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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9DEF

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 **11/18/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **120** (L18)
13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room
* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NEII 12/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/22/2016 (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
09/19/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 245203

On November 11, 2016, a Post Certification Revisit was comleted by the Department of health to verify the faclity achieved and maintained compliance with Federal participation requiremnets, which included verification of compliance with the complaint investigation number H5203050 substantiated at F322. Based on our PCR, we have determined the complaint investigation and remaining deficiencies not corrected at the time of the October 5, 2016 PCR, pursuant to the August 5, 2016 stnadard survey have been corrected as of November 3, 2016.

As a result of our revisit findings, the Department discontinued the Category 1 remedy of State monitoring as of November 3, 2016.

In addition, we recommneded to the CMS Region V Office, the following action as it relates to the imspoed remedies of our letters of October 13, 2016 and October 19, 2016:

- Mandatory Denial of payemnt for new Medicare and Medicaid admissions, effective November 5, 2016, be rescinded.

Since Mandatory Denial of payment didn't go into effect, the NATCEP prohibition would also be rescinded.

The facility's request for a continuing waiver of life safety code deficiency cited at K067, has previously been forwarded to CMS. Approval of the waiver is recommended.

Refer to the CMS 2567b for the results of this visit.

Effective November 3, 2016, the facility is certified for 120 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245203

December 22, 2016

Mr. Michael Marchant, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, Minnesota 55405

Dear Mr. Marchant:

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 November 3, 2016 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 waiver that you requested for the following Life Safety Code Requirements: K067.

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 these deficiency or renew your request for waiver in order to continue your participation in the Medicare 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist - Program Assurance Unit
Licensing and Certification Program - Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 / Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 22, 2016

Mr. Mike Marchant, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, Minnesota 55405

RE: Project Number S5203025, H5203050, H5203051

Dear Mr. Marchant:

On October 13, 2016, we informed you, as authorized by the CMS Region V office, that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 5, 2016. (42 CFR 488.417 (b))

In accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 5, 2016.

In addition, On October 19, 2016, the Department informed you that we were imposing the following Category 1 remedy:

- State Monitoring effective October 24, 2016. (42 CFR 488.422)

Furthermore, on October 19, 2016, the Department recommended the following enforcement action to the CMS Region V Office as it relates to the imposed remedy in our letter of October 13, 2016:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 5, 2016, remain in effect. (42 CFR 488.417 (b))

This was based on lack of verification of health and life safety code deficiencies issued pursuant to the standard survey completed on August 5, 2016, and not achieving substantial compliance at the Post Certification Revisit (PCR) completed on October 5, 2016. The most serious deficiencies in your facility were found 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 November 18, 2016, the Department completed a PCR to verify the facility had achieved substantial compliance with Federal certification deficiencies not corrected at the October 5, 2016 PCR. Based on

our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on October 5, 2016, as of November 3, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 3, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letters of October 13, 2016 and October 19, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 5, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 5, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 5, 2016, is to be rescinded.

In our letter of October 19, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 3, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency cited under K067 at the time of the August 5, 2016 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245203	A. Building B. Wing	11/18/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 11/03/2016	ID Prefix F0322 Reg. # 483.25(g)(2) LSC	Correction Completed 11/03/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) GL/mm	DATE 12/22/2016	SIGNATURE OF SURVEYOR 31591	DATE 11/18/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 22, 2016

Mr. Mike Marchant, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, Minnesota 55405

RE: Project Number S5203025, H5203050, H5203051

Dear Ms. Marchant:

On November 21, 2016, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on November 21, 2016, imposed a daily fine in the amount of $700.00.

On November 21, 2016, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on November 18, 2016 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is $700.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $174.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $874.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 ax: (651) 215-9697

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00175 (Y1)	A. Building B. Wing (Y2)	11/18/2016 (Y3)

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 11/03/2016	ID Prefix 20930 Reg. # MN Rule 4658.0525 Subp. 7 B. LSC	Correction Completed 11/03/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GL/mm	12/22/2016	31591	11/18/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 8/5/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9DEF

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 **10/05/2016** (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)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NEII 10/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/23/2016 (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
09/19/2016
(L33)

DETERMINATION APPROVAL

CCN: 245203

On October 13, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 5, 2016. (42 CFR 488.417 (b))

Also, the facility was notified in our letter of October 13, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 5, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on August 5, 2016, that included an investigation of complaint numbers H5203050 and H5203051, and lack of verification of substantial compliance with the health deficiencies at the time of our October 13, 2016 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), hereby corrections were required.

