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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7JOA

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 **09/17/2018** (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: **A5*** (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:
Eva Loch, Unit Supervisor 09/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 10/01/2018 (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
09/24/2018
(L33)

DETERMINATION APPROVAL

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

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency:

K 521 - HVAC

The facility's request has been forwarded to the CMS Region V Office for their review and determination.

Approval of the waiver has been recommended.

Electronically delivered

CMS Certification Number (CCN): 245203

September 19, 2018

Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, MN 55405

Dear Administrator:

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 September 11, 2018 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: K-521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 19, 2018

Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, MN 55405

RE: Project Number S5203027

Dear Administrator:

On August 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 9, 2018. 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 September 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 9, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 11, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 9, 2018, effective September 11, 2018 and therefore remedies outlined in our letter to you dated August 23, 2018, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K0521 at the time of the August 9, 2018 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7JOA

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00175

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(L1) **245203**

2.STATE VENDOR OR MEDICAID NO.
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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 **08/09/2018** (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
X 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)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (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:
Lisa Hakanson, HPR-Dietary Specialist — 09/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 09/21/2018 (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**

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency:

K 521 - HVAC

The facility's request has been forwarded to the CMS Region V Office for their review and determination.

Approval of the waiver has been recommended.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 23, 2018

Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, MN 55405

RE: Project Number S5203027

Dear Administrator:

On August 9, 2018, 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 electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the August 9, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5203064 that was found to be unsubstantiated.

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;

Electronic 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Eva Loch, 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: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 September 18, 2018, 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 September 18, 2018 the following remedy will be imposed:

- Civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- 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 ePoC 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 ePoC 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 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, 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 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.

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 November 9, 2018 (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 February 9, 2019 (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 an ePoC 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections

Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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 _____	C 08/09/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/6/18 through 8/9/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 8/6/18 throught 8/9/18, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint H5203064 was completed and was found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		9/11/18

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

Electronically Signed | 08/30/2018

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 _____ B. WING _____	C 08/09/2018

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 558	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call light was accessible for 1 of 1 residents (R28) who was capable of using the call light reviewed for environment. Findings include: On 8/6/18, at 2:10 p.m. R28 was observed sitting on the edge of her bed in a shared room with her roommate present. R28 was holding a denture cup with water in it and stated she wanted someone to help her dump the water out. When asked why she did not use her call light R28 responded she did not have one and needed to wheel herself down to the nurse's station whenever she needed assistance. R28 also stated the call light had been missing for about three weeks and she had told staff she wanted one multiple times but still did not have one. R28 said there had been instances where she was scared for herself and her roommate during the night when she would have to take the time to get herself into her wheelchair to go to the nurses station for assistance because she did not have a call light. On 8/6/18, at 2:24 p.m. the writer informed registered nurse (RN)-A R28 would like assistance. RN-A entered R28's room, reached over and behind the farthest of two nightstands lined up and approximately five feet away from R28's bed and retrieved the call light button. After she retrieved the call light button RN-A wrapped it around the front handle of the night stand next to R28's bed and stated "that is where R28 likes to have it." RN-A stated R28 could not have known	F 558	Resident #28 call light is within reach. All residents call lights are within reach. All staff have been re-educated regarding appropriate call light placement to be within reach of resident Call light placement will be audited with Eight (8) rooms per station daily x four (4) weeks; then four (4) rooms daily per station. Audit results will be reviewed at QAPI.	

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 _____	C 08/09/2018

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 558	Continued From page 2 where her call light button was located, been able to retrieve it from where it was and did not know for how long the call light has been behind the nightstand and toward the floor. RN-A also stated R28 was capable of using her call light and had R28 demonstrate she was able to use it. R28's quarterly minimum data set dated 5/18/18, indicated R28 had intact cognitive function. R28's care area assessment dated 9/6/17, indicated activities of daily living objectives of avoiding complications and minimizing risk. The call light was not addressed in R28's care plan. On 8/7/18, at 9:06 a.m. the assistant director of nursing (ADON) stated all call lights should have been accessible to residents, and if not, the situation needed to be corrected immediately. The ADON also stated the facility did not have a policy and procedure for call lights.	F 558		
F 584 SS=E	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	F 584		9/11/18

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F 584	Continued From page 3 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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean, orderly and comfortable environment for 4 of 4 residents (R48, R6, R61, R78) reviewed for maintenance concerns. In addition the facility failed ensure the second floor dining area, the secured unit, and the outside patio were kept clean and in good repair, which had the potential to affect residents who utilized these areas. Findings include:	F 584	Residents #48, #6, #61, and #78 rooms have been reviewed and maintenance concerns identified have been corrected.¿ The Preventative maintenance schedule has been updated to include provision of cleanliness and good repair for the 2nd floor dining area, secured unit, and outside patio. All resident rooms and public areas have been reviewed for maintenance and cleaning needs.¿ Areas identified have	

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F 584	Continued From page 4 R48's room was observed on 8/8/18, at 8:04 a.m. and R48 was interviewed regarding a drawer front missing from his dresser. R48 said, "I don't have enough fingers to count the weeks I have waited to get that fixed. Finally I just brought it to the desk and put it on the counter. I got no explanation, and sooner or later you stop asking". R48 went on to explain the bathroom sink overflowed often and water leaked out from the bathroom all the way across the room. R48 believed the water was the reason for dark areas on the floor tiles. The tiles by the bathroom had a dark black substance and the metal molding around the bathroom door looked rusted. The toilet was dirty looking at the bottom of the bowl. There was dried yellow stains around the top of the bowl and the room smelled strongly of urine. A housekeeper was observed working in the area but had not yet entered R48's room. The second floor dining room was observed on 8/08/18, at 08:19 a.m. The dining room ceiling tiles had bits of left over tape and paper hanging down. A plastic plant was covered in a heavy layer of gray dust. Ten fluorescent light fixtures had evidence of dirt and bug debris inside the cover. The shared bathroom for R6, R61 and R78 was observed on 8/8/18, at 8:51 a.m..There was a strong urine odor in the bathroom and in R6's room. Nursing Assistant (NA)-A verified the odor at the time of the observation. NA-A said the bathroom smelled very strong all the time and made her sick to smell it every day. R61 was interviewed on 8/9/18, at 9:02 a.m. and said the smell from the bathroom bothered him. On 8/8/18, at 10:02 a.m. Housekeeper (Hskp)-A	F 584	been corrected. All staff have been educated regarding reporting of maintenance and cleaning needs through the TELS system and through communication with the LNHA. The LNHA/Designee will round the facility bi- weekly with housekeeping to ensure that areas remain appropriately cleaned and to ensure that any problem areas are appropriately reported for resolution.¿ LNHA/Designee will round the facility bi-weekly with maintenance and review maintenance work orders to ensure that problem areas are appropriately reported and resolved.¿ Results of audits will be reviewed at QAPI.	

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F 584	Continued From page 5	F 584		

was interviewed regarding R6's room. Hskp-A said the room and bathroom were mopped every day and the toilet cleaned every day, but the room continued to smell. Hskp-A explained R6 smelled because he refused to wear incontinent products or wash his clothes. Hskp-A believed the smell was in the floor.

A facility tour was conducted on 8/8/18, at 1:00 p.m. with the administrator, maintenance director (MD), housekeeping supervisor (HS), and two representatives from the contracted housekeeping service (CHS). During the tour the following items were observed:
- The room for R48 was observed during the tour and a drawer front was missing from the resident's cupboard. An explanation for the state of the cupboard was not given. The administrator said, "we can do better". R48's room also had dark soiling on the floor by the bathroom. The CHS representative tried to wipe the area with a wet rag, but the stain did not come off. Cracked floor tiles were noted. MD said they could change tiles individually. The toilet bowl was still soiled at the time of the tour. CHS representative verified the soil and said it was not up to standard and would be cleaned right away.
- The 2nd floor dining room was observed at the time of the tour and CHS representatives verified the dusty plants, dusty blinds, left over tape and paper on ceiling tiles and debris in the light fixtures. CHS representative explained the blinds and other issues would be addressed during deep cleaning of the dining room. However, they did not know when it had last been deep cleaned or when it was scheduled to be cleaned in the future.
- The shared bathroom for R6, R61 and R78 was observed on the tour. The administrator and CHS

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F 584	Continued From page 6	F 584		

representatives verified the odor. They explained they have cleaned the floor regularly and have tried various cleaning agents, but the odor was right back after about 20 minutes. They said the odor may have penetrated into the flooring.
- The exhaust vent in the shared bathroom was tested with a piece of toilet paper. The paper was not drawn to the vent, indicating a weak air flow. The facility director verified he was aware the ventilation was weak on that end of the building. He stated the vents had been checked and were working, but the draw was weak.

