-B stated he was missing them entirely on two subsequent visits and staff were unable to locate them. FM-B stated no one from the facility contacted her about the missing eyeglasses. FM-B stated she had to replace R15’s eyeglasses. Facility Grievance logs with dates from 1/21/26 to 6/14/26 failed to identify missing items for R10 and R15. During interview with nursing assistant (NA)-A on 6/15/26 at 4:32 p.m., NA-A stated expectation of staff to fill out a grievance form for reported missing items. NA-A stated she was aware of R10’s missing eyeglasses and nightgowns yet did not file a grievance because she thought “someone else did”. During interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of all staff to fill out a grievance form for reported missing items and the social services department would conduct a formal investigation. During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated resident belongings were documented on a “personal inventory form” which was attached to the admission packet. LPN-B was unaware of who documented it and where it would be located in the electronic medical record (EMR). LPN-B stated social services department was responsible for investigating missing items once staff identify and	21890		07/29/2026

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21890	Continued from page 23 fill out a grievance form. During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated the facility had a “personal inventory form” to identify all belonging that are brought in by the resident at admissions but was unaware of where to locate the document or determine if there was one completed for R10 and R15. During interview with social services designee (SS)-D on 6/17/26 at 8:33 a.m., SS-D stated she was responsible for investigating missing items once the staff fill out a grievance form. SS-D stated she was unaware of R10 and R15’s missing items. SS-D reviewed the grievance logs and verified they were not reported missing. SS-D stated she believed the mental health technician (MH)-T was responsible for documenting personal inventory of all residents upon admission to the facility. SS-D was unable to locate the form in the EMR for both R10 and R15. During interview with MH-T on 6/17/26 at 8:34 a.m., MH-T stated he was assigned to review personal inventory for all residents upon admission. MH-T stated his role was to complete the personal belonging inventory form electronically which was attached to the admission forms. MH-T verified both R10 and R15 were located in their EMRs with their admissions packets with eyeglasses documented as present on admission. During interview with RN-C on 6/17/26 at 9:31 a.m., RN-C verified she had completed the 3/20/26 Hearing/Vision Assessment form for R15. RN-C stated, “I know he wears glasses and do not know why I documented that he did not wear them.” RN-C verified the incorrect information she documented failed to trigger a Care Area Assessment (CAA) R15’s admissions MDS which failed to create a care plan and kardex for R15 with regard to eyeglasses. During interview with the facility’s MDS Coordinator (M)-C on 6/17/26 at 9:59 a.m., M-C stated she was responsible for submitting all MDS information to Centers of Medicare and Medicaid. M-C reviewed the vision section of R15’s admissions MDS and stated it was not filled out correctly. “I think he wears eyeglasses.” M-C stated R15’s inaccurate MDS resulted in the CAA section to not be triggered for vision therefore causing R15’s care plan and kardex to not include his prescription eyeglasses. M-C stated, “the ball got dropped”. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of	21890		07/29/2026

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21890	Continued from page 24 staff to fill out a “personal inventory form” for anything that the resident brought with them upon admission. DON was unaware of who was assigned to complete the form and download it in the EMR. For missing items, the DON stated expectation of staff to fill out a grievance form and social services department could then investigate. DON verified the grievance logs failed to identify missing eyeglasses for R10 and R15. DON stated the staff had failed to document and follow up on missing items. Facility policy on missing items was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to missing items to ensure they are acted upon and the resident given a resolution to the missing item. The director of nursing, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure concerns around reported missing items are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21890		07/29/2026
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment	21925	corrected	07/29/2026

