DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2CJY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00175

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245203**
2.STATE VENDOR OR MEDICAID NO.
(L2) **1780028878**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE VILLA AT BRYN MAWR**
(L4) **275 PENN AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55405**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2013**

6. DATE OF SURVEY **06/19/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 06/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/30/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/12/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5203

On 06/19/2015, a Post Certification Revisit (PCR) was completed by the Department of Health and on 06/25/2015, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 05/07/2015 standard survey.

The facility's request for a continuing waiver involving the LSC deficiency cited under K67 at the time of the standard survey has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245203

June 30, 2015

Ms. Pat Voelker, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, Minnesota 55405

Dear Ms. Voelker:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 10, 2015 the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 30, 2015

Ms. Pat Voelker, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, Minnesota 55405

RE: Project Number S5203024

Dear Ms. Voelker:

On May 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 7, 2015 that included an investigation of complaint number . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 25, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 7, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 7, 2015, effective 06/10/2015 and therefore remedies outlined in our letter to you dated May 18, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the May 7, 2015 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245203	A. Building B. Wing	6/19/2015

Name of Facility	Street Address, City, State, Zip Code
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **06/10/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/10/2015**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **06/10/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/10/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GL/kfd	**Date:** 06/30/2015	**Signature of Surveyor:** 15507	**Date:** 06/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/7/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245203	A. Building 01 - MAIN BUILDING 01 B. Wing	6/25/2015

Name of Facility	Street Address, City, State, Zip Code
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	05/05/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/kfd	Date: 06/30/2015	Signature of Surveyor: 28120	Date: 06/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/5/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2CJY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00175

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245203**
2.STATE VENDOR OR MEDICAID NO.
(L2) **1780028878**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE VILLA AT BRYN MAWR**
(L4) **275 PENN AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55405**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2013**

6. DATE OF SURVEY **05/07/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NEII 06//05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/10/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5203

At the time of the May 7, 2015 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the LSC deficiency cited under K67 at the time of the May 7, 2015 standard survey has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. The facility's compliance is based on pending CMS approval of your request for waiver. The waiver was recommended for approval. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0143

May 18, 2015

Ms. Pat Voelker, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, Minnesota 55405

RE: Project Number S5203024

Dear Ms. Voelker:

On May 7, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 16, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 16, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 August 7, 2015 (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).

This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 7, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