The back patio/smoking area was found to be littered with cigarette butts in the two planting areas and scattered around the ground. The patio wood picket fence had white stains resembling bird droppings along the fence boards, and the fence was not straight. The ground under the fence was littered with cigarette buts and some garbage. MD stated they just put weed killer on the planting areas to prepare the area for a re-do, and had plans to fix the fence and remove weeds around the fence. HS verified the patio was to be swept daily. Review of the project management log for capital expenses for 2018, indicated money requested fro the courtyard fence and gate, but had not yet been approved.

Also found during the tour was the door to the second floor secured unit was heavily marred from inside the unit and dining room curtains were hanging off the hooks. The administrator verified the findings.

A policy concerning general housekeeping dated 6/2016, indicated quality service can only be delivered and maintained through use of proper environmental services methods.

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F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any	F 660		9/11/18

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F 660	Continued From page 8 referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide effective discharge planning process to facilitate finding an	F 660	Resident #90 has had a discharge plan initiated. All residents have had discharge plans	

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F 660	Continued From page 9 alternative placement in a timely manner for 1 of 2 residents (R90) reviewed for discharge planning. Findings include: During observation and interview on 8/6/18, at 6:27 p.m. R90 stated he was trying to discharge to Wisconsin and was waiting for the social workers response. R90 verbalized he was unsure of where the facility was at with the discharge plan and that all of the social workers were aware of his discharge goal. R90 did not specify how long he had been waiting for dischage. R90 had a disheaveled appearance and voiced that he was unhappy that he was still at the facility. R90 began to wretch hands while he shook his legs up and down as he voiced his frustration regarding his discharge plan. R90's quarterly Minimum Data Set dated 7/21/18, indicated R90 was cognitively intact. R90's diagnosis report, dated 8/9/18, identified current diagnoses personality changes, bipolar disorder and personal history of traumatic brain injury. R90's care plan, dated 7/20/18, indicated R90 was at the facility for long term care. However, the care plan did not identify what the plan was for R90's discharge. R90's progress notes were reviewed: -The note dated 4/25/17, indicated R90 would like to look at discharge to Wisconsin or Silver Bay, Minnesota. R90 was accepted at both facilities but guardian was not in agreement at this time; -The note dated 4/27/17, indicated R90, guardian and social worker would meet to discuss discharge planning. Social worker left guardian a	F 660	reviewed.¿ The discharge planning process will be initiated upon admission and reviewed and updated on a quarterly basis and as needed to meet the individual discharge plans of each resident. LSW have been re-educated regarding discharge planning. LNHA/Designee will audit 5 residents/week for 2 weeks and then 2 residents per week for the presence of appropriate discharge planning.¿ Audit results will be reviewed at QAPI.	

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F 660	Continued From page 10 voicemail; -The note dated 1/23/18, indicated R90 discharge plan was long term care; -The note dated 3/30/18, indicated R90's social worker (SW- B) contacted facility in Silver Bay, Minnesota for R90's discharge however was awaiting return telephone call; -The note dated 4/23/18, indicated R90's guardian was looking into a facility located in Silver Bay, Minnesota for R90's discharge; -The note dated 6/22/18, indicated SW- B left a voicemail message for Silver Bay, Minnesota facility however was awaiting return telephone call; -The note dated 7/20/18, indicated R90 stated he would like to discharge to the facility located in Silver Bay, Minnesota. R90's progress notes lacked evidence of follow-up from the facility staff regarding R90's discharge plan and furthermore lacked communication to R90 with an updated discharge plan. On 8/8/18, at 2:16 p.m. the social worker (SW)-B stated he was aware of R90's discharge goal to discharge to the VA facility in Silver Bay, Minnesota. SW-B indicated he has left voicemail's for the VA facility on 3/30/18 and 6/22/18 without return telephone calls. SW-B explained the need for R90's guardian to contact the VA facility for completion of a form however was unaware if this had been done. SW-B identified he had not communicated this to R90. SW-B stated R90 "doesn't rationalize it when trying to explain things to him and whenever we try to rationalize anything with him he doesn't really understand certain things ... He just doesn't understand." SW-B identified R90's most recent brief interview for mental status (BIMS) for	F 660		

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F 660	Continued From page 11 quarterly assessment, dated 7/20/18, indicated 15/15 intact cognition. On 8/9/18, at 11:53 a.m. the director of social services (DSS) verbalized her expectations for discharge planning begins at admission and continued on an on-going as needed basis. DSS stated she would expect this to be covered on-going in care conferences. DSS indicated she would expect social worker to continually follow-up if the facility wasn't getting a response and she would expect the social worker to be in constant contact with R90's guardian. DSS identified she had only been employed at the facility for two months and could not state a reasonable time frame for R90's discharge plan. The facility's discharge care plan guideline revised on 5/3/18, indicated the resident will be re-evaluated periodically to identify changes and the discharge care plan will be modified to reflect any changes.	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided to 1 of 2 residents (R92) reviewed for activities of daily living (ADLs) and whom was dependent on staff for care. Findings include:	F 677	Resident #92 has received nail care. All dependent residents are receiving appropriate nail care. All nursing staff have been re-educated regarding provision of appropriate nail care for dependent residents. ADON/Designee will audit 4 dependent	9/11/18

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F 677	Continued From page 12 R92's admission record dated 3/20/10, indicated diagnoses of schizoaffective disorder, mild intellectual disabilities and adult failure to thrive. R92's quarterly Minimum Data Set dated 4/14/18, indicated R92 sometimes was able to understand others and sometimes was able to make self understood, had severe cognitive impairment, and needed extensive assist of two person for personal hygiene. R92's care plan dated 7/13/18, indicated alteration in activities of daily living with need for extensive assist of two for grooming. The care plan further indicated R92 had communication problem, resident was able to make his needs know but due to R92's mild intellectual disability and garbled speech, he was not able to make himself entirely understood or understand others. Facility staff were expected to anticipate and meet needs. During an observation on 8/6/18, at 5:45 p.m. R92's finger nails on both hands were long and dark colored substance under nails. During an observation on 8/8/18, at 1:26 p.m. R92 was sitting in a wheelchair by the nurses station, and R92's was observed with long finger nails and dark colored substance under his nails. The undated facility document, identified R92 (by room number) will get a bath on Wednesday on the "PM Shift," including "NAIL CARE, SHAVE RESIDENT, NOTIFY NURSE FOR DIABETIC RESIDENT NAIL CARE." During an observation and interview on 8/9/18, at 11:30 a.m. nursing assistant (NA)-C verified R92 had dark grayish, black matter under fingernails. NA-C offered R92 nail care and was observed to	F 677	residents per station x 4 weeks, then 2 residents per station weekly.¿ Audit results will be reviewed in QAPI.	

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F 677	Continued From page 13 clean under R92's fingernails. NA-C used a nail brush to brush out black matter R92's fingernails and a wet washcloth to clean up black matter from fingernails. During an interview on 8/9/18, at 12:39 p.m. the assistant director of nursing (ADON) stated she expected facility staff to have cleaned resident's fingernails on scheduled bath days and as needed. ADON verified R92 had skin check done on 8/8/18, the same day resident was scheduled for a shower. Requested facility policy in regards to personal cares and grooming, however none received.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote safety with smoking for 2 of 3 residents (R10, R90) reviewed for smoking. Findings include: R10's quarterly Minimum Data Set dated 5/5/18, indicated moderate cognitive impairment. R10's	F 689	Residents #10 and #90 have had their smoking interventions reviewed. All residents who smoke have had their smoking interventions reviewed and where appropriate interventions modified and care plans updated. Nursing and Social Service staff have been re-educated regarding smoking interventions and ensuring interventions are in place.	9/11/18

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F 689	Continued From page 14 diagnosis report dated 8/9/18, identified current diagnoses schizophrenia and muscle weakness. R10's care plan dated 5/11/18, indicated R10 was an unsafe smoker. R10's care plan interventions included to observe clothing and skin for signs of cigarette burns and R10 must get cigarettes and smoking apron from nursing station before going out to smoke on patio. Care plan identified R10 can smoke unsupervised, light his own cigarette and keep lighter at bedside. R10's smoking risk observation dated 5/3/18, indicated R10 was an unsafe smoker. R10 was deemed as careless with smoking materials. On 8/6/18, at 2:45 p.m. R10 was observed to wheel himself to smoking patio with an unlit cigarette hanging from his mouth, a lighter in his left hand and no smoking apron on. At 2:51 p.m. R10 was observed independently lighting the cigarette and had no smoking apron on. No ashes were observed falling on R10's clothing. On 8/6/18, at 3:16 p.m. R10 was observed again on the smoking patio smoking a cigarette with no smoking apron on. R10 asked another smoking resident to place cigarette into ashtray. No ashes were observed falling on R10's clothing. During interview on 8/6/18, at 5:47 p.m. R10 stated the facility held his cigarettes locked in the medication cart and gave R10 three cigarettes twice a day. R10 explained he was able to keep his cigarette lighter on his person. R10 indicated the seven burn holes on the front of the wheel chair cushion and seat were from cigarette ashes falling down. R10 verbalized he held his lit cigarette with his hand resting downward between	F 689	LSW/Designee will audit 5 smokers per week x 2 weeks and then 2 smokers weekly.¿ Audit results will be reviewed at QAPI.	