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21925	Continued from page 25 program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide a written bed hold (BH) for 3 of 3 residents (R9, R15, R100) reviewed for hospitalization. Findings Include: R15 R15's admissions MDS dated 4/7/26 identified R15 with inability to determine cognition, adequate vision with no corrective lenses, impaired function of one side of upper extremity, utilized a wheelchair for mobility, required substantial assistance with dressing and personal hygiene. In addition, R15 had diagnoses of Encephalopathy (malfunction in the brain causing mental status changes), blood clots, ischemic colitis requiring colostomy (bag outside body to collect stool), kidney disease, anxiety, depression, and rhabdomyolysis (breakdown of muscle causing kidney damage). R15's progress notes for 3/19/26 and 3/20/26 identified R15 with admission to facility on 3/19/26 and suffered a fall with head strike on 3/20/26 with return to the hospital. R15's progress note dated 4/1/26, stated R15 had readmitted to the facility. Also, R15's progress note dated 5/23/26 identified hospitalization and subsequent return on that date. R15's Care Conference form dated 4/8/26 identified R15 had admitted to facility on 3/19/26 and had a fall with a head strike and was admitted to the hospital. Also, R15 was readmitted to facility on 4/1/26. R15's Hospital Transfer form dated 5/23/26 documented by registered nurse (RN)-A identified R15 had another fall with a head strike and was sent to the hospital. The assessment form failed to mark section of "7. Bed hold form" with indication of sending a signed bedhold form with R15 to the hospital. Form stated daughter, family member (FM)-B was notified.	21925		07/29/2026

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21925	Continued from page 26 During interview with R15's FM-B on 6/16/26 at 9:23 a.m., FM-B stated she and the rest of R15's family were never notified or informed regarding a bedhold or transfer form with both hospitalizations on 3/19/26 and 5/23/26. FM-B stated she called the facility on 3/19/26 to follow up on R15's hospitalization because the hospital contacted her and not the facility. During interview with social services designee (SS)-D on 6/14/26 at 1:14 p.m., SS-D stated R15 was competent to make his own decision and reviewed R15's electronic medical record (EMR) and verified hospitalizations on 3/20/26 with return to facility on 4/1/26, and 5/23/26. SS-D stated nursing was responsible for ensuring a written and signed bedhold form was completed and scanned into the EMR. If form was not signed then a progress note would have to be done in the EMR and social services would have to follow up. SS-D stated this was not done for R15 for both his hospitalizations on 3/19/26 and 5/23/26. R100 R100's quarterly MDS dated 4/15/26 identified R100 with intact cognition, substantial assistance needed for dressing, and toileting hygiene and had diagnoses of schizoaffective disorder, cancer, heart disease, diabetes, seizures, anxiety, depression, bipolar, and lung disease. R100's EMR identified hospitalizations on 1/28/26, 2/25/26, 3/15/26, 5/19/26, 5/22/26, and 6/11/26 from the Hospital Transfer form assessments. All assessments failed to identify a signed bedhold form was offered and signed. During interview on 6/14/26 at 3:14 p.m., R100 stated he had never been asked to sign a bedhold form prior to any of his hospitalizations. Review of Ombudsman notices from facility to the Office of the State Long-Term Care Ombudsman for January to May 2026 failed to identify R4, R15, and R100's hospital transfers. During interview with social services director (S)-D on 6/17/26 at 11:15 a.m., S-D stated there was staff turnover and verified notices to the Office of the State Long-Term Care Ombudsman failed to include residents who transferred to the hospital and that bedholds were not documented in the EMR and should be.	21925		07/29/2026