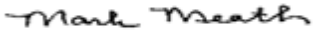
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
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Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 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
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Please accept the following as the Facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and sound not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulations.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164 06/03/15 GL/mm	F 164 The Facility reviewed the policy and procedure for personal privacy, resident rights and ADL assistance. Resident R7 was interviewed by Social Services and denied any concerns r/t cares, privacy or staff interaction. Resident R7 remains at base line. All staff meetings were held on 5/20 and 5/21 to review and reinforces policies and standards. The facility will complete audits of baths and personal cares weekly for privacy. Results of audits will be reported to the QAPI committee monthly for 6 months then ongoing as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pat L. Voelker	Administrator	6-1-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal privacy for 1 of 3 residents (R7) whose body was exposed and visible from the hallway during personal cares. Findings include: R7's morning cares were observed on 5/6/15, at 7:13 a.m. When the surveyor entered R7's room, the resident was lying on the bed and was completely naked. Two nursing assistants (NA)-A and (NA)-B explained they were getting the resident for a shower. R7's privacy curtain was not pulled to ensure the maximum privacy possible. The NAs proceeded to roll the resident side to side to place the Hoyer (a mechanical full body lift) sling underneath the resident for transferring. Because R7 had been incontinent of stool, NA-A needed to gather supplies to clean the resident. NA-C then knocked and entered the room to retrieve the Hoyer lift to use for another resident. R7 was completely exposed and visible to anyone passing in the hallway. NA-B then pulled up the bed sheet to cover R7's private area, however, after he was assisted into the shower chair, he was again fully exposed to the hallway as NA-B opened the door to remove the Hoyer lift from the room. After R7's shower at 7:40, NA-A wheeled the resident back to his room. A registered nurse (RN)-A was then	F 164	The Director of Nursing or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is June 10, 2015. RECEIVED JUN 3 - 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 164	Continued From page 2 planning to apply a new dressing to R7's wound. Using the Hoyer lift, R7 was assisted by NA-A and NA-B to get back into bed. The resident was still naked and dripping wet, having not been properly dried prior to leaving the shower/tub room. While water continued to drip from the resident's naked body, he was assisted back into bed. Neither NA-A or NA-B attempted to pull R7's privacy curtain or cover the resident. As R7 continued to be exposed on his bed, RN-A entered the room a few minutes later, visualized the resident's wound, and then left the room with the resident still uncovered. RN-A returned approximately five minutes later and covered R7 with a bath sheet and pulled the privacy curtain half way. When RN-A finished providing wound care, she left the room and the resident's door wide open. Although the privacy curtain was pulled half way, R7 could be visually seen from the hallway and NA-A proceeded to dress the resident. R7 was interviewed on 5/6/15, at approximately 8:20 a.m. He stated he received care in the same manner each morning with staff only pulling the privacy curtain half way. R7 looked away and was silent. He then stated, "Thank you for caring about my privacy." R7's annual Minimum Data Set (MDS) dated 3/6/15, revealed diagnoses including paraplegia and schizophrenia. He required extensive assistance of two staff for transferring and dressing. R7's care plan dated 9/23/14, indicated R7 was selectively mute and for staff were to ensure the resident's privacy curtains was pulled, and anticipate his needs. During an interview on 5/7/15, at 7:53 a.m.	F 164		

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F 164	Continued From page 3 director of nursing (DON) explained staff should have provided dignity and privacy for all residents. The DON added that when staff was providing care for a resident who was unclosed or exposed in some way, the door, privacy curtain and window shade should have all been closed to ensure privacy. The facility's 10/09 Quality of Life--Dignity policy indicated "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal cares and during treatment procedures."	F 164		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post prior survey results. This had the potential to affect all 105 residents residing in the facility and visitors. Findings include:	F 167	F 167 The Facility has completed lobby renovations. The survey results have been placed where resident families and visitors can readily access them. Resident R35 met with the Director of Nurses to review the survey results. Residents will be updated to the results at the June Resident Council Meeting. Audit will be completed daily for location and intact binder. Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is June 10, 2015.	

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F 167	Continued From page 4 During the initial facility tour on 5/4/15, at 11:50 a.m. prior survey results were not posted. A business office employee stated, "In the past, survey results were in a sleeve on the wall outside of the business office [copy room] but since the remodel the results have not been there." She proceeded to look for the survey results. At 12:07 she returned with the survey book and verified it had been placed in the locked nursing station on the first floor identified as 1-E. On 5/6/15, at 9:40 a.m. the president of resident council (R35) stated the survey results from the prior year were usually on the wall in the front of the building, but with the renovation she did not know where the survey results "or anything else" had been moved. "I think maybe [the administrator] has it." R35 stated she found the results too technical and wished they were easier to understand. On 5/7/15, at 1:51 p.m. the administrator stated the survey book had always been in the front lobby and did not know how it ended up in the nursing station. She verified the survey book was not readily assessable to residents and visitors, but expected it would have been. A related policy was request, but was not provided.	F 167		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	F250 The Facility reviewed the policy and procedure, resident rights and ADL assistance. Resident R31's Room and personal items have been cleaned and or replaced.	