On October 5, 2016, the Department completed a revisit to verify the facility achieved and maintained substantial compliance with Federal participation requirements and follow up on complaint investigation numbers H5203050 and H5203051. We presumed based on the facility's plan of correction that the facility had corrected the deficiencies as of September 7, 2016, based on our visit we have determined the facility had not achieved substantial compliance. The deficiencies not corrected are as follows:

- F309 S/S: D 42 CFR| 483.25 - Provide Care/services For Highest Well Being
- F322 S/S: D 42 CFR 483.25(g)(2) - Ng Treatment/services-Restore Eating Skills

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 24, 2016. (42 CFR 488.422)

In addition, we are recommending to the CMS Region V office, the following action related to the imposed remedy in our letter of October 13, 2016:

- Mandatory Denial of payment for new Medicare and Medicaid admissions, effective November 5, 2016, remain in effect. (42 CFR 488.417 (b))

The facility’s request for a continuing waiver involving the life safety code deficiency cited under K67 at the time of the August 5, 2016 survey was previously forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Approval of the waiver has been recommended.

Refer to the CMS 2567 along with the facility's plan of correction for health only and CMS 2567b. Post Certification Revisit (PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5694 9919

October 19, 2016

Mr. Mike Marshon, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, Minnesota 55405

RE: Project Number S5203025, H5203050, H5203051

Dear Mr. Marshon

On October 13, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 5, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 13, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 5, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on August 5, 2016, that included an investigation of complaint numbers H5203050 and H5203051, and lack of verification of substantial compliance with the health deficiencies at the time of our October 13, 2016 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), hereby corrections were required.

On October 5, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 7, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 5, 2016. The deficiencies not corrected is/are as follows:

F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0322 -- S/S: D -- 483.25(g)(2) -- Ng Treatment/services - Restore Eating Skills

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 24, 2016. (42 CFR 488.422)

In addition, we are recommending to the CMS Region V office, the following action related to the imposed remedy in our letter of October 13, 2016:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 5, 2016, remain in effect. (42 CFR 488.417 (b))

Further, as we notified you in our letter of October 13, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 5, 2016.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

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 _____	R 10/05/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on October 4 and 5, 2016. The deficiencies found corrected at the time of the revisit can be found on form CMS2567B. Deficiencies found not corrected at the time of onsite PCR are dileneated on the form CMS 2567. Investigation of complaint number H5203050, which was substantiated at F322 at the time of the survey, was found not corrected at the revisit. Investigation of complaint number H5203051, which was substantiated at F425 at the time of the survey, was found corrected at the revisit.	{F 000}	F000 Please accept the following as the facilities credible allegation of compliance. Please note that this POC is submitted per the State and Federal requirements only and should not be considered as the facilities admission of non-compliance with any State or Federal standard, requirements or regulations.	
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care was provided appropriately and services were coordinated for 1 of 2 resident (R47) receiving dialysis. Findings include:	{F 309}	POC accepted by Tanita 10/27/16 F309 R47 was reviewed by IDT. R47's Plan of Care and assessments were updated. The resident was identified to have no adverse effects from the comments identified by the MDH surveyors. All residents currently receiving dialysis had their care plans reviewed and updated as warranted to ensure compliance. The policy and	