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F 689	Continued From page 15	F 689		

legs. R10 identified he was sitting on top of his smoking apron, sometimes he wore the smoking apron and sometimes did not. No burns were observed on R10's hands.

During interview on 8/8/18, at 10:05 a.m. the trained medication aide (TMA)-A stated R10 had a smoking plan for three cigarettes every morning and evening, needed a smoking apron before he went to smoke and was allowed to smoke without supervision on the patio. TMA-A explained R10 had the smoking precaution of needing to wear the smoking apron. TMA-A indicated she watched for R10 and reminded him when he wasn't wearing his smoking apron. TMA-A stated R10 did check-in prior to going to smoke. TMA-A identified R10 had burnt his clothing in the past and wasn't safe smoking without his smoking apron.

On 8/9/18, at 9:29 a.m. R10 was observed seated in his wheelchair in the dining room sitting on his smoking apron with an unlit cigarette and lighter on the table in front of him.

On 8/9/18, at 10:32 a.m. R10 was observed to wheel himself in wheel chair with an unlit cigarette in his mouth outside onto the smoking patio. R10 was not wearing smoking apron.

During interview on 8/9/18, at 10:25 a.m. the assistant director of nursing (ADON) explained R10's smoking plan included R10 to have smoking apron on. ADON stated R10 must have smoking apron on and given one cigarette at a time up to six cigarettes per day. ADON indicated R10 could get his cigarette from the assigned TMA or nurse anytime he wanted. ADON verbalized R10 had not had any injuries or

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accidents related to smoking. ADON expressed her expectations for the assigned TMA or nurse were to provide encouragement and education when they saw R10 going out to smoke without his smoking apron. ADON explained her expectation for the assigned TMA or nurse were to either go out and supervise R10 or find someone who can when R10 refused to put on the smoking apron.

R90's quarterly Minimum Data Set (MDS), dated 7/21/18, indicated R90 was cognitively intact. R90's diagnosis report, dated 8/9/18 included current diagnoses personality changes, bipolar disorder and personal history of traumatic brain injury.

R90's care plan, dated 7/20/18, indicated R90 was potentially unsafe smoker, had a history of smoking in unauthorized areas and at times will not wear appropriate footwear when going outside to smoke. R90's care plan interventions included R90's cigarettes were stored at the nurse's station and R90 was to receive one cigarette after taking medications and wearing proper footwear six times per day. R90 was to be offered an extra cigarette for completion of showering.

R90's smoking risk observation, dated 3/8/18, indicated R90 was a potentially unsafe smoker.

R90's physician order, dated 10/15/16, indicated R90 to keep cigarettes in the medication cart and to hold the cigarette until R90 has taken his medications.

R90's psychology recommendation, dated 3/16/18, indicated R90 should have a consistent

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program to decrease irritability and needed to wear shoes prior to being given a cigarette.

On 8/6/18, at 3:00 p.m. R90 was observed on the smoking patio dressed with black regular socks on both feet. R90 threw the lit cigarette into the middle weedy area of the smoking patio. R90's cigarette continued to smoke for a few minutes then stopped burning on it's own, without any intervention.

On 8/6/18, at 3:16 p.m. R90 was observed seated on the smoking patio dressed with black regular socks on both feet. R90 set the lit cigarette onto the cement underneath the chair that R90 sat on. R90's cigarette continued to smoke for a few minutes then stopped burning on it's own.

On 8/6/18, at 3:24 p.m. R90 was observed seated on the smoking patio dressed with black regular socks on both feet. R90 threw the lit cigarette into the plants on the perimeter of the patio. R90's cigarette continued to smoke for a few minutes then stopped burning on it's own.

During interview on 8/6/18, at 6:26 p.m. R90 stated that he was allowed six cigarettes per day three in the morning and three in the evening. R90 explained facility kept his cigarettes for him but R90 kept his lighter. R90 verbalized he knew that there were ash trays located on the smoking patio.

During interview on 8/8/18, at 10:09 a.m. trained medication assistant (TMA)-A stated R90 was given three cigarettes in the morning and evening. TMA-A denied resident having any smoking precautions or needed items prior to smoking. TMA-A indicated R90 had tried to go

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F 689	Continued From page 18 walk outside without socks or shoes in the past. TMA-A explained when R90 didn't want to wear shoes they encouraged R90 to wear gripper socks. On 8/9/18, at 9:28 a.m. R90 was observed seated at dining room table with one gripper sock on right foot and regular sock on left foot. During interview on 8/9/18, at 10:00 a.m. the assistant director of nursing (ADON) stated R90 had a smoking plan that included R90 was an independent smoker, cigarettes stored at nurse's station and one cigarette to be given out after R90 had taken medication and wearing proper footwear with a daily maximum of six cigarettes per day. ADON verbalized proper footwear was season dependent shoes or gripper socks were preferred. ADON explained her expectations were for R90 to wear something protective on his feet when outside as long as R90's bare feet were covered. ADON stated she preferred R90 to wear shoes or gripper socks but it was R90's preference. ADON was unaware of any smoking concerns regarding R90's smoking safety. The facility's resident policy and procedure for safe smoking revised and reviewed on 10/11/17, indicated that resident's will be assessed for their ability to smoke safely and a safe smoking plan could include the following: smoking aprons, designated smoking times, limits on facility assistance with purchasing smoking materials and additional supplies when needed. Furthermore, it also indicated that the facility provided cigarette containers for the safe disposal of cigarettes and ashes.	F 689		
F 740	Behavioral Health Services	F 740		9/11/18

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F 740 SS=D	Continued From page 19 CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop and implement identified psychological interventions to promote well-being and reduce irritation for 1 of 3 residents (R90) reviewed for behavioral and emotional concerns. Findings include: R90's ACP progress note dated 12/1/17, indicated R90 engaged in activities which stimulated his mood such as chess and checkers. The note recommended the facility continue to offer opportunities for these games. In addition, R90 was identified as being very focused on smoking, and he may have been responsive to a smoking incentive plan. A subsequent ACP note dated 3/16/18, indicated R90 presented more irritable since his last session on (12/1/17). R90 appeared more anxious versus the last time and as time went by. ACP recommended the facility should consider having a new smoking program that needed to	F 740	Resident #90 Behavioral Health Program has been reviewed and is appropriate and follow up documentation is in place. All residents Behavioral Health Programs have been reviewed and are appropriate and follow up documentation is in place. Social Services and Nursing have been re-educated on Behavioral Health Programs and follow up documentation.¿ LNHA/Designee will audit Behavioral Health Programs and follow up documentation on 5 residents weekly x 2 weeks and then 2 residents weekly. Audit results will be reviewed at QAPI.	

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have a consistent response for R90 and further suggested facility staff to respond to R90 as follows, "I can give you a cigarette as soon as you have your shoes on." or "You have your shoes on, that is great, here is your cigarette." ACP noted that facility staff should be mindful that R90 was likely to still swear at staff, especially while adjusting to this new routine. Not following this consistently had the potential to increase R90's irritability and further suggested to consider offering time for R90 to play chess or checkers for mood stimulation. ACP addressed they would continue to follow R90 while he resided at the facility, however, no further evidence was in the medical record to demonstrate subsequent visits had occurred.

R90's quarterly Minimum Data Set dated 7/21/18, indicated R90 was cognitively intact. R90's diagnosis report dated 8/9/18, identified R90 had diagnoses including personality changes, bipolar disorder and personal history of traumatic brain injury. In addition, R90's Behavior Care Area Assessment (CAA) dated 4/20/18, indicated R90 had behavioral symptoms including physical and verbal behavioral symptoms, however, R90 was independent with decisions regarding tasks of daily living. Further, R90's CAA indicated Associated Clinic of Psychology (ACP) had been offered, however, was declined at that time.

R90's care plan dated 7/20/18, indicated R90 was independent for meeting his own emotional, intellectual, physical and social needs; however, also had verbal and physical aggression, threatening others and resistance to care. The plan listed interventions for staff to follow including psychiatric follow up as indicated, education, one to one activities,eating candy bars

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and offering/providing cigarettes when he had proper footwear on. R90's care plan lacked evidence of person centered individualized behavioral interventions as identified by ACP on 3/16/18.