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F 250	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide medically related social services to address behaviors of refusal/rejection of cares and services to ensure a neat personal and room appearance for 1 of 1 resident (R31) whose emotional and behavioral status was reviewed. Findings include: On 5/4/15, at 2:30 p.m. R31's room was observed with soiled underwear and socks hanging on the headboard. An off-white colored blanket was soiled with a black film. Personal objects (such as stuffed animals) on the bed were filthy and covered in black marks. The following day at 10:00 a.m. R31's shirt had food spills down the front. On 5/6/15, at 3:00 p.m. the resident was wearing the same soiled shirt she had worn on the previous day. R31's quarterly Minimum Data Set (MDS) dated 3/6/15, revealed the resident had diagnoses including schizophrenia. The resident showed cognitive impairment, with modified decision making skills in new situations only. On 2-6 days during the assessment period R31 was short-tempered or easily annoyed, and felt badly about herself, and had delusions. She displayed no behavioral problems, including no rejection of care. R31 independently dressed herself with oversight help only for grooming and bathing. Additionally, she was always continent. The corresponding care plan for R31 did not address rejection of care and services, or other reasons	F 250	A house wide audit of resident rooms and personal possessions was completed by the IDT by 5/29. Audit included bathing patterns, laundry utilization, room order and ADL need. Residents identified have been placed in groups. The root cause of each residents needs will be care plan and resident roster updated as needed. All staff meetings were held on 5/20 and 5/21 to review and reinforces policies and standards. Results of audits/group work will be reported to the QAPI committee monthly for 6 months then ongoing as needed. The Director of Social Services or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is June 10, 2015.	

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F 250	Continued From page 6 why R31's room and belongings were unclean or why she would have been dressed in unclean clothing. On 5/5/15, at 9:45 a.m. the housekeeping director and administrator observed R31's room to view the soiled clothing draped on the headboard, the dirty blanket and personal items on the bed. The housekeeping director verified it was usual for R31 to drape soiled clothing on the bed and around the room. The administrator, however, was unaware of the soiled clothing, or whether it was documented R31 refused care and room cleaning. Housekeeping or nursing staff did not provide documentation of attempts to clean R31's room or personal items. The director of nursing (DON) was interviewed on 5/7/15, at 10:22 a.m. The DON explained R31 was "independent" with cares, including dressing and grooming. The DON reported she was unaware the resident hung soiled items in the room, or that she was dressed in soiled clothing. On 5/7/15, at 11:00 a.m. the social service director (SSD) reported being unaware the resident maintained soiled clothing in her room, or that her personal items in the room were unclean. He also reported being unaware the resident had been dressed in soiled clothing on the previous two days.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 309	Continued From page 7 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate services to ensure a dialysis access site was managed to minimize the risk of infection and clotting for 1 of 1 resident (R81) reviewed for dialysis. Findings include: R81 was observed in her room waiting for transportation to dialysis on 5/5/15, at 3:07 p.m. The resident stated she was dialyzed three times each week on Tuesdays, Thursdays, and Saturdays. She also explained her access site dressing was changed at the dialysis facility and she removed the dressing when she returned to the facility. She directed attention to her personal garbage receptacle where a discarded dressing was observed. She denied staff had assessed or removed the dressing. On 5/6/15, at 7:10 a.m. R81 was sitting in her wheelchair in her room. She reported she had already removed the dressing (applied at the dialysis facility) herself, and had again discarded the dressing. The soiled dressing was observed in the garbage receptacle in her room. During an interview on 5/6/15, at 2:18 p.m. a licensed practical nurse (LPN)-C stated he was R81's primary nurse. LPN-C reviewed the treatment administration record (TAR) and the Physician Order Sheet. LPN-C reported, "Nothing	F 309	F309 The Facility reviewed the policy and procedure for dialysis care. R81's care coordination with dialysis has been addressed. Treatment sheets have been updated to reflect the cares as ordered. The facility now has developed a dialysis commutation book that travels to all dialysis runs with the pt. All dialysis residents have had a communication book developed and reviewed with their dialysis program. All staff meetings were held on 5/20 and 5/21 to review and reinforces policies and standards. The facility will audit communication books weekly with review with dialysis units monthly and prn. Results of audits will be reported to the QAPI committee monthly for 6 months then ongoing as needed. The Director of Nursing or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is June 10,, 2015.	