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

10/26/2016 ADMINISTRATOR

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
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{F 309}	Continued From page 1 R47 returned from dialysis on 10/5/16, at 1:39 p.m. and at that time reported he went to dialysis three times each week on Monday, Wednesday and Friday. He had an undated dressing in place to his right antecubital space. R47 further explained that he did not feel staff was providing satisfactory care related to his dialysis. Examples included not taking his blood pressure when he returned from dialysis, not applying Lidocaine (a topical pain medication) regularly to his dialysis site as ordered, and providing no care related to the bandage. R47 said the dialysis put on the bandage "and that is it--nobody does anything here. I just take it off myself when I know the bleeding has stopped." He denied carrying dialysis communication report sheets between the facility and dialysis center explaining that they instead faxed the reports back and forth. A physician's order written for R47 dated 11/16/15, directed staff to check blood pressure three times weekly (Monday, Wednesday, Friday) however,r the medication administration sheets (MAR) and the treatment administration sheets (TAR) indicated a blood pressure was taken only once since the facility's correction date of 9/7/16. An order written 9/2/16, directed staff to check thrill and bruit (to ensure fistula access site function) every shift and as needed. Review of the MAR and TAR revealed the order was not followed as written. An order written 9/12/16, directed staff to apply a small amount of Lidocaine cream 2.5% to skin three times weekly as directed 60 minutes prior to dialysis. The MAR and TAR were not signed off to indicate R47 received the cream as ordered.	{F 309}	procedure for dialysis communication was reviewed and remains current. Licensed nursing staff have been in-serviced on the policy and procedure for residents receiving dialysis services. In servicing completed by the Director of Nursing (DON)/ or designee. The facility also implemented the use of an electronic medication and treatment administration system. A weekly audit of all residents receiving dialysis services will be conducted for the next 3 months to ensure compliance. Audits to be completed by the DON/ designee. The results of the audits will be reviewed in the monthly QA meetings and audits will continue as warranted. The DON will be responsible for maintaining compliance. Compliance date 11/03/2016.	

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{F 309}	Continued From page 2 The physician's order sheet, as well as the MAR and TAR, lacked direction regarding care of R47's dialysis dressing. Although an order was not written by the physician, the MAR and TAR directed staff to weigh R47 on dialysis days. A total of three weights had been documented since the facility's correction date. In addition, the site was to be monitored for signs of infection or bleeding every shift, however the documentation lacked evidence the monitoring was consistently being performed. R47's nursing progress notes lacked documentation concerning dialysis care and assessments from the correction date through present. The current care plan initiated 6/23/15 stated when going to dialysis, R47 will bring a dialysis communication sheet in an envelope for the dialysis center to fill out and return with the current dialysis run results. The care plan further stated communication forms will be faxed to dialysis center. The dialysys center will review it,fill out, and fax backto be entered in the resident chart (date initiated 8/5/16). In addition, the care plan directs staff to -check and change dressing daily ataccess site per dialysis instructions. Document on treatment sheets. -obtain weight three times each week on dialysis days. -after dialysis, check the site and monitor for infection and or s/s 9signs and symptoms) of bleeding. -check the thrill and bruit qevery shift and as	{F 309}		

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{F 309}	Continued From page 3 needed -monitor/document/report as needed any s/s of infection to the access site (redness, swelling, warmth or drainage During an interview on 10/5/15, at 1:44 p.m. the director of nursing (DON) verified that dialysis care and services were not being provided on a regular basis for R47. She stated she expected the physician's orders and the care plan be followed to obtain the maximum benefits and minimize risks for R47. She further verified there was no physician's order or monitoring of the dialysis dressing. In addition, the DON explained that although the dialysis report sheets were being faxed to and from the facility to dialysis, this had actually only taken place two times. She further stated that she expected R47's blood pressure to be taken within 60 minutes upon return from dialysis. The facility's 10/10, Hemodialysis Access Care policy directed the staff to document in the resident's medical record every shift as follows: location of the catheter, condition of the dressing, if dialysis was done during the shift, any part of report from dialysis nurse post-dialysis being given and observations post dialysis.	{F 309}	F322 R70 was reviewed by IDT. R70's Plan of Care and assessments were updated. R70's physician clarified the route of administration for all medications. The resident was identified to have no adverse effects from the comments identified by the MDH surveyors. All residents with a g-tube have been reviewed and Plan of Care has been updated as needed to ensure compliance. Licensed nursing staff have been in-serviced on the policy and procedure for medication administration via g-tube. In servicing completed by the DON/ designee. The facility also	
{F 322} SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was	{F 322}		