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21925	Continued from page 27 During interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of staff to start a Hospital Transfer form in the EMR for every incident of transferring a resident to the hospital. RN-A verified he documented R15's 5/23/26 Hospital Transfer form and also R100's 1/28/26, 2/25/26, 3/15/26, 5/19/26 ,5/22/26,and 6/11/26 Hospital Transfer forms. RN-A stated, "I do not know anything about a bedhold form. I have never been told that I have to have a resident sign [that]. I only fill out the hospital transfer form in the EMR and mark the sections that I complete." During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated expectation of nursing staff to document bed hold conversations in the Hospital Transfer form when sending resident to the hospital. Also, staff were supposed to document whether they obtained the signed form or not and to inform social services to follow up if form was not signed. During interview with RN-C on 6/17/26 at 9:05 a.m., RN-C stated expectation of nursing staff to create a document in the EMR titled Hospital Transfer form for each episode of transferring a resident to the hospital. RN-C stated the form identified what paperwork needed to accompany resident to the hospital and a signed bedhold form was included. RN-C reviewed R15's EMR and verified he was admitted to hospital on 3/19/26 with no Hospital Transfer form documented and no indication or scanned bed hold in the EMR. She also verified R15 was sent to the hospital on 5/23/26 and the EMR identified a Hospital Transfer form but no bed hold was offered or signed. RN-C reviewed R100's EMR and verified hospitalizations on 1/28/26, 2/25/26, 3/15/26, 5/19/26, 5/22/26, and 6/11/26. RN-C also verified bedhold were never offered and signed. RN-C stated, the EMR "does not have bedholds uploaded and not done, it should be.". During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of nursing staff to create a Hospital Transfer form in the EMR for each resident sent to the hospital. DON also stated expectation of staff to offer and have resident or guardian sign the form and if they were unable to, then document that in the EMR and have social services follow up. DON verified the process was not being done and "it is on the radar to educate [staff] further for the bedhold process". R9's quarterly Minimum Data Set (MDS) dated 4/14/26 indicated R9 was cognitively intact, had no	21925		07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/17/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS AT BRYN MAWR LLC	**275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405**

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21925	Continued from page 28 delusions, and did not refuse personal cares. R9's MDS indicated diagnoses of hypertension, diabetes, bipolar disorder, anxiety disorder, and chronic pulmonary disease. R9's progress notes indicated he was hospitalized on 1/7/26 and 1/30/26. R9's progress notes lacked evidence of a BH being discussed with the resident or representative at time of transfer for the 1/7/26 or the 1/30/26 hospitalizations or during either hospitalization. Facility's forms titled Hospital Transfer forms dated 1/7/26 and 1/30/26 lacked documentation about the BH. During review of R9's entire electronic medical record (EMR) lacked documentation whether a written BH form was sent to the hospital during R9's hospital stays on 1/7/26 and/or 1/30/26. During interview on 6/14/26 at 12:04 p.m., R9 stated he was very sick and was hospitalized twice in January. R9 said he was very sick with pneumonia at the beginning of January and later in the same month he returned to the hospital due to increase weakness in his right arm. During interview on 6/15/26 at 4:11 p.m., registered nurse (RN)-D stated when a resident was sick the nurse assessed the resident, updated the primary doctor, and the doctor decided if a sick resident needed to be sent to the hospital. RN-D stated the nurse sent a copy of the resident's face sheet, POLST (code status) form, medication record, treatment record, and hospital transfer form. When asked about the BH form, RN-D stated, sometimes the residents could sign the BH form before they are transferred to the hospital. RN-D stated there was a section on the Hospital Transfer form where the nurse would check if a BH form was sent with the resident or not. RN-D added they also wrote a progress note indicating what forms were sent to the hospital and whether a resident wanted to hold their bed or not. RN-D stated if a resident was unable to sign the BH before leaving the facility or the family/guardian could not be contacted, then the nurse working the following shift needed to follow up. RN-D verified there were no BH forms in R9's EMR for his two hospitalizations in the month of January. During interview on 6/16/26 at 10:45 a.m., the medical records manager (MRM) verified R9's EMR did not contain any BH forms. MRM stated the BHs	21925		07/29/2026

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21925	Continued from page 29 were scanned into the miscellaneous section, and if they were not scanned, the forms were never completed or signed. Facility's policy titled Bed-Holds and Returns dated 2/2026, indicated prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. The policy also indicated: Prior to the transfer, written information will be given to the residents and the residents' representatives that explains in detail: The rights and limitations of the resident regarding bed holds. The reserve bed payment policy as indicated by the state plan (Medicaid residents). The facility per diem rate requires to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and The details of the transfer (per the Notice of Transfer). SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21925		07/29/2026
21930	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 30 Subd. 30. Protection and advocacy services. Patients and residents shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.	21930	corrected	07/29/2026