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F 309	Continued From page 8	F 309		

is written on the TAR or an order for taking care of the dressing. We don't remove the dressing unless she is having problems. I usually go by the treatment book." He then verified the TAR lacked information to direct staff in the management of the dressing access site, assessment of potential clotting, infection and presence of bruit and thrill. LPN-C then stated, "The only thing it [TAR] says is to put Bacitracin on it" (anti-bacterial ointment on the site).

A telephone interview with R81's primary dialysis nurse on 5/6/16, at 2:45 p.m. revealed the dialysis facility generally did not give direction or orders to manage the access site and was left up to the discretion of the facility of residence. She then asked the DaVita dialysis nurse practitioner (NP) for further clarification. The NP reported to the dialysis nurse she expected the facility staff would have monitored bruit and thrill at least daily and to manage the access site. She explained the dialysis facility did not give orders regarding site management, but could see why it may be problematic. The nurse stated, "We don't know what they are doing and they don't know what we are doing. We will have to come up with a better plan. We will talk about this."

During an interview on 5/7/15, at 10:36 a.m. the director of nursing (DON) checked R81's record. Monitoring of bruit and thrill was on the TAR through 3/15, but no direction regarding dressing care was found with the exception to apply Bacitracin to the site. She stated, "I believe it fell off [no longer appeared on the consecutive TAR] and was not added to the April TAR. It happens. We all make mistakes. We have no specific orders from dialysis to manage the site. We have a call out to DaVita. This needs to be discussed.

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F 309	Continued From page 9 They send back sheets after dialysis but there is never anything on them." The undated DaVita Dialysis Guidelines directed staff to: "Check dressing site daily...Monitor, document and report prn any s/sx [as needed signs and symptoms] of infection to access site: redness, swelling, warmth or drainage. A facility policy was requested, but was not provided.	F 309		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food palatability for 9 of 40 sampled residents (R71, R78, R143, R81, R110, R25, R141,R119, R130) reviewed for food quality. Findings include: During resident interviews, the following was noted: R71 stated on 5/4/15, at 3:36 p.m. she did not bother asking staff to warm up the food anymore because, "The aides get mad at me, so I just eat it cold." She further explained she was on a gluten-free diet and received limited food choices. "They don't change it up enough--same ol', same	F 364	F 364 Facility reviewed diets and personal preferences for R71, R78, R143 discharged, R81, R110, R25, R141 discharged, R119 and R130. Updates were completed to the dietary ticket, care plan and when appropriate to diet orders. The dietary department has had an education session on preparation, diet restriction, and service completed on May 28, 2015 The service of the meals was addressed in all staff inservices completed on 5/20 and 5/21. Audits of meal palatability and acceptance are completed by IDT weekly in all dining areas. The IDT team brings concerns to morning meeting to be addressed by the team.. Results of audits will be reported to the QAPI committee monthly for 6 months then ongoing as needed. The Dietician or designee is responsible for ongoing compliance.	

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F 364	Continued From page 10 ol'...We don't get apples anymore. I have to buy my own apples, oranges and bananas." She further stated at a food committee meeting she asked for a taco salad, but the dietitian was not willing to make "hamburger and stuff, so I let it go." R78 reported on 5/4/15, at 4:52 p.m. R78 stated the food was "always cold" but did not bother asking for hotter food because he felt it did not do any good. He further denied the food was appetizing stating, "It's the same thing over and over. I have complained about always getting waffles at night." R143 stated in an interview on 5/5/15, at 9:48 a.m. that the food was "disappointing" and many times she did not eat. "You get the same stuff over and cannot get something [different] on the spot. You have to pre-order." She further stated even though staff covered the food, it was still served cold. "I don't ask them to warm it anymore, because the first thing that comes out of their mouths is that they 'are serving trays right now' and will do it when they are finished. But they never do. I am a diabetic and don't get snacks. Only a yogurt once in a while. I have to buy my own." R81 responded on 5/5/15, at 10:03 a.m. regarding whether the food tasted good and looked appetizing, "No way! I don't even eat it most of the time--same stuff.' She further said it was served "very cold." R110 stated on 5/4/15, at 3:30 p.m. regarding whether the food was appetizing, "No. We're not going to even talk about that--some of the most horrible food I've eaten in my life...not seasoned...." R110 reported budget cuts had been made in the kitchen.	F 364	Date certain for the purposes of ongoing compliance is June 10, 2015.	