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 _____	R 10/05/2016

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{F 322}	Continued From page 4 unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer medication according to physician orders for 1 of 3 residents (R70) whose medication administration via gastrostomy tube was observed. Findings include: R70's medication administration was observed on 10/5/16, at 9:38 a.m. by licensed practical nurse (LPN)-G. LPN-G entered the resident's room and began setting up R70's gastrostomy (G-tube that provides feeding through a tube inserted into the stomach) tube feeding. LPN-G double checked the physician orders, and sanitized hand and donned gloves. LPN-G date the bag explaining it was viable for 24 hours. LPN-G set two medication cups on a washcloth, one containing a liquid medication and the other crushed medications in water (also known as cocktailing medications). LPN-G then explained and checked the placement of R70's feeding tube. LPN-G then	{F 322}	implemented the use of an electronic medications and treatment administration system. A weekly audit of all residents with a g-tube will be conducted for the next 3 months to ensure compliance. Audits will be done by the DON/designee The results of the audits will be reviewed in the monthly QA meetings and audits will continue as warranted. The DON or designee will be responsible for maintaining compliance. Compliance date 11/03/2016.	

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{F 322}	Continued From page 5 flushed 100 cc's of water into the tube and administered the liquid medication, followed by 30 cc's of water. LPN-G explained this allowed the medication that may have been stuck in the tube to continue to flow into R70 for absorption. LPN-G then recapped the feeding tube, stating this reduced the amount of air flowing into R70's system. LPN-G then used the open end of the syringe to stir medications in the second cup, and said the cup contained several crushed medications in water. After stirring the medications and water, the nurse proceeded to pour the cocktailed medications into the open end of the syringe, with gravity pulling the mediation down the tube into R70's system. LPN-G then used another 30 cc's of water to flush the tube and proceeded with the enteral feeding per physician orders. R70's 10/16, physician orders directed staff to: - Provide Isosource 1.5 1 box six times daily including at 10:00 a.m. -100 milliliters (cc's) water flush before and after feeding -Check placement of tube prior to administering food or medications -Do not cocktail medications -Check residual every shift and enter amount Medication orders for 10/16 included: -Amlodipine besylate 10 milligram (mg) tab (Norvasc) 1 tab via g-tube every morning for hypertension -Atenolol 25 mg tab, 1 tab via g-tube every morning for hypertension -Certavite-Antioxidant 1 tab via g-tube every morning for osteoporosis -citalopram 20 mg tab, 1 tab every morning for depression	{F 322}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 322}	Continued From page 6 -clonidine HCL 0.1 mg tab 1 tab via g-tube every morning for hypertension -lisinopril 20 mg, 1 tab via g-tube every morning for hypertension -loratadine (Claritin) 10 mg tab, 1 tab via g-tube daily for allergic rhinitis -gabapentin 400 mg capsule, 1 cap via g-tube three times daily for pain R70's annual Minimum Data Set (MDS) dated 7/13/16, indicated R70 had a feeding tube. A Nutritional Care Plan indicated R70 had a nutritional problem and used had tube feeding via g-tube for total mutational/fluid intake due to dysphagia (swallowing disorder). Care Plan interventions directed staff to administer medications as ordered and to monitor/document for side effects and effectiveness and to provide and provide Isosource 1.5 and flush as ordered. The care plan also directed staff to not cocktail medications. On 10/5/16, at 10:58 a.m. the director of nursing (DON) stated an order that read "Do Not Cocktail Medications" referred to both liquid and crushed medication. The DON explained that one medication could have been mixed with water, then flushed and another given, but no more than one medication should have been given at a time. On 10/5/16, at 11:02 a.m. LPN-G referred to a white binder book with tube feeding orders and stated he had crushed atenolol, Norvasc, certavite, citalopram, clonidine, lisinopril, Claritin and gabapentin into one cup, added water and adminsitered the medicaiton to R70. When asked specifically about the "Do Not Cocktail Medications" order, LPN-G stated the order referred to liquid medication.	{F 322}		

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{F 322}	Continued From page 7 On 10/5/16, at 11:10 a.m. registered nurse (RN)-E stated an order of "Do Not Cocktail Medications" meant they were not to co-mingle medications and give them together. She confirmed that putting multiple crushed medications into one medication cup, stirring, and administering together was considered cocktailing medications. The facility's Neteral Tube (Med-Pass, revised 2011)'policy directed staff if administering more than one medication, to flush with at least 15 ml (or prescribed amount) warm sterile water between medications.	{F 322}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245203 Y1	A. Building B. Wing Y2	10/5/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0248	Correction	ID Prefix F0250	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(f)(1)	Completed	Reg. # 483.15(g)(1)	Completed
LSC	09/07/2016	LSC	09/07/2016	LSC	09/07/2016
ID Prefix F0282	Correction	ID Prefix F0371	Correction	ID Prefix F0425	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.60(a),(b)	Completed
LSC	09/07/2016	LSC	09/07/2016	LSC	09/07/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	10/19/2016	33043	10/05/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/5/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Emailed on November 21, 2016.