On 8/6/18, at 3:00 p.m. R90 was observed smoking outside on the smoking patio with black regular socks on both feet. R90 did not have shoes on despite the ACP recommendation in 3/16/18, to have shoes on his feet before being given cigarettes. R90 shouted aloud, "This place sucks and I hope it goes down." When interviewed at that time, R90 stated he was allowed six cigarettes per day, with three in the morning and three in the evening. R90 added the facility kept his cigarettes for him, but he kept his own lighter.

On 8/6/18, at 7:05 p.m. R90 was standing at the medication cart when LPN-D asked him to put shoes on. R90 shouted back, "No." LPN-D offered gripper socks to R90 who responded, "No they are too hard to put on." LPN-D offered assistance to R90 to put the gripper socks on, however, again, R90 shouted "No!" and walked off of the unit.

On 8/7/18, at 10:15 a.m. R90 was observed pacing up and down the unit hallway to and from the unit bathroom multiple times. R90 indicated he was frustrated as he was unable to use the bathroom in his room due to his roommate. R90 stated that he wanted the unit bathroom left unlocked and shouted down the unit hallway at various unidentified staff to leave the door unlocked. None of the staff in the hallway turned or responded to R90, however, they did go unlock the door.

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On 8/9/18, at 8:09 a.m. R90 was observed smoking outside on the smoking patio with black regular socks on both feet. R90 did not have shoes on.

R90's Medication Administration Record (MAR) dated 8/1/18 to 8/8/18, indicated R90 had two orders for behavior monitoring in place. The first listed several target behaviors including verbal aggression, anxiety, depression, insomnia, biting, hitting, scratching, kicking, spitting, throwing items, yelling, banging, delusions, and self-harm. The MAR listed interventions for staff to record for these behaviors which included redirection, remove from environment, see notes and as-needed medication given. R90 was recorded as having one episode of anxiety, three episodes of insomnia, one episode of depression symptoms, one episode of yelling, banging, one episode of verbal aggression and one episode of spitting/ throwing items. These behaviors had corresponding interventions listed which identified following redirection and removal from environment six out of eight times R90's behavior remained the same, one time behavior improved and one time behavior worsened. The second order from R90's MAR dated 8/2018, identified R90's behavior monitoring was to occur every shift for verbal aggression, obsessing about Wisconsin and refusal of cares, including dressing and showers. Documentation indicated R90 had 10 instances of these behaviors between 8/1/18, to 8/8/18. However, this MAR entry lacked any recorded evidence of attempted behavioral interventions staff completed to help reduce and/or eliminate R90's behaviors as recommended by ACP on 3/16/18. R90's MAR, dated July 2018, indicated R90 had 15 episodes

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of recorded behaviors. However, the progress notes lacked any evidence of recorded behavior and attempted behavioral interventions staff completed for R90's behaviors.

R90's progress note, dated 8/7/18, indicated R90 used inappropriate offensive words towards the trained medication aide (TMA) on duty. Intervention by nurse indicated one to one conversation with resident were effective. However, there were no additional progress notes that addressed R90's behaviors from 8/1/18-8/8/18.

During interview on 8/8/18, at 10:09 a.m. TMA-A stated R90 was given three cigarettes in the morning and evening. TMA-A denied that R90 needed gripper socks or shoes on before cigarettes were given and explained R90 had tried to walk outside without socks or shoes in the past. TMA-A verbalized when R90 did not want to wear shoes they encouraged R90 wear gripper socks, however, then had times when he would yell or become upset and this would be documented in the medical record or TMA-A would notify the nurse.

On 8/8/18, at 2:16 p.m. the social worker (SW)-B stated R90 got verbally aggressive during their interactions. SW-B indicated R90's interventions included one to one time, chess, milky ways if he did not show the behavior, walk with activities, television and Associated Clinic of Psychology (ACP) but when offered R90 refused. SW-B verbalized he was "certain" R90 had refused to be seen by ACP since at facility. SW-B explained when a resident refused to be seen, ACP would place a note into the resident chart stating they had any recommendations made from ACP were

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reviewed during the morning meeting between staff. Further SW-B commented the nurse manager and social service director also read any ACP recommendations, as well.

On 8/9/18, at 10:00 a.m. the assistant director of nursing (ADON) stated R90 had a smoking program and received one cigarette up to six times per day when R90 had shoes or gripper socks on his feet. ADON verbalized R90 had a history of going outside with bare feet. ADON stated unit four which R90 lived on was staffed by a TMA and the nurse covering unit four was located on station one. ADON explained it was her expectation that the TMA assigned to station four participated in cues and reminders for activities of daily living- including reminding R90 to put on shoes or gripper socks and to implement behavior interventions for residents who resided on the unit. ADON also indicated the TMA would be expected to notify the assigned nurse located on station one for help with behaviors when needed. ADON explained medication administration record was used to document behaviors and interventions, and it was an expectation that behaviors were reassessed as needed and on-going by daily review of the resident's progress notes. ADON stated, "in a perfect world a progress note would be written for behavior documentation but the eMAR lists out a progress note."

On 8/9/18, at 11:53 a.m. the director of social services (DSS) stated Associated Clinic of Psychology (ACP) had a list of residents that they saw, resident refusals were documented in a progress note, the resident report was then reviewed by social services and put into the resident chart. DSS explained all

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F 740	Continued From page 25 recommendations were care planned and immediately acted upon, and passed along to the right department. DSS verbalized progress notes were reviewed daily for behaviors from the previous day, and anything of concern was addressed in morning clinical meetings. DSS confirmed R90 was followed by ACP and was to be seen as needed. DSS identified R90 had been at his baseline for behaviors and hasn't had any changes with current behaviors. DSS indicated that if there were no changes in the resident's behaviors they did not need to be seen by ACP. DSS stated that she was unable to answer how ACP recommendations were processed at the facility previously, as she had only been employed for 2 months. DSS explained the new process was for her to receive the ACP recommendations and to ensure they were acted upon immediately. The facility's behavior management program effective 11/28/17, indicated that the facility would assess residents for risk factors with ongoing evaluation of potential risks and care plan effectiveness as part of the overall treatment plan for all residents.	F 740		
F 761 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	F 761		9/11/18

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F 761	Continued From page 26 §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 ensure an expired vial of Tuberculin solution was discarded on 1 of 3 stations reviewed for medication storage. This had the potential to affect residents who could have been tested with the remaining two doses. In addition, the facility failed to ensure an expired diskus of Advair medication was unavailable for continued use for 1 of 2 residents (R66) on station 4 who used an Advair inhaler. Findings include: During observation of medication refrigerator on station 3 on 8/6/18, at 2:59 p.m. with licensed practical nurse (LPN)-A there was a vial of tuberculin solution opened, 1/5 full, and with a handwritten opened date of 6/27/18, verified by LPN-A. LPN-A stated tuberculin solution was only good for 30 days after opening. LPN-A stated she would put this vial in the destroyed drawer to be	F 761	The inhaler and Tuberculin solution have been removed from the medication cart and medication refrigerator. There are no inhalers or Tuberculin solutions in the medication carts/refrigerators that are past 30 days from being opened. All Nursing staff have been re-educated on inhalers and Tuberculin solutions not being available for use post 30 days from being opened.¿ ADON/Designee will audit all medication carts and refrigerators bi-weekly x 2 weeks; then 1x weekly. Audit results will be reviewed at QAPI.	

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 _____	C 08/09/2018

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 761	Continued From page 27 disposed and would get a new vial from station 1. During observation of medication cart on station 4 on 8/9/18, at 9:11 a.m. with trained medication assistant (TMA)-A, there was a diskus of Advair inhaler for R66 opened, 23 of 60 blisters full, and with a handwritten opened date of 7/2/18, verified by TMA-A. TMA-A stated she did not know how long the Advair inhaler was good for after opened and would just go by when the number of blisters went down and the reorder date on the label. TMA-A stated R66 received the Advair inhaler two times daily and had not yet administered the Advair inhaler to R66 today. TMA-A verified the pharmacy label on R66's diskus indicated R66's Advair inhaler had came from pharmacy on 7/1/18, had a refill date of 7/25/18. TMA-A also verified there was no other diskus of Advair inhaler for R66 on the medication cart. The Assistant Director of Nursing (ADON) came walking up to the medication cart and verified the Advair had been administered 7 days (14 doses) past the recommended disposal date. ADON stated she would notify the physician of the 14 doses given after the recommended disposal date, would audit the rest of the medication cart and notify pharmacy to send up a new Advair diskus for R66. ADON stated staff were to follow the guidelines for medication expiration hanging up in each medication room. ADON verified the guidelines indicated Advair diskus should have been disposed 30 days after foil opened. ADON verified R66 received the Advair 8/2 through 8/8/18, for 7 days, 14 doses after recommended disposal date. R66's physician order dated 4/18/18, indicated R66 was to receive Advair Diskus Aerosol Powder Breath 250-50 mg (milligrams)/dose 1	F 761		