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F 364	Continued From page 11 R25 stated during an interview on 5/5/15, at 8:49 a.m. "The food is lukewarm--not hot when they bring up the trays." R141 reported on 5/4/15 at 5:32 p.m., "The food is cold. Even the hot dogs are cold." The resident's Nutrition Assessment dated 4/23/15, indicated R141 was at nutritional risk. R119 said on 5/5/15, at 9:06 a.m. "The food does not look good." R130 stated on 5/4/15, at 4:14 p.m. "The food has no taste." During a kitchen observation on 5/4/15, at 11:51 a.m. the dietary manager (DM) explained the food delivery process. Cooked food was placed in pans on a warming table, then dished up and those plates were placed on resident trays at the time of delivery to the various units. Temperatures were then measured and were acceptable when observed by the surveyor, and was placed into pans. The DM said as soon as trays were put on the transport cart, it was then taken to the unit by kitchen staff, and then the trays were passed to the residents by nursing staff. The Unit 3 dining room was observed at breakfast on 5/5/15, at 7:57 a.m. Nursing assistants and a nurse served trays to residents from a transport cart. Trays of food were placed in front of each resident and the insulated lids were removed and placed on a the table near each tray. On 5/7/15, at 8:36 a.m. a test tray was requested for breakfast which was the last tray dished for Unit 1. The cart was immediately taken from the	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 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
F 364	Continued From page 12 kitchen to Unit 1. Nursing staff began serving as soon as the cart arrived. Staff was observed to shut the cart door to conserve heat after each tray was removed from the cart. At 8:52 a.m. residents continued to be served breakfast from the trays in the cart, with the last resident served at 9:01 a.m. The test tray was then tested by the DM in the presence of two surveyors on 9:05 a.m. The oatmeal measured 109 degrees Fahrenheit (F). The DM stated, "The scrambled eggs are at 96ish," but said she would have preferred the food temperatures had been over 120 F. "The eggs should be warmer. The oatmeal needs to be a little warmer, and the toast is cool." The surveyors tasted the food and found the eggs were cool in temperature with a gritty, dry texture. The oatmeal was only slightly warm. The toast was limp and cool. The DM then explained she thought the problem was the lack of timeliness in passing trays to residents. She also stated many residents rose late, making it hard to keep the food warm long enough to maintain palatability. The DM said she had been at the facility approximately six months and was working with the administrator to revamp the meal serving process. "We are considering steam tables on the units instead of delivering trays by cart, or different carts or [insulating] dishes if that idea doesn't work out--and to make sure that temps in the kitchen are good to start with." She further indicated they were making one change at a time, "Mealtimes were changed in the last week. That was the start of all this process to get the food to the units warmer within the present system. And once we make the steam table change...there will be even less	F 364		

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	245203	A. BUILDING _____ B. WING _____	05/07/2015

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THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

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F 364	Continued From page 13 opportunity for the food to cool." During an interview on 5/7/15, at 12:22 p.m. the administrator confirmed she and the DM had been meeting to improve the dining experience for residents. The administrator stated, "So do we do steam tables for hotter food?...We recently changed the meal times to get food there hotter." The administrator added that they were looking into the meal service system, including covers than may have kept food hotter, as well as the elevator transport system. The 11/7/14, Resident Council Agenda indicated resident concerns regarding food as follows: "Dietary: Food temps & flavor better." However, on 3/16/15, residents reported in Resident Council Minutes, "Residents voiced concerns regarding cold food often...."	F 364		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 document review, the facility failed to ensure adequate housekeeping and maintenance throughout the building, potentially affecting 55 residents residing in the facility. Findings include:	F 465	F 465 Facility IDT's completed walk through with focus on repairs and replacement. The facility administrator reviewed the preventive maintenance schedule to ensure it is complete. The housekeeping department has had an education session on expectations, deep cleaning, reporting of concerns, and customer service on May 22 and 29th.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