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21930	Continued from page 30 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 3 of 3 residents (R11, R40, R53) who were seated at the dining room table with other residents who were served meals without being served meals themselves resulting in them waiting for their meals while tablemates dined. Findings include: R11's quarterly Minimum Data Set (MDS) assessment dated 5/21/26, identified R11 had intact cognition and required set up or clean-up assistance from staff for eating. R40's annual MDS assessment dated 4/30/26, identified R40's short term and long term memory appeared "OK" and a Brief Interview for Mental Status (BIMS) was not completed indicating R40 was rarely/never understood. Further, the assessment identified R40 was independent with eating. R53's significant change MDS assessment dated 6/9/26, identified R53 had moderately impaired cognition and required set up or clean-up assistance from staff for eating. On 6/14/26 at 12:09 p.m., the lunch meal service was observed on 2nd floor main dining room. There were residents in the dining room waiting for lunch. The meal cart came up to the floor at 12:13 p.m., and the food was transferred to the steam table. It was observed that R11 and R20 were seated next to each other at the same table on opposite side of the dining room than the steam table along with two other unidentified residents. At 12:30 p.m., R11 was observed to be eating his lunch. At 12:35 p.m., R11 expressed frustration as R11 was "still waiting" for his lunch. R11 stated it "pisses me off" as "happens all the time" [referring to tablemates being served before him]. It was observed that the 2 unidentified residents had finished eating and left the table and R20 was almost done with lunch. At 12:48 p.m. R11 was served lunch (18 minutes after tablemates had been observed eating). At 12:52 p.m., staff delivered desserts to some residents while other residents had not yet been served lunch. On 6/16/26 at 8:14 a.m., the breakfast meal service was observed on the 2nd floor main dining room. There was a table with 2 residents (R82 and R40). At 8:18 a.m., R82 was served a bowl of cold cereal and milk. At 8:30 a.m., R40 was served breakfast (12	21930		07/29/2026

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21930	Continued from page 31 minutes after tablemate was served breakfast and eating). During the same observation during the breakfast meal service, another table had 4 residents seated and R53 was seated at the end of the table. Other residents had been served cold cereal in front of them at the start of the observation at 8:14 a.m. At 8:22 a.m., R53 was observed to request oatmeal for breakfast as he did not have any food in front of him despite tablemates having been served. At 8:35 a.m., R53 requested, again, to have some oatmeal which was then provided at 8:37 a.m. (23 minutes after tablemates had been served) During an interview on 6/16/26 at 8:51 a.m., R53 stated he had to wait for breakfast this morning after asking couple of times for oatmeal. During an interview on 6/16/26 at 8:58 am., R40 stated that “it happens all the time” and stated she frequently had to wait for meals after others at the table are served and added “I am used to it.” During an interview on 6/16/26 at 10:26 a.m., nursing assistant (NA)-A stated they assist serving residents in the dining room. NA-A stated they served residents as they came into the dining room. NA-A stated if the residents were already in the dining room, they served them as the trays were prepared. NA-A stated they did not serve residents by table. During an interview on 6/17/26 at 9:04 a.m., NA-B stated residents were served by how the trays were prepared and that was determined by the order of the meal tickets. NA-B stated residents were served on a first come first served basis and not by table. During an interview on 6/17/26 at 10:18 a.m., director of nursing (DON) stated that every unit’s process for serving food was a little different. DON stated meals should be served table by table. During an interview on 6/17/26 at 11:12 a.m., administrator stated the process for the order of serving residents in the dining room was as the tickets came up from dietary, the residents are served. Administrator verified residents seated at the same table should be served at the same time. A facility policy on dignified dining was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee should review and revise	21930		07/29/2026