November 21, 2016

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

Re: Project # S5203025, H5203050, H5203051, H5203053

Dear Ms. Krebs:

On October 5, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 5, 2016 with orders received by you on September 1, 2016.

State licensing orders issued pursuant to the last survey completed on August 5, 2016 and found corrected at the time of this October 5, 2016 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on August 5, 2016, found not corrected at the time of this October 5, 2016 revisit and subject to penalty assessment are as follows:

20830 -- MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General - $350.00
20930 -- MN Rule 4658.0525 Subp. 7 B. -- Rehab - Nasogastric, Gastrostomy Tubes - $350.00

The details of the violations noted at the time of this revisit completed on October 5, 2016 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, **you will be assessed an amount of $700.00 per day beginning on the day you receive this notice**.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, PO Box 64900 St Paul Mn 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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 _____	R 10/05/2016

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: On October 4 and 5, 2016, surveyors of the Minnesota Department of Health completed an on-site revisit to follow up on licensing orders issued as a result of a survey completed on August 5, 2016. During this onsite visit it was determined that the following corrections orders 4658.0520 Subpart 1 and 4658.0525 Subpart 7B	{2 000}		

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{2 000}	Continued From page 1 were not corrected. The uncorrected orders will remain in effect and will be reviewed at the next onsite visit. Also uncorrected orders will be reviewed for possible penalty assessments. Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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 which are in violation of the state statute after the statement, "This Rule 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.	{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	{2 830}		

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{2 830}	Continued From page 2 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 ensure care was provided appropriately and services were coordinated for 1 of 1 resident (R47) receiving dialysis. Findings include: R47 returned from dialysis on 10/5/16, at 1:39 p.m. and at that time reported he went to dialysis three times each week on Monday, Wednesday and Friday. He had an undated dressing in place to his right antecubital space. R47 further explained that he did not feel staff was providing satisfactory care related to his dialysis. Examples included not taking his blood pressure when he returned from dialysis, not applying Lidocaine (a topical pain medication) regularly to his dialysis site as ordered, and providing no care related to the bandage. R47 said the dialysis put on the bandage "and that is it--nobody does anything here. I just take it off myself when I know the bleeding has stopped." He denied carrying dialysis communication report sheets between the facility and dialysis center explaining that they instead faxed the reports back and forth.	{2 830}		

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{2 830}	Continued From page 3 A physician's order written for R47 dated 11/16/15, directed staff to check blood pressure three times weekly (Monday, Wednesday, Friday) however,r the medication administration sheets (MAR) and the treatment administration sheets (TAR) indicated a blood pressure was taken only once since the facility's correction date of 9/7/16. An order written 9/2/16, directed staff to check thrill and bruit (to ensure fistula access site function) every shift and as needed. Review of the MAR and TAR revealed the order was not followed as written. An order written 9/12/16, directed staff to apply a small amount of Lidocaine cream 2.5% to skin three times weekly as directed 60 minutes prior to dialysis. The MAR and TAR were not signed off to indicate R47 received the cream as ordered. The physician's order sheet, as well as the MAR and TAR, lacked direction regarding care of R47's dialysis dressing. Although an order was not written by the physician, the MAR and TAR directed staff to weigh R47 on dialysis days. A total of three weights had been documented since the facility's correction date. In addition, the site was to be monitored for signs of infection or bleeding every shift, however the documentation lacked evidence the monitoring was consistently being performed. R47's nursing progress notes lacked documentation concerning dialysis care and assessments from the correction date through present.	{2 830}		

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{2 830}	Continued From page 4 During an interview on 10/5/15, at 1:44 p.m. the director of nursing (DON) verified that dialysis care and services were not being provided on a regular basis for R47. She stated she expected the physician's orders and the care plan be followed to obtain the maximum benefits and minimize risks for R47. She further verified there was no physician's order or monitoring of the dialysis dressing. In addition, the DON explained that although the dialysis report sheets were being faxed to and from the facility to dialysis, this had actually only taken place two times. She further stated that she expected R47's blood pressure to be taken within 60 minutes upon return from dialysis. The facility's 10/10, Hemodialysis Access Care policy directed the staff to document in the resident's medical record every shift as follows: location of the catheter, condition of the dressing, if dialysis was done during the shift, any part of report from dialysis nurse post-dialysis being given and observations post dialysis.	{2 830}		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.	2 930		