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F 465	Continued From page 14 R53 reported a concern regarding the tub room on the second floor was not in good repair, when interviewed on 5/6/15, at 2:29 p.m. R53 detailed the needed repairs as follows: 1) the two pads on the tub's seat had large long rips that were uncomfortable to sit on; 2) the base of the walls was dark black in color and appeared like mold; 3) floor grooves were covered in a dark black "grungy/goopy dirt;" and 4) tiles on the bathtub were loose and some were missing. The resident stated he had reported the disrepair it to the director of housekeeping multiple times, "but nothing ever gets done about it." R53's annual Minimal Data Set (MDS) dated 3/30/15, revealed the resident was cognitively intact, was his own decision maker, and was independent with activities of daily living. An environmental tour was conducted with the administrator and director of maintenance on 5/6/15, at 1:45 p.m. and the following was noted: Second floor tub room: It was confirmed the shower room on the 2nd floor was in disrepair. Tiles on the floor were missing grout which left large gaps along the edge of the floor and wall. Areas of grout was missing throughout the shower floor leaving large patches of dark black areas. The tiles on the side of the bathtub were falling off and some missing. The paint in the shower room was peeling off the walls and some areas was missing paint altogether. The bath chair had two white foam cushion pads with multiple tears with exposed foam. The tears felt very rough to the touch with sharp edges. The administrator verified the padding should not have been torn. The pads were then immediately removed from the tub room.	F 465	The Maintenance department reviewed the use of the "orange books". The Director of Maintenance or his designee checks each stations book for repairs. The facility staff was re-educated to the use of the books to ensure repairs are made timely at the all staff meeting on 5/20 and 5/21. The IDT will complete grievance forms during resident council and address items per the facility policy. Deep clean audit are completed weekly by the Director of Housekeeping. Audits of cleanliness will be completed weekly by the IDT. Results of audits will be reported to the QAIP committee monthly for 6 months then ongoing as needed. The Director of Housekeeping or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is June 10, 2015.	

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F 465	Continued From page 15 First floor tub room: Additionally, the tub room on the first floor was in need of repair. Grout was missing throughout the floor leaving large patches of dark black areas. During the tour, the administrator and director of maintenance both verified the shower and tub rooms on first and second floors were in need of repairs. The administrator stated the area should have looked more appealing for the residents. The director of maintenance stated he would apply new grout to the tiles, re-sand and re-paint the walls. The director of housekeeping and director of maintenance were interviewed on 5/6/15, at 2:40 p.m. She confirmed R53 had in fact voiced concerns regarding the torn pads in the tub room. The director of housekeeping stated she had requested new pad from the previous maintenance supervisor. She was unaware of any other ripped pads in the facility. The director of maintenance said that although the facility utilized a preventative maintenance plan, it did not include checking tub chair cushions, nor was he aware cushions were being utilized on the chairs. In a follow-up interview on 5/7/15, at 10:36 a.m. with the director of housekeeping, she explained that it was the housekeeping staffs' responsibility to clean the shower/tub rooms daily. It was maintenance staffs' responsibility to ensure paint was not chipped or missing from the walls. Both housekeeping and maintenance staff were responsible for ensuring concerns were reported to the directors, and stated no concerns had been brought to her attention.	F 465		