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21930	Continued from page 32 policies and procedures related to dining experiences to ensure residents experience a dignified dining experience at all meals. The administrator or designee should educate staff to the policy or procedure changes and audit meals to ensure residents are being served meals at the same time. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21930		07/29/2026
23075	Corridor Handrails; Existing Construction CFR(s): MN Rule 4658.5015 Securely anchored, durable handrails must be provided on both sides of corridors used by residents. If a length of corridor space between doorways is 60 inches or less, a handrail is not necessary for that portion of the corridor. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure handrails on the second floor were securely attached to the wall. This had the potential to affect all residents, staff, and visitors who had access to the handrails. Findings include: During observation on 6/14/26 at 9:17 a.m., second floor hallway handrails were loosely attached to wall across from the elevator, across from the dining room and nursing desk, between two resident rooms. In addition, one handrail was unattached at one end pulling away from the wall outside a resident room. During review of April, May, and June 2026 electronic work orders (TELS) reports, there was no report of loose handrails. During observation and interview on 6/15/26 at 5:26 p.m., the regional maintenance director (RM)-D and the maintenance operation director (MO)-D reviewed and verified the loose and unattached handrails on the second floor. MO-D stated expectation of staff to submit an electronic work order (TELS) report for anything that is need of repair or replacement including loose and unattached handrails. MO-D and	23075	corrected	07/29/2026

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23075	Continued from page 33 RM-D stated they had reviewed TELS reports for January through June 2026 and they failed to identify any work order report for the loose and unattached handrails. During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated, “when you hear about or see anything that needs fixing or replacing, we have to let maintenance know by using TELS”. TMA-A stated she had not submitted any TELS reports in recent memory. During interview with registered nurse (RN)-C on 6/17/26 at 9:13 a.m., RN-C stated unattached and loose handrails “are a safety concern”. RN-C stated expectation of all staff to submit a TELS report for any maintenance issues or concerns. During interview with director of nursing (DON) on 6/17/26 at 10:35 a.m., DON stated unattached and loose handrails, “are not safe”. DON stated expectation of all staff to submit a TELS report for any maintenance issues or concerns. Undated facility policy titled Safety stated the facility was “to provide a safe environment by encouraging and empowering residents/employees to live and work in a manner that fosters personal safety. SUGGESTED METHOD OF CORRECTION: The administrator or designee should identify how it will maintain a homelike environment and ensure the facility have written policies and procedures developed and implemented for ensuring all handrails are secured. The facility should describe the procedures for maintaining and providing preventative maintenance in order to provide housekeeping and maintenance services necessary to maintain secured handrails. The facility should educate staff who are responsible for reporting needed repairs and those in charge of maintenance and perform monthly routine environmental rounds. The facility should then perform measurable audits to ensure all are adhering to the policy. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	23075		07/29/2026

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	245203	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/16/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/16/2026. At the time of this survey, The Villas At Bryn Mawr was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		07/29/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villa at Bryn Mawr is a 3-story building with a partial basement. The building was constructed at 2 different times. The original 4-story building was constructed in 1967 and was determined to be of Type II(222) construction. In 1969, a 3 story addition was constructed to the West that was determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. Because the original building and the addition are of the same type of construction, the facility was surveyed as one building. The facility has a capacity of 105 beds and had a census of 91 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		07/29/2026

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K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026, between 8:45 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide documentation showing that a weekly	K0918	K918: Electrical Systems – Essential Electric System Maintenance and Testing Immediate Corrective Action: Educational moment to maintenance director regarding weekly generator testing. Recurrence will be prevented by: Audit generator testing weekly x4 weeks to ensure it is completed The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

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K0918 SS = F Bldg. 01	Continued from page 3 inspection of the generator was completed during the week of June 8th, 2026. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0918		07/29/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected	K0222	K222: Egress Doors Immediate Corrective Action: Door by resident room 119 was repaired Recurrence will be prevented by: Full house audit all exit doors to ensure that they are able to be opened easily Audit 3 exit doors a week to ensure that they are able to be opened easily x 4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS AT BRYN MAWR LLC	**275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405**

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K0222 SS = E Bldg. 01	Continued from page 4 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/16/2026 at 11:17 AM, it was revealed by observation that the exit door near resident room 119 was difficult to open. The door was binding and getting stuck at the bottom. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0222		07/29/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K0321	K321: Hazardous Areas Enclosure Immediate Corrective Action: Room 104 was transitioned back to a resident room.	07/29/2026