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F 761	Continued From page 28 puff orally two times a day for chronic obstructive pulmonary disease. R66's August 2018 Medication Administration Record indicated R66 had received Advair inhaler twice a day from 8/2/18-8/8/18. On 8/9/18, at 1:44 p.m. the consultant pharmacist (CP) stated Advair was good for one month after opened per manufacturer's instruction and Tubersol solution was good for one month after first use per manufacturer's instructions. CP stated staff were to follow manufacturer's instructions for administering both Advair inhaler and Tubersol. The undated Tubersol manufacturer instructions indicated, "A vial of TUBERSOL which has been entered and in use for 30 days should be discarded." The undated Advair diskus manufacturer instructions indicated, "Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads "0" (after all blisters have been used), whichever comes first." Facility guidelines undated, GUIDELINES FOR MEDICATION EXPIRATION indicated Tubersol expired 30 days after opening and Advair Diskus expired 30 days after opening foil. Facility policy dated Rev 6/2014, Storage of Medications indicated, "Medications and biologicals must be stored safely, securely, and properly, following manufacturer's recommendations".	F 761		
F 791	Routine/Emergency Dental Srvcs in NFs	F 791		9/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 791 SS=D	Continued From page 29 CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		

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F 791	Continued From page 30 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident received dental services as needed for 1 of 4 residents (R38) reviewed who had ongoing dental needs including pain without further dental services provided or arranged. Findings include: R38's admission Minimum Data Set (MDS) dated 2/26/18, indicated R38 had no cognitive impairment and identified dental issues including obvious or likely cavity or broken natural teeth. R38's care area assessment (CAA), dated 2/28/18 indicated a referral to the dentist was warranted and would be done upon R38's request. R38's care plan initiated on 5/25/18, indicated R38 had oral/dental health problems. The goal dated 5/31/18, indicated R38 would be free of infection pain or bleeding in the oral cavity. No interventions were located to provide staff with direction to improve or maintain R38's oral health. There was no evidence in the medical record if R38 had seen the dentist since admission. During an observation and interview on 8/6/18, at 2:25 p.m., R38 did have obvious broken teeth. R38 stated he was seeing the dentist prior to admission and there was more work that needed to be done. When asked about pain R38 stated "Yes, I had a toothache the last couple of nights and I told the nurse about that". R38 was unable	F 791	Resident #6 has been seen by the dentist. All Residents who need to see the dentist have been scheduled for appointments. LSW/Nursing/Medical Records have been re-educated on ensuring dental appointments are made for residents. LSW/Designee will audit all new admissions for dental needs weekly.¿ LSW/Designee will audit (3) residents per week with Quarterly care conferences for dental needs weekly.¿ Audit results will be reviewed at QAPI.	

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F 791	Continued From page 31	F 791		

to remember if the facility offered a dental appointment. R38 stated the broken teeth did not affect the ability to eat or chew, although sometimes "they hurt and they give my Tylenol". R38 shared the concern that the oral issues would get worse and R38 felt self conscious that they "look bad."

During interview on 8/8/18, at 8:45 a.m., the with social worker (SW)-B stated that the SW originally assigned to R38 was no longer employed with the facility and SW-B was trying to assist. SW-B recalled the dental issue being discussed at R38's care conference held on 5/30/18, and SW-B provided the email request for a dental appointment to the health unit coordinator (HUC). The email, dated 5/30/18, at 3:14 p.m., requested a dental appointment be set up as R38 stated "his teeth has been hurting."

During an interview on 8/8/18, at 9:29 a.m. HUC-D stated she did not make the appointment. After reviewing the record HUC-D stated that she would have charted an appointment or a refusal and neither could be located.

During an interview on 8/8/18, at 10:12 a.m. the assistant director of nursing (ADON) verified that R38 had broken teeth, had not seen a dentist since admission and that the expectation was that R38's oral/dental needs would have been addressed.

A facility's Expanded Assessment Guideline policy dated 11/28/17, indicated that upon admission the interdisciplinary team would complete a comprehensive assessment that included resident needs, goals and preferences including oral health status.

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F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a pest free environment related to flies entering the building from loose fitting plexiglass around the air conditioners for 3 of 3 residents (R6, R61, R78) reviewed. This had the potential to affect all residents with loose fitting plexiglass in the facility. Findings include: R6's was observed 8/8/18, at 8:43 a.m. The bottom sheet of the bed had a wet and stained soiled area in the middle. There were several flies congregating on the soiled area. The Nursing Assistant (NA-A) was interviewed at the time of the observation and said the flies used to be worse due to dirty clothes hanging in the room and she complained to the facility administration as she felt it was an "infestation" problem. R6's room was again observed on 8/9/18, at 8:07 a.m. with NA-B. The bottom sheet of the bed had a soiled area. Flies were observed congregating on the soiled area. NA-B verified the flies were there every day and they were a nuisance. NA-B said the bed was changed every day due to soiling. The window air conditioner unit was also observed with NA-B. The plexiglass around the air conditioning unit was not secure to the window frame allowing access for flies to enter the room from the outside.	F 925	The Plexiglas around all air conditioner units in the facility have been re-taped. All linens on the beds have been changed. Maintenance has been re-educated on taping air conditioner units. Nursing has been re-educated on changing linens. Administrator/ADON/Designee will audit 5 resident rooms per week for 2 weeks and then 2 resident rooms weekly for clean linens.¿¿ Audit results will be reviewed at QAPI.	9/11/18

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F 925	Continued From page 33	F 925		

R61, who occupied the adjoining room to R6, was interviewed on 8/9/18, at 9:02 a.m. R61 and said he was bothered by flies "all the time." R78, who also occupied the adjoining room to R6, was interviewed on 8/9/18 at 10:23 a.m. and stated R78 was bothered by flies. R78 said, "when I lie down they start attacking".

An environmental tour was conducted on 8/8/18, at 1:00 p.m. with the administrator, the maintenance director (MD), the environmental supervisor, and two representatives from a contracted housekeeping service. The air conditioner for R61's and R78's rooms were observed. The plexiglass around the window air conditioner was taped to the window frame from inside the room. The tape was not holding the plexiglass securely to the window frame allowing large gaps to the outside. R6 was sleeping at the time of the tour, so an observation of his room was not made. However, the administrator and facility director verified all window air conditioners had been installed in the same manner with the same tape from inside the room. Additionally, they verified flies and other pests could enter the facility in the gaps around the window. The administrator stated they had been inspecting rooms to remove food or other items that might attract flies, but was not aware of the window gaps.

The policy Preventative Maintenance and Inspections, dated 1/3/18, indicated a preventative maintenance program was implemented to maintain equipment in a state of good repair and condition to provide a safe environment for residents, employees, and visitors.

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	245203	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2018**

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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 09, 2018. At the time of this survey, The Villa 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/31/2018

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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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@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. 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 is 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 120 beds and had a census of 97 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all residents in Stations 1 and 2. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on August 09, 2018, observation revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficiency only	K 521	Please see attached K521 waiver	9/11/18

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K 521	Continued From page 3 affects Stations 1 and 2. This deficient practice was verified by the Administrator at the time of discovery.	K 521		

Name of Facility **2000 CODE**

The Villa at Bryn Mawr 275 Penn Avenue North, Minneapolis MN 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~~ ~~K67~~ K-521 The building heating and ventilation and Air Conditioning (HVAC) equipment does not comply with the Life Safety Code (00), Section 9.2, and NFPA 90A, 1999 Edition, because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for ~~K-67:~~ K-521 A. Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because: 1. The most recent cost estimate for complying HVAC dated 7/14/14, is $259,000.00 and will include the upgrade of the following systems; please the attached quote from Gilbert. Plus an additional amount of $17,800 for structural engineering and installing sheet rocks enclosures for the resident rooms. 2. Installing a complying HVAC system will force disruption to the facility residents by displacing 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 last 3 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 5.5% over 20 years would add $142,450.00 in interest to the cost of the project. 5. The building is 48 years old and is not slated for replacement. B. There will be no adverse effect on the building occupants safety in accordance with SOM 2480B because: 1. 1.The buiodling 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: notified frie alarms through, reliable and Tyco bran sprinkler system throughout, automatic dialer to fire department monitor by Transalarm, UL300 rated kitchen hood suppression system.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

Name of Facility **2000 CODE**

The Villa at Bryn Mawr 275 Penn Avenue North, Minneapolis MN 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~~ ~~K67~~ K-521 The building heating and ventilation and Air Conditioning (HVAC) equipment does not comply with the Life Safety Code (00), Section 9.2, and NFPA 90A, 1999 Edition, because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for ~~K-67.~~ K-521 4. Our fire safety plan addresses: fire containment, fire extinguish, evacuation, fire compartments, location of ambulatory and non-ambulation residents, notification of fire department. 5.. We have a fire watch program. We have two 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 b. Lower level: 8 residents c. First floor: two units: 50 residents d. Second floor: two unit: 62 residents e. We do not have a TCU unit. WE are a 120 bed SNF facility which admits medical/mental health residents. 9.. Closest fire department is: 1600 Glenwood Ave. 0.4 miles.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

Exclusions:
Work to be performed during normal working hours.
We have not included any asbestos abatement.
Existing AC and Heat system for the hallways will remain in place.
Pricing is based on 2016 installation costs.