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2 930	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer medication according to physician orders for 1 of 3 residents (R70) whose medication administration via gastrostomy tube was observed. Findings include: R70's medication administration was observed on 10/5/16, at 9:38 a.m. by licensed practical nurse (LPN)-G. LPN-G entered the resident's room and began setting up R70's gastrostomy (G-tube that provides feeding through a tube inserted into the stomach) tube feeding. LPN-G double checked the physician orders, and sanitized hand and donned gloves. LPN-G date the bag explaining it was viable for 24 hours. LPN-G set two medication cups on a washcloth, one containing a liquid medication and the other crushed medications in water (also known as cocktailing medications). LPN-G then explained and checked the placement of R70's feeding tube. LPN-G then flushed 100 cc's of water into the tube and administered the liquid medication, followed by 30 cc's of water. LPN-G explained this allowed the medication that may have been stuck in the tube to continue to flow into R70 for absorption. LPN-G then recapped the feeding tube, stating this reduced the amount of air flowing into R70's system. LPN-G then used the open end of the syringe to stir medications in the second cup, and said the cup contained several crushed medications in water. After stirring the medications and water, the nurse proceeded to	2 930		

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2 930	Continued From page 6 pour the cocktailed medications into the open end of the syringe, with gravity pulling the mediation down the tube into R70's system. LPN-G then used another 30 cc's of water to flush the tube and proceeded with the enteral feeding per physician orders. R70's 10/16, physician orders directed staff to: - Provide Isosource 1.5 1 box six times daily including at 10:00 a.m. -100 milliliters (cc's) water flush before and after feeding -Check placement of tube prior to administering food or medications -Do not cocktail medications -Check residual every shift and enter amount Medication orders for 10/16 included: -Amlodipine besylate 10 milligram (mg) tab (Norvasc) 1 tab via g-tube every morning for hypertension -Atenolol 25 mg tab, 1 tab via g-tube every morning for hypertension -Certavite-Antioxidant 1 tab via g-tube every morning for osteoporosis -citalopram 20 mg tab, 1 tab every morning for depression -clonidine HCL 0.1 mg tab 1 tab via g-tube every morning for hypertension -lisinopril 20 mg, 1 tab via g-tube every morning for hypertension -loratadine (Claritin) 10 mg tab, 1 tab via g-tube daily for allergic rhinitis -gabapentin 400 mg capsule, 1 cap via g-tube three times daily for pain R70's annual Minimum Data Set (MDS) dated 7/13/16, indicated R70 had a feeding tube. A Nutritional Care Plan indicated R70 had a nutritional problem and used had tube feeding via	2 930		

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2 930	Continued From page 7 g-tube for total mutational/fluid intake due to dysphagia (swallowing disorder). Care Plan interventions directed staff to administer medications as ordered and to monitor/document for side effects and effectiveness and to provide and provide Isosource 1.5 and flush as ordered. The care plan also directed staff to not cocktail medications. On 10/5/16, at 10:58 a.m. the director of nursing (DON) stated an order that read "Do Not Cocktail Medications" referred to both liquid and crushed medication. The DON explained that one medication could have been mixed with water, then flushed and another given, but no more than one medication should have been given at a time. On 10/5/16, at 11:02 a.m. LPN-G referred to a white binder book with tube feeding orders and stated he had crushed atenolol, Norvasc, certavite, citalopram, clonidine, lisinopril, Claritin and gabapentin into one cup, added water and adminsitered the medicaiton to R70. When asked specifically about the "Do Not Cocktail Medications" order, LPN-G stated the order referred to liquid medication. On 10/5/16, at 11:10 a.m. registered nurse (RN)-E stated an order of "Do Not Cocktail Medications" meant they were not to co-mingle medications and give them together. She confirmed that putting multiple crushed medications into one medication cup, stirring, and administering together was considered cocktailing medications. The facility's Neteral Tube (Med-Pass, revised 2011) policy directed staff if administering more than one medication, to flush with at least 15 ml (or prescribed amount) warm sterile water	2 930		