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K0321 SS = E Bldg. 01	Continued from page 5 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3, 19.3.2.1.5, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/16/2026 at 11:14 AM, it was revealed by observation that resident Room 104 had been repurposed for storage use and was not equipped with a self-closing door device.	K0321	Continued from page 5 Room 127 was transitioned back to a resident room. Recurrence will be prevented by: Full house audit of all rooms to ensure if they are storage rooms they have a self-closing door device. Audit 1 unit weekly to ensure no resident rooms have turned into storage rooms x 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

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K0321 SS = E Bldg. 01	Continued from page 6 2. On 06/16/2026 at 11:31 AM, it was revealed by observation that resident Room 127 had been repurposed for storage use and was not equipped with a self-closing door device. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified these deficient findings at the time of discovery.	K0321		07/29/2026
K0345 SS = E Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 17.4.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/16/2026 at 10:29 AM, it was revealed by observation that the smoke detector located outside the medical storage room in the basement was hanging from its wiring and was not securely mounted. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0345	K345: Fire Alarm System – Testing and Maintenance Immediate Corrective Action: Smoke detector located outside the medical storage room in the basement was secured back to the ceiling. Recurrence will be prevented by: Full house audit of all smoke detectors to ensure they are properly mounted to the ceiling. Audit 1 unit weekly to ensure no smoke detectors are hanging from the ceiling and not secured x 4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

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K0355 SS = E Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.2.1.2, 7.2.2 (3), 7.2.3, and 7.2.3.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 06/16/2026 at 10:27 AM, it was revealed by observation that the fire extinguisher located in the medical storage room in the basement was missing the monthly inspection for May. 2. On 06/16/2026 at 11:00 AM, it was revealed by observation that the fire extinguisher located near the oxygen room on the second floor had a pressure gauge reading within the red range, indicating that it was not properly charged. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0355	K355: Portable Fire Extinguishers Immediate Corrective Action: Educational moment to maintenance director regarding checking fire extinguishers to ensure the fire gauge reading is in the proper range and complete the monthly inspection. Recurrence will be prevented by: Full house audit of all fire extinguishers to ensure they are in the proper range and have their monthly inspections completed. Audit one unit weekly to ensure the fire extinguishers are in the proper range and the monthly inspections are completed x 4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved	K0372	K372: Subdivision of Building Spaces – Smoke Barrier Construction Immediate Corrective Action: Smoke barrier by resident room 212 was repaired and fully sealed. Smoke barrier by resident room 224 was repair and fully sealed.	07/29/2026

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K0372 SS = E Bldg. 01	Continued from page 8 sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/16/2026 at 10:11 AM, it was revealed by observation that a penetration around the sprinkler pipe above the smoke barrier doors near Resident Room 212 was not fully sealed. 2. On 06/16/2026 at 10:14 AM, it was revealed by observation that a penetration above the smoke barrier doors near Resident Room 224 was not fully sealed. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified these deficient finding at the time of discovery.	K0372	Continued from page 8 Recurrence will be prevented by: Full house audit of all smoke barriers to ensure they are all sealed. Audit 1 unit weekly to ensure the smoke barrier is fully sealed x 4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026
K0541 SS = E Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in	K0541	K541: Rubbish Chutes, Incinerators, and Laundry Chutes Immediate Corrective Action: Trash chute in second floor was replaced and latches. Recurrence will be prevented by: Full house audit of all trash chutes to ensure that they latch. Audit all trash chutes weekly to ensure that they	07/29/2026

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K0541 SS = E Bldg. 01	Continued from page 9 accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain laundry chutes per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.1, 19.3.1.1, and 19.5.4.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/16/2026 at 11:01 AM, it was revealed by observation that the door to the trash chute in the utility room on the second floor did not latch. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0541	Continued from page 9 latch x4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026
K0741 SS = E Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.	K0741	K741: Smoking Regulations Immediate Corrective Action: Smoking reciprocal was replaced on the station 5 smoking patio. Recurrence will be prevented by: Full house audit of all smoke reciprocals to ensure they are closed/have lids/self-closing cover Audit all smoke reciprocals weekly x4 weeks The results of these audits will be shared with the	07/29/2026