Payment Terms: Project will be invoiced monthly as work progresses. Invoice terms are net 30 days.

Proposed By:
Gilbert Mechanical Contractors, Inc.

_____ Date: 9/2/16
Ed Dahlgren
Vice President, PE

Accepted By:

_____ Date: _____
Print Name: _____

GILBERT

Gilbert Mechanical Contractors, Inc
Gilbert Electrical Technologies
4461 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:	09/02/16
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:	Andrea Krebs / Jack Johnson	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: $280,000.00 (budget price)

Add: $1,400.00 to $4,400.00 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: $15,000.00 (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 $6,000.00?)

Electronically delivered
August 23, 2018

Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, MN 55405

Re: State Nursing Home Licensing Orders - Project Number S5203027

Dear Administrator:

The above facility was surveyed on August 8, 2018 through August 9, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5203064 that was found to be unsubstantiated. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 Eva Loch at (651) 201-3792 or eva.loch@state.mn.us.

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 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.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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
	00175	A. BUILDING: _____ B. WING _____	C 08/09/2018

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) COMPLETE DATE
2 000	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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On 8/6/18 through 8/9/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote safety with smoking for 2 of 3 residents (R10, R90) reviewed for smoking. Findings include: R10's quarterly Minimum Data Set dated 5/5/18, indicated moderate cognitive impairment. R10's diagnosis report dated 8/9/18, identified current diagnoses schizophrenia and muscle weakness. R10's care plan dated 5/11/18, indicated R10 was	2 830	Corrected	9/11/18

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2 830	Continued From page 3 an unsafe smoker. R10's care plan interventions included to observe clothing and skin for signs of cigarette burns and R10 must get cigarettes and smoking apron from nursing station before going out to smoke on patio. Care plan identified R10 can smoke unsupervised, light his own cigarette and keep lighter at bedside. R10's smoking risk observation dated 5/3/18, indicated R10 was an unsafe smoker. R10 was deemed as careless with smoking materials. On 8/6/18, at 2:45 p.m. R10 was observed to wheel himself to smoking patio with an unlit cigarette hanging from his mouth, a lighter in his left hand and no smoking apron on. At 2:51 p.m. R10 was observed independently lighting the cigarette and had no smoking apron on. No ashes were observed falling on R10's clothing. On 8/6/18, at 3:16 p.m. R10 was observed again on the smoking patio smoking a cigarette with no smoking apron on. R10 asked another smoking resident to place cigarette into ashtray. No ashes were observed falling on R10's clothing. During interview on 8/6/18, at 5:47 p.m. R10 stated the facility held his cigarettes locked in the medication cart and gave R10 three cigarettes twice a day. R10 explained he was able to keep his cigarette lighter on his person. R10 indicated the seven burn holes on the front of the wheel chair cushion and seat were from cigarette ashes falling down. R10 verbalized he held his lit cigarette with his hand resting downward between legs. R10 identified he was sitting on top of his smoking apron, sometimes he wore the smoking apron and sometimes did not. No burns were observed on R10's hands.	2 830		

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2 830	Continued From page 4 During interview on 8/8/18, at 10:05 a.m. the trained medication aide (TMA)-A stated R10 had a smoking plan for three cigarettes every morning and evening, needed a smoking apron before he went to smoke and was allowed to smoke without supervision on the patio. TMA-A explained R10 had the smoking precaution of needing to wear the smoking apron. TMA-A indicated she watched for R10 and reminded him when he wasn't wearing his smoking apron. TMA-A stated R10 did check-in prior to going to smoke. TMA-A identified R10 had burnt his clothing in the past and wasn't safe smoking without his smoking apron. On 8/9/18, at 9:29 a.m. R10 was observed seated in his wheelchair in the dining room sitting on his smoking apron with an unlit cigarette and lighter on the table in front of him. On 8/9/18, at 10:32 a.m. R10 was observed to wheel himself in wheel chair with an unlit cigarette in his mouth outside onto the smoking patio. R10 was not wearing smoking apron. During interview on 8/9/18, at 10:25 a.m. the assistant director of nursing (ADON) explained R10's smoking plan included R10 to have smoking apron on. ADON stated R10 must have smoking apron on and given one cigarette at a time up to six cigarettes per day. ADON indicated R10 could get his cigarette from the assigned TMA or nurse anytime he wanted. ADON verbalized R10 had not had any injuries or accidents related to smoking. ADON expressed her expectations for the assigned TMA or nurse were to provide encouragement and education when they saw R10 going out to smoke without his smoking apron. ADON explained her expectation for the assigned TMA or nurse were	2 830		

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2 830	Continued From page 5	2 830		

to either go out and supervise R10 or find someone who can when R10 refused to put on the smoking apron.

R90's quarterly Minimum Data Set (MDS), dated 7/21/18, indicated R90 was cognitively intact. R90's diagnosis report, dated 8/9/18 included current diagnoses personality changes, bipolar disorder and personal history of traumatic brain injury.

R90's care plan, dated 7/20/18, indicated R90 was potentially unsafe smoker, had a history of smoking in unauthorized areas and at times will not wear appropriate footwear when going outside to smoke. R90's care plan interventions included R90's cigarettes were stored at the nurse's station and R90 was to receive one cigarette after taking medications and wearing proper footwear six times per day. R90 was to be offered an extra cigarette for completion of showering.

R90's smoking risk observation, dated 3/8/18, indicated R90 was a potentially unsafe smoker.

R90's physician order, dated 10/15/16, indicated R90 to keep cigarettes in the medication cart and to hold the cigarette until R90 has taken his medications.

R90's psychology recommendation, dated 3/16/18, indicated R90 should have a consistent program to decrease irritability and needed to wear shoes prior to being given a cigarette.

On 8/6/18, at 3:00 p.m. R90 was observed on the smoking patio dressed with black regular socks on both feet. R90 threw the lit cigarette into the middle weedy area of the smoking patio. R90's

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2 830	Continued From page 6 cigarette continued to smoke for a few minutes then stopped burning on it's own, without any intervention. On 8/6/18, at 3:16 p.m. R90 was observed seated on the smoking patio dressed with black regular socks on both feet. R90 set the lit cigarette onto the cement underneath the chair that R90 sat on. R90's cigarette continued to smoke for a few minutes then stopped burning on it's own. On 8/6/18, at 3:24 p.m. R90 was observed seated on the smoking patio dressed with black regular socks on both feet. R90 threw the lit cigarette into the plants on the perimeter of the patio. R90's cigarette continued to smoke for a few minutes then stopped burning on it's own. During interview on 8/6/18, at 6:26 p.m. R90 stated that he was allowed six cigarettes per day three in the morning and three in the evening. R90 explained facility kept his cigarettes for him but R90 kept his lighter. R90 verbalized he knew that there were ash trays located on the smoking patio. During interview on 8/8/18, at 10:09 a.m. trained medication assistant (TMA)-A stated R90 was given three cigarettes in the morning and evening. TMA-A denied resident having any smoking precautions or needed items prior to smoking. TMA-A indicated R90 had tried to go walk outside without socks or shoes in the past. TMA-A explained when R90 didn't want to wear shoes they encouraged R90 to wear gripper socks. On 8/9/18, at 9:28 a.m. R90 was observed seated at dining room table with one gripper sock on right foot and regular sock on left foot.	2 830		

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2 830	Continued From page 7 During interview on 8/9/18, at 10:00 a.m. the assistant director of nursing (ADON) stated R90 had a smoking plan that included R90 was an independent smoker, cigarettes stored at nurse's station and one cigarette to be given out after R90 had taken medication and wearing proper footwear with a daily maximum of six cigarettes per day. ADON verbalized proper footwear was season dependent shoes or gripper socks were preferred. ADON explained her expectations were for R90 to wear something protective on his feet when outside as long as R90's bare feet were covered. ADON stated she preferred R90 to wear shoes or gripper socks but it was R90's preference. ADON was unaware of any smoking concerns regarding R90's smoking safety. The facility's resident policy and procedure for safe smoking revised and reviewed on 10/11/17, indicated that resident's will be assessed for their ability to smoke safely and a safe smoking plan could include the following: smoking aprons, designated smoking times, limits on facility assistance with purchasing smoking materials and additional supplies when needed. Furthermore, it also indicated that the facility provided cigarette containers for the safe disposal of cigarettes and ashes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents to assure they are receiving the necessary treatment/services to provide adequate care regarding smoking safety. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure management of smoking.	2 830		