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2 930	Continued From page 8 between medications.	2 930		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00175 Y1	A. Building B. Wing Y2	10/5/2016 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302	Correction	ID Prefix 20565	Correction	ID Prefix 21000	Correction
Reg. # MN State Statute 144.6503	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0610 Subp. 4	Completed
LSC	10/05/2016	LSC	10/05/2016	LSC	10/05/2016
ID Prefix 21426	Correction	ID Prefix 21435	Correction	ID Prefix 21475	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.0900 Subp. 1	Completed	Reg. # MN Rule 4658.1005 Subp. 1	Completed
LSC	10/05/2016	LSC	10/05/2016	LSC	10/05/2016
ID Prefix 21550	Correction	ID Prefix 21565	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.1325 Subp. 1	Completed	Reg. # MN Rule 4658.1325 Subp. 4	Completed	Reg. #	Completed
LSC	10/05/2016	LSC	10/05/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GL/mm	10/19/2016	33043	10/05/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/5/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9DEF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00175

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245203**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1780028878**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

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

6. DATE OF SURVEY **08/05/2016** (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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sandra Tatro, HFE NEII — 09/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 09/16/2016 (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
(L33)

DETERMINATION APPROVAL

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

CCN: 245203

At the time of the August 5, 2016 survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. In addition an investigation of the following complaints were conducted:

H5203050 was found to be substantiated at F322
H5203051 was found to be substantiated at F425
H5203053 was found not to be substantiated

The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required.

The facility’s request for a continuing waiver involving the life safety code deficiency cited under K 67 at the time of the August 5, 2016 survey has been to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. The facility's compliance is based on pending CMS approval of your request for waiver. Refer to the CMS 2786R Provision Number K84 Justification Page.

Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5575

August 22, 2016

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

RE: Project Number S5203025, H5203051, H5203051 and H5203053
Dear Ms. Krebs:

On August 5, 2016, 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. In addition, at the time of the August 5, 2016 standard survey the Minnesota Department of Health completed an investigation of following complaint numbers:

H5203050, found to be substantiated at F322
H5203051, found to be substantiated at F425
H5203053, found to be unsubstantiated

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 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 14, 2016, 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 14, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 5, 2016 (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 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

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 _____	08/05/2016

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition to the recertification survey, complaints were investigated. H5203050 was substantiated at F322; H5203051 was substantiated at F425; H5203053 was unsubstantiated.	F 000	Please accept the following as the Facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirements or regulations.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents who self-administered medications had been assessed and/or reassessed as safe to do so for 2 of 2 residents (R47, R20) reviewed for self administration of medications. Findings include: R47 was interviewed on 8/2/16, at 4:15 p.m. R47 stated he attended renal dialysis on Mondays,	F 176	F176: It is the policy of The Villa at Bryn Mawr that our facility will permit resident to self-administer their medications unless such practice for the resident is deemed unsafe. If the resident wishes to self-medicate, the facility Interdisciplinary Team will assess cognitive, physical and visual ability to carry out this responsibility. Plan of correction for residents cited with this survey: Nursing staff completed self-administration evaluations on R47 and R20. R47 and R20 incurred no adverse effects as a result of the observations identified during the survey. Plan to address/prevent this deficiency for other residents: Nursing staff has completed self-administration evaluations on all current residents. Nursing staff have been educated on self-administration policy and procedure. All residents deemed appropriate to self-administer medications have been reviewed by IDT (Inter-Disciplinary Team) and have requested physician orders to self-	

POC accepted as plan to 9/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin Master | (X6) DATE: 9/1/16