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K0741 SS = E Bldg. 01	Continued from page 10 (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the designated smoking area per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/16/2026, at 10:41 AM, it was revealed by observation that used cigarettes were not being discarded into a metal container with a self-closing cover. They were being discarded into a bucket with no top and large holes in the bottom. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0741	Continued from page 10 facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026
K0211 SS = D Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by:	K0211	K211: Means of Egress - General Immediate Corrective Action: Chairs were removed from hallway. Recurrence will be prevented by: Education to all staff regarding unnecessary items in the hallways. Audit 1 unit weekly to ensure hallways are clear	07/29/2026

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K0211 SS = D Bldg. 01	Continued from page 11 Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/16/2026 at 10:25 AM, it was revealed by observation that four chairs were in the egress corridor outside the laundry room and conference room in the basement. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0211	Continued from page 11 from unnecessary items x 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K0363	K363: Corridor - Doors Immediate Corrective Action: Room 105 door latch was repaired. Recurrence will be prevented by: Education to all staff regarding doors needing to latch and entering a TELS order if a door does not latch Audit 1 unit weekly to ensure all doors latch properly x4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

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K0363 SS = D Bldg. 01	Continued from page 12 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/16/2026 at 11:21 AM, it was revealed by observation that the door to the resident room 105 would not latch. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0363		07/29/2026
K0912 SS = D Bldg. 01	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain electrical outlets per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.2.1, and NFPA 70, (2011 edition), National Electrical Code, section 110.12. This deficient finding could have an isolated	K0912	K912: Electrical Systems – Receptacles Immediate Corrective Action: Outlet by room 114 was repaired. Recurrence will be prevented by: Education to all staff regarding burnt outlets and adding a TELs order if burnt outlet is noticed Audit 1 unit weekly to ensure outlets in hallways are intact x 4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by:	07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS AT BRYN MAWR LLC	**275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0912 SS = D Bldg. 01	Continued from page 13 impact on the residents within the facility. Findings include: On 06/16/2026, at 11:07 AM, it was revealed by observation the electrical outlet across from resident room 114 had burn marks on it. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0912	Continued from page 13 Administrator/designee Date of Compliance: 7/29/26	07/29/2026
K0353 SS = C Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.4, 5.4.1.4, and 5.4.1.4.2. This deficient finding could have a widespread impact on the residents within the facility.	K0353	K353: Sprinkler System – Maintenance and Training Immediate Corrective Action: Sprinkler head box was purchased and mounted to the wall for extra sprinkler heads. Education to maintenance director regarding sprinkler heads must go in a sprinkler head box Recurrence will be prevented by: Audit the sub basement weekly to ensure sprinkler heads are in the box x 4 weeks The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS AT BRYN MAWR LLC	**275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353 SS = C Bldg. 01	Continued from page 14 Findings include: On 06/16/2026 at 10:48 AM, it was revealed by observation that spare sprinkler heads were found placed on top of the sprinkler cabinet and were not stored within the cabinet. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0353		07/29/2026
K0712 SS = C Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026, between 08:45 AM and 11:45 AM, it was revealed by a review of available documentation that the fire drills that were conducted during the first and second shifts were not being conducted at varied times. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.	K0712	K712 – Fire Drills Immediate Corrective Action: Educational moment to maintenance director regarding varied fire alarm times. Recurrence will be prevented by: Audit fire drill times monthly x 3 months The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator/designee Date of Compliance: 7/29/26	07/29/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 5, 2026

Administrator
VILLAS AT BRYN MAWR LLC
275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

RE: CCN: 245203
Cycle Start Date: June 17, 2026

Dear Administrator:

On August 4, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 5, 2026

Administrator
VILLAS AT BRYN MAWR LLC
275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

Re: Reinspection Results
Event ID: 231C8B-H2

Dear Administrator:

On August 4, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 17, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us