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2 830	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure nail care was provided to 1 of 2 residents (R92) reviewed for activities of daily living (ADLs) and whom was dependent on staff for care. Findings include: R92's admission record dated 3/20/10, indicated diagnoses of schizoaffective disorder, mild intellectual disabilities and adult failure to thrive. R92's quarterly Minimum Data Set dated 4/14/18, indicated R92 sometimes was able to understand others and sometimes was able to make self understood, had severe cognitive impairment, and needed extensive assist of two person for personal hygiene. R92's care plan dated 7/13/18, indicated alteration in activities of daily living with need for extensive assist of two for grooming. The care plan further indicated R92 had communication problem, resident was able to make his needs know but due to R92's mild intellectual disability and garbled speech, he was	2 860	Corrected	9/11/18

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2 860	Continued From page 9 not able to make himself entirely understood or understand others. Facility staff were expected to anticipate and meet needs. During an observation on 8/6/18, at 5:45 p.m. R92's finger nails on both hands were long and dark colored substance under nails. During an observation on 8/8/18, at 1:26 p.m. R92 was sitting in a wheelchair by the nurses station, and R92's was observed with long finger nails and dark colored substance under his nails. The undated facility document, identified R92 (by room number) will get a bath on Wednesday on the "PM Shift," including "NAIL CARE, SHAVE RESIDENT, NOTIFY NURSE FOR DIABETIC RESIDENT NAIL CARE." During an observation and interview on 8/9/18, at 11:30 a.m. nursing assistant (NA)-C verified R92 had dark grayish, black matter under fingernails. NA-C offered R92 nail care and was observed to clean under R92's fingernails. NA-C used a nail brush to brush out black matter R92's fingernails and a wet washcloth to clean up black matter from fingernails. During an interview on 8/9/18, at 12:39 p.m. the assistant director of nursing (ADON) stated she expected facility staff to have cleaned resident's fingernails on scheduled bath days and as needed. ADON verified R92 had skin check done on 8/8/18, the same day resident was scheduled for a shower. Requested facility policy in regards to personal cares and grooming, however none received. SUGGESTED METHOD OF CORRECTION:	2 860		

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2 860	Continued From page 10 The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure nail care needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident received dental services as needed for 1 of 4 residents (R38) reviewed who had ongoing dental needs including pain without further dental services provided or arranged. Findings include: R38's admission Minimum Data Set (MDS) dated 2/26/18, indicated R38 had no cognitive	21325	Corrected	9/11/18

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21325	Continued From page 11	21325		

impairment and identified dental issues including obvious or likely cavity or broken natural teeth. R38's care area assessment (CAA), dated 2/28/18 indicated a referral to the dentist was warranted and would be done upon R38's request. R38's care plan initiated on 5/25/18, indicated R38 had oral/dental health problems. The goal dated 5/31/18, indicated R38 would be free of infection pain or bleeding in the oral cavity. No interventions were located to provide staff with direction to improve or maintain R38's oral health. There was no evidence in the medical record if R38 had seen the dentist since admission.

During an observation and interview on 8/6/18, at 2:25 p.m., R38 did have obvious broken teeth. R38 stated he was seeing the dentist prior to admission and there was more work that needed to be done. When asked about pain R38 stated "Yes, I had a toothache the last couple of nights and I told the nurse about that". R38 was unable to remember if the facility offered a dental appointment. R38 stated the broken teeth did not affect the ability to eat or chew, although sometimes "they hurt and they give my Tylenol". R38 shared the concern that the oral issues would get worse and R38 felt self conscious that they "look bad."

During interview on 8/8/18, at 8:45 a.m., the with social worker (SW)-B stated that the SW originally assigned to R38 was no longer employed with the facility and SW-B was trying to assist. SW-B recalled the dental issue being discussed at R38's care conference held on 5/30/18, and SW-B provided the email request for a dental appointment to the health unit coordinator (HUC). The email, dated 5/30/18, at 3:14 p.m., requested a dental appointment be set up as R38 stated "his teeth has been hurting."

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21325	Continued From page 12 During an interview on 8/8/18, at 9:29 a.m. HUC-D stated she did not make the appointment. After reviewing the record HUC-D stated that she would have charted an appointment or a refusal and neither could be located. During an interview on 8/8/18, at 10:12 a.m. the assistant director of nursing (ADON) verified that R38 had broken teeth, had not seen a dentist since admission and that the expectation was that R38's oral/dental needs would have been addressed. A facility's Expanded Assessment Guideline policy dated 11/28/17, indicated that upon admission the interdisciplinary team would complete a comprehensive assessment that included resident needs, goals and preferences including oral health status. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are seen by dental services in a timely manner; then inservice staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by:	21620		9/11/18

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21620	Continued From page 13 Based on observation, interview and document review, the facility failed to ensure an expired vial of Tuberculin solution was discarded on 1 of 3 stations reviewed for medication storage. This had the potential to affect residents who could have been tested with the remaining two doses. In addition, the facility failed to ensure an expired diskus of Advair medication was unavailable for continued use for 1 of 2 residents (R66) on station 4 who used an Advair inhaler. Findings include: During observation of medication refrigerator on station 3 on 8/6/18, at 2:59 p.m. with licensed practical nurse (LPN)-A there was a vial of tuberculin solution opened, 1/5 full, and with a handwritten opened date of 6/27/18, verified by LPN-A. LPN-A stated tuberculin solution was only good for 30 days after opening. LPN-A stated she would put this vial in the destroyed drawer to be disposed and would get a new vial from station 1. During observation of medication cart on station 4 on 8/9/18, at 9:11 a.m. with trained medication assistant (TMA)-A, there was a diskus of Advair inhaler for R66 opened, 23 of 60 blisters full, and with a handwritten opened date of 7/2/18, verified by TMA-A. TMA-A stated she did not know how long the Advair inhaler was good for after opened and would just go by when the number of blisters went down and the reorder date on the label. TMA-A stated R66 received the Advair inhaler two times daily and had not yet administered the Advair inhaler to R66 today. TMA-A verified the pharmacy label on R66's diskus indicated R66's Advair inhaler had came from pharmacy on 7/1/18, had a refill date of 7/25/18. TMA-A also verified there was no other diskus of Advair inhaler for R66 on the medication cart. The	21620	Corrected	

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21620	Continued From page 14 Assistant Director of Nursing (ADON) came walking up to the medication cart and verified the Advair had been administered 7 days (14 doses) past the recommended disposal date. ADON stated she would notify the physician of the 14 doses given after the recommended disposal date, would audit the rest of the medication cart and notify pharmacy to send up a new Advair diskus for R66. ADON stated staff were to follow the guidelines for medication expiration hanging up in each medication room. ADON verified the guidelines indicated Advair diskus should have been disposed 30 days after foil opened. ADON verified R66 received the Advair 8/2 through 8/8/18, for 7 days, 14 doses after recommended disposal date. R66's physician order dated 4/18/18, indicated R66 was to receive Advair Diskus Aerosol Powder Breath 250-50 mg (milligrams)/dose 1 puff orally two times a day for chronic obstructive pulmonary disease. R66's August 2018 Medication Administration Record indicated R66 had received Advair inhaler twice a day from 8/2/18-8/8/18. On 8/9/18, at 1:44 p.m. the consultant pharmacist (CP) stated Advair was good for one month after opened per manufacturer's instruction and Tubersol solution was good for one month after first use per manufacturer's instructions. CP stated staff were to follow manufacturer's instructions for administering both Advair inhaler and Tubersol. The undated Tubersol manufacturer instructions indicated, "A vial of TUBERSOL which has been entered and in use for 30 days should be discarded."	21620		

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21620	Continued From page 15 The undated Advair diskus manufacturer instructions indicated, "Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads "0" (after all blisters have been used), whichever comes first." Facility guidelines undated, GUIDELINES FOR MEDICATION EXPIRATION indicated Tubersol expired 30 days after opening and Advair Diskus expired 30 days after opening foil. Facility policy dated Rev 6/2014, Storage of Medications indicated, "Medications and biologicals must be stored safely, securely, and properly, following manufacturer's recommendations". SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage and labeling of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors,	21695		9/11/18

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21695	Continued From page 16 ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean, orderly and comfortable environment for 4 of 4 residents (R48, R6, R61, R78) reviewed for maintenance concerns. In addition the facility failed ensure the second floor dining area, the secured unit, and the outside patio were kept clean and in good repair, which had the potential to affect residents who utilized these areas. Findings include: R48's room was observed on 8/8/18, at 8:04 a.m. and R48 was interviewed regarding a drawer front missing from his dresser. R48 said, "I don't have enough fingers to count the weeks I have waited to get that fixed. Finally I just brought it to the desk and put it on the counter. I got no explanation, and sooner or later you stop asking". R48 went on to explain the bathroom sink overflowed often and water leaked out from the bathroom all the way across the room. R48 believed the water was the reason for dark areas on the floor tiles. The tiles by the bathroom had a dark black substance and the metal molding around the bathroom door looked rusted. The toilet was dirty looking at the bottom of the bowl. There was dried yellow stains around the top of the bowl and the room smelled strongly of urine. A housekeeper was observed working in the area but had not yet entered R48's room. The second floor dining room was observed on 8/08/18, at 08:19 a.m. The dining room ceiling	21695	Corrected	

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21695	Continued From page 17	21695		

tiles had bits of left over tape and paper hanging down. A plastic plant was covered in a heavy layer of gray dust. Ten fluorescent light fixtures had evidence of dirt and bug debris inside the cover.