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

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F 176	Continued From page 1 Wednesdays and Fridays. At that time, R47 expressed concerns he had about his dialysis care by the facility staff stating, "the nursing staff here does nothing for my dialysis access site." R47 explained that one hour prior to dialysis the nurse was suppose to apply a numbing medication Lidocaine, to his access site. He stated, "this never happens. I have to do it." R47 said the cream was stored in a drawer in his room, and the nurse provided the resident with gauze to cover the site. R47 stated, "I don't know why I have to do this. Nursing should be doing this, but they don't. It's been going on like this for some time now." R47 explained that the dialysis nurse put a bandage on his arm after the run was completed, and he removed the bandage himself in the evening after it stopped bleeding. When asked if anyone had ever observed him apply the Lidocaine to determine if he correctly used the medication he replied, "No, I keep the cream in my top drawer in my room." R47 was outside on 8/3/16, at 1:02 p.m. when he called for the surveyor. His access site was bandaged. The resident informed the surveyor, "I went to dialysis today and again the nurse did not put the numbing cream on. I had to do myself." R47 explained the dialysis clinic ordered the cream, but the nurse placed a bandage over the cream prior to his appointment. A Quarterly Review Minimum Data Set (MDS) dated 6/16/2016 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 indicating a good memory. The resident was able to communicate needs. The resident's current care plan dated 6/25/2015 indicated facility staff were to complete dialysis access site care daily.	F 176	administer medications. All care plans have been updated accordingly. Self-administration of medication evaluations will be completed upon admission, then quarterly, annually and PRN. If the resident is deemed safe to self-administer medications, nursing staff will request a physician order to self-administer. Education will be conducted on August 31st to nursing staff and will be presented at new employee orientation. Plan to monitor: A self-administration of medication policy and procedure along with a self-administration of medication evaluation has been implemented. To ensure compliance, the nursing management staff or designee will conduct random audits of 10% of our census for the next 3 months. The results of the audit will be presented to at the Quality Assurance Committee Meeting with audits continuing as warranted. The QA Committee will monitor compliance, review trends and make recommendations as necessary. Responsible for maintaining compliance: Director of Nursing Completion date: 9/7/16	

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F 176	Continued From page 2 Licensed practical nurse (LPN)-H who routinely worked with R47 was interviewed on 8/3/16, at 1:07 p.m. LPN-H verified R47 self-administered the Lidocaine cream prior to dialysis. She explained that the dialysis clinic had provided the resident with a tube of the cream and a bandage, and he performed the treatment "himself." LPN-H stated she used to help the resident when his dialysis appointments were at 10:00 a.m. adding, "now he goes before I start work." Registered nurse (RN)-A stated at 1:10 p.m. she was unaware R47 was applying prescribed topical medication to his dialysis access site. She verified anyone taking or applying medications should have been assessed as safe to do so by a nurse, and R47 had not been assessed for medication self-administration. RN-A reported to the surveyor that in 12/15, R47 was sent back an order from the dialysis clinic to apply Lidocaine to the access site one hour prior to his appointment. RN-A said sometimes the resident did not give the paperwork to the facility nurse upon returning from dialysis. Later that day R47's dialysis nurse (RN-C) was interviewed by telephone. She verified R47 obtained the order for Lidocaine cream from the dialysis center, which was to be applied to the access site one hour prior to his appointments. RN-C stated, "I don't think the facility looks at the information sheets we send back with him after each dialysis run. We [dialysis nurses] have found out that if we have something that really needs to be addressed or changed. we have to call the facility directly." RN-C restated, "I really don't think the facility looks at the sheets we send back with [R47]."	F 176		

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F 176	Continued From page 3 On 8/4/16, at 10:38 a.m. R47 stated he had just been moved to a new room last evening. When asked if he had the Lidocaine cream he replied, "Yes--come, I will show you." However, when R47 opened the drawer he could no find the cream. RN-D who worked on the resident's new unit could not locate the Lidocaine cream in the treatment cart. RN-D said it would have been left in the treatment cart on the unit where R47 resided until last evening. At 12:58 p.m. however, LPN-H reported she was unable to find the cream." Later, at 2:14 p.m. the administrator and RN-E verified R47 should have been assessed prior to self-administering medication. R20 was observed on 8/3/16, at 10:01 a.m. lying on bed on right side, eyes open, with nebulizer mask over face, with machine running. During continuous observation at 10:07 a.m. R20 was observed with eyes closed nebulizer mask still in place, machine running. One minute later trained medication assistant (TMA)-C walked down the hall and looked in R20's room and then walked away. At 10:26 a.m. R20 was observed lying on the right side with the nebulizer mask on face, machine running with no steam going into the mask. R20's quarterly Minimum Data Set dated 7/29/16, indicated R20 had short and long term memory problems, had severely impaired daily decision making skills, and had delirium present, which fluctuated. R20's Care Area Assessment (CAA) dated 4