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F 465	Continued From page 16 The Resident Council Meeting Minutes for the months of 1/15, 2/15, and 3/15, were reviewed and indicated the following: On 1/19/15, "a resident brought up a concern stating 'that station one's tub room smells of mold.'" However, in the subsequent meeting on 2/16/15, follow up to the previous concerns regarding the tub room had not been addressed, and again it was indicated, "continue to have mold smell on 1st floor bathtub and tubs should be scrubbed after each use on each floor." The next meeting minutes on 3/16/15, indicated "No old business discussed." A request for documentation on the resolution of the residents' complaints about the shower and tub rooms was not provided. The Director of Maintenance Services [DMS] Job Description dated 1/2/15, indicated the DMS was responsible for "preventative maintenance and repairs inside and outside the facility to provide a safe, attractive and orderly environment for the benefit of residents." The Administrator Job Description also dated 1/2/15, indicated responsibility for "overall facility management, operations, resident satisfaction and oversees the proper maintenance of the building, grounds and equipment to ensure safe, sanitary, attractive environment for residents and to protect the company assets through proper preventative maintenance."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, The Villa at Bryn Mawr was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok WLAW for K67 6-5-15 RECEIVED JUN - 3 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-16-15
EXIT: 5-7-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pat Voelker	Administrator	5/28/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/05/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT BRYN MAWR	**275 PENN AVENUE NORTH** **MINNEAPOLIS, MN 55405**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bryn Mawr Health Care Center is a 3-story building with a partial basement. The building was constructed at 2 different times. The original 3 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. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 105 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020	NFPA 101 LIFE SAFETY CODE STANDARD	K 020		

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	245203	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/05/2015**

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THE VILLA AT BRYN MAWR	**275 PENN AVENUE NORTH** **MINNEAPOLIS, MN 55405**

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K 020 SS=F	Continued From page 2 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 05/05/2015, observation revealed that the soiled linen chute door in room 5-U is propped open with a bolt preventing the linen chute door from closing. This deficient practice was verified by the administrator at the time of the inspection.	K 020	The bolt was removed which prevented the linen chute door from closing. The door is able to close correctly.	5/5/2015
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by:	K 067	K-067 Plenum Waiver K 84 attached.	

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K 067	Continued From page 3 Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: During the facility tour between 10:00 AM and 12:00 PM on 05/05/2015, observation revealed that the ventilation system for the 1967 corridors appears to be utilizing the egress corridor as an air plenum for the resident rooms. This deficient practice was verified by the administrator at the time of the inspection.	K 067		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, June 05, 2015 12:05 PM
To: rochi_lsc@cms.hhs.gov
Cc: robert.rexeisen@state.mn.us; 'pvoelker@villahc.com'; Dehler, Robert; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH)
Subject: Villa at Bryn Mawr (245203) 2015 K67 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that Villa at Bryn Mawr is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 5-7-15.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility **2000 CODE**

The Villa at Bryn Mawr 275 Penn Avenue North Minneapolis, Minnesota 55405

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K-067	A. An annual/continuing waiver is being requested for K-067 Compliance with this provision will cause an unreasonable hardship because: 1. the most recent cost estimate for complying HVAC dated 7/14/2014, is $259,000.00 and will include the upgrade of the following systems: See description from Gilberts on the work that would need to completed for this waiver. Plus an additional amount of $49,000 for structural engineering and installing sheet rock enclosures for the resident rooms. 2. installing a complying HVAC system will force disruption to the facility residents by displacing from their living area during the period of installation in specific rooms and add to noise and dust levels for an extended period. 38 rooms would be affected by this project. 3. under current CMS reimbursement rates it is estimated to take 10 or more years to recoup the cost. This facility has had operating losses during each of the past 5 years. 4. Given the facility's financial condition. It would be difficult to acquire a loan in the amount of the estimate. However , a bank loan at 5 1/2 % over 20 years would add $142,450.00, in interest to the cost of the project. 5. The building 48 years old and is not slated for replacement. B. There will be no adverse effect on the building occupant's safety in accordance with SOM2480B. 1. The building is Type II (2222) construction with an interior finish ration Class A. 2. The walls, floors, ceiling and vertical resist the passage of smoke. 3. the following life safety features are installed: notifier fire alarms through, reliable and Tyco bran sprinkler system throughout, automatic dialer to fire department monitor by Transalarm, UL300 rated kitchen hood suppression system. 4. Our fire safety plan addresses: fire containment, fire extinguish, evacuation, fire compartments, location of ambulatory and non-ambulation residents, notification of fire department.