The shared bathroom for R6, R61 and R78 was observed on 8/8/18, at 8:51 a.m..There was a strong urine odor in the bathroom and in R6's room. Nursing Assistant (NA)-A verified the odor at the time of the observation. NA-A said the bathroom smelled very strong all the time and made her sick to smell it every day. R61 was interviewed on 8/9/18, at 9:02 a.m. and said the smell from the bathroom bothered him.

On 8/8/18, at 10:02 a.m. Housekeeper (Hskp)-A was interviewed regarding R6's room. Hskp-A said the room and bathroom were mopped every day and the toilet cleaned every day, but the room continued to smell. Hskp-A explained R6 smelled because he refused to wear incontinent products or wash his clothes. Hskp-A believed the smell was in the floor.

A facility tour was conducted on 8/8/18, at 1:00 p.m. with the administrator, maintenance director (MD), housekeeping supervisor (HS), and two representatives from the contracted housekeeping service (CHS). During the tour the following items were observed:
- The room for R48 was observed during the tour and a drawer front was missing from the resident's cupboard. An explanation for the state of the cupboard was not given. The administrator said, "we can do better". R48's room also had dark soiling on the floor by the bathroom. The CHS representative tried to wipe the area with a wet rag, but the stain did not come off. Cracked floor tiles were noted. MD said they could change

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tiles individually. The toilet bowl was still soiled at the time of the tour. CHS representative verified the soil and said it was not up to standard and would be cleaned right away.
- The 2nd floor dining room was observed at the time of the tour and CHS representatives verified the dusty plants, dusty blinds, left over tape and paper on ceiling tiles and debris in the light fixtures. CHS representative explained the blinds and other issues would be addressed during deep cleaning of the dining room. However, they did not know when it had last been deep cleaned or when it was scheduled to be cleaned in the future.
- The shared bathroom for R6, R61 and R78 was observed on the tour. The administrator and CHS representatives verified the odor. They explained they have cleaned the floor regularly and have tried various cleaning agents, but the odor was right back after about 20 minutes. They said the odor may have penetrated into the flooring.
- The exhaust vent in the shared bathroom was tested with a piece of toilet paper. The paper was not drawn to the vent, indicating a weak air flow. The facility director verified he was aware the ventilation was weak on that end of the building. He stated the vents had been checked and were working, but the draw was weak.

The back patio/smoking area was found to be littered with cigarette butts in the two planting areas and scattered around the ground. The patio wood picket fence had white stains resembling bird droppings along the fence boards, and the fence was not straight. The ground under the fence was littered with cigarette buts and some garbage. MD stated they just put weed killer on the planting areas to prepare the area for a re-do, and had plans to fix the fence and remove weeds around the fence. HS verified the patio was to be

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21695	Continued From page 19 swept daily. Review of the project management log for capital expenses for 2018, indicated money requested fro the courtyard fence and gate, but had not yet been approved. Also found during the tour was the door to the second floor secured unit was heavily marred from inside the unit and dining room curtains were hanging off the hooks. The administrator verified the findings. A policy concerning general housekeeping dated 6/2016, indicated quality service can only be delivered and maintained through use of proper environmental services methods. SUGGESTED METHOD OF CORRECTION: 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	21695		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel.	21730		9/11/18

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21730	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a pest free environment related to flies entering the building from loose fitting plexiglass around the air conditioners for 3 of 3 residents (R6, R61, R78) reviewed. This had the potential to affect all residents with loose fitting plexiglass in the facility. Findings include: R6's was observed 8/8/18, at 8:43 a.m. The bottom sheet of the bed had a wet and stained soiled area in the middle. There were several flies congregating on the soiled area. The Nursing Assistant (NA-A) was interviewed at the time of the observation and said the flies used to be worse due to dirty clothes hanging in the room and she complained to the facility administration as she felt it was an "infestation" problem. R6's room was again observed on 8/9/18, at 8:07 a.m. with NA-B. The bottom sheet of the bed had a soiled area. Flies were observed congregating on the soiled area. NA-B verified the flies were there every day and they were a nuisance. NA-B said the bed was changed every day due to soiling. The window air conditioner unit was also observed with NA-B. The plexiglass around the air conditioning unit was not secure to the window frame allowing access for flies to enter the room from the outside. R61, who occupied the adjoining room to R6, was interviewed on 8/9/18, at 9:02 a.m. R61 and said he was bothered by flies "all the time." R78, who also occupied the adjoining room to R6, was	21730	Corrected	

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21730	Continued From page 21 interviewed on 8/9/18 at 10:23 a.m. and stated R78 was bothered by flies. R78 said, "when I lie down they start attacking". An environmental tour was conducted on 8/8/18, at 1:00 p.m. with the administrator, the maintenance director (MD), the environmental supervisor, and two representatives from a contracted housekeeping service. The air conditioner for R61's and R78's rooms were observed. The plexiglass around the window air conditioner was taped to the window frame from inside the room. The tape was not holding the plexiglass securely to the window frame allowing large gaps to the outside. R6 was sleeping at the time of the tour, so an observation of his room was not made. However, the administrator and facility director verified all window air conditioners had been installed in the same manner with the same tape from inside the room. Additionally, they verified flies and other pests could enter the facility in the gaps around the window. The administrator stated they had been inspecting rooms to remove food or other items that might attract flies, but was not aware of the window gaps. The policy Preventative Maintenance and Inspections, dated 1/3/18, indicated a preventative maintenance program was implemented to maintain equipment in a state of good repair and condition to provide a safe environment for residents, employees, and visitors. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of maintaining an effective pest control program. The DON or designee, could coordinate with	21730		

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21730	Continued From page 22 maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure pests is controlled to ensure a clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call light was accessible for 1 of 1 residents (R28) who was capable of using the call light reviewed for environment. Findings include: On 8/6/18, at 2:10 p.m. R28 was observed sitting on the edge of her bed in a shared room with her roommate present. R28 was holding a denture cup with water in it and stated she wanted someone to help her dump the water out. When asked why she did not use her call light R28	21810	Corrected	9/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00175	A. BUILDING: _____ B. WING _____	C 08/09/2018

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21810	Continued From page 23	21810		

responded she did not have one and needed to wheel herself down to the nurse's station whenever she needed assistance. R28 also stated the call light had been missing for about three weeks and she had told staff she wanted one multiple times but still did not have one. R28 said there had been instances where she was scared for herself and her roommate during the night when she would have to take the time to get herself into her wheelchair to go to the nurses station for assistance because she did not have a call light.

On 8/6/18, at 2:24 p.m. the writer informed registered nurse (RN)-A R28 would like assistance. RN-A entered R28's room, reached over and behind the farthest of two nightstands lined up and approximately five feet away from R28's bed and retrieved the call light button. After she retrieved the call light button RN-A wrapped it around the front handle of the night stand next to R28's bed and stated "that is where R28 likes to have it." RN-A stated R28 could not have known where her call light button was located, been able to retrieve it from where it was and did not know for how long the call light has been behind the nightstand and toward the floor. RN-A also stated R28 was capable of using her call light and had R28 demonstrate she was able to use it.

R28's quarterly minimum data set dated 5/18/18, indicated R28 had intact cognitive function.

R28's care area assessment dated 9/6/17, indicated activities of daily living objectives of avoiding complications and minimizing risk. The call light was not addressed in R28's care plan.

On 8/7/18, at 9:06 a.m. the assistant director of nursing (ADON) stated all call lights should have

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21810	Continued From page 24 been accessible to residents, and if not, the situation needed to be corrected immediately. The ADON also stated the facility did not have a policy and procedure for call lights. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a placing call lights within reach of the resident. The DON or designee, could coordinate with nursing, maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21810		