Surveyor *(Signature)*	Title	Office	Date
		State Fire Marshal	
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office	Date 6-5-15

Name of Facility	2000 CODE
The Villa at Bryn Mawr 275 Penn Avenue North Minneapolis, Minnesota 55405	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K-067	B. There will be no adverse effect on the building occupant's safety in accordance with SOM2480B. 5. We have a fire watch program. We have 2 secured smoking rooms which are secured or have camera's for observation. 6. Current facility staff to resident ratio is 3.65. 7. There is a total of 13 smoke compartments per floor in the facility. basement: 1 compartment; Lower level: 2 compartments; first floor: 5 compartments; second floor 5 compartments. 8. Location of all residents: a. basement --zero residents b. lower level -- 8 residents c. first floor-- two units: 50 residents d. second floor -- two units: 62 residents We do not have a TCU unit. We are a 120 bed snf facility which admits medical/mental health residents. 9. closet fire department is: 1600 Glenwood Ave. 0.4 miles.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date 6-05-15

GILBERT

Gilbert Mechanical Contractors, Inc
Gilbert Electrical Technologies
4451 West 76th Street
Minneapolis, MN 55435
Phone: (952) 835-3810
Fax: (952) 835-4765

HVAC • Plumbing • Electrical • Controls • Fire Protection • Service

Company:	Bryn Mawr Health Care	**Date:**	07/14/14
Street:	275 Penn Avenue	**Project:**	Bryn Mawr Health Care – Ducted
City/State:	Minneapolis, MN		Fresh Air to Resident Rooms – Station 1 & 2 North & South Wings
ATTN:	Craig Nicholson	**Pages**	2

Proposal

Gilbert Mechanical Contractors will provide the necessary labor and materials to complete the following at 275 Penn Avenue in Minneapolis:

Installation of two 9 ton Aaon heat/cool 100% outside air roof top units and associated air distribution ductwork to directly serve air to resident rooms. Station 1 and station 2 south wings would be served by one roof top unit. Station 1 and station 2 north wings would be served by the second roof top unit. We are delivering air to a total of 38 resident rooms and the associated corridors for these stations beyond the fire doors. Ductwork will be run on the roof and penetrate above resident rooms and corridors. Ductwork will run through roof to a register in the second floor resident room and continue through a fire damper at the floor to a register in the first floor resident room. Two diffusers will be added to the corridors on each floor of the 4 wings. The installation of these systems will achieve 2 air changes of fresh air per hour in the resident rooms and 4 total air changes per hour in the corridor. Work specifically includes: 2 new Aaon double wall construction 100% outside air heat/cool roof top units, roof top unit curbs, duct penetration curbs, duct support bucks, roofing for all duct roof curbs, core drilling and saw cutting of holes through roof and floors, double wall insulated ductwork on roof, single wall externally insulated ductwork inside space, supply air registers & diffusers, fire dampers at penetrations through first floor ceiling, gas piping to new units, power wiring from main panel, discharge air temp control with space temperature override, control wiring, smoke detector inside unit, crane, professional mechanical engineering, drawing, labor, material, taxes, check/test/start, air balance and one year warranty

Amount: $259,000.00 (budget price)

Add: $1,300.00 to $3,800.00 for structural engineering: Considering the unique design of the roof and floor, we recommend that structural engineering is performed in connection with the holes and roof top placements.

Add: $14,000.00 (rough approximate price) to have a general contractor install sheet rock enclosures around each of approximately 14 vertical ducts in the resident rooms as a result of this project. You may also want to have a contingency fund for patching and painting at penetrations (approximately $5,000.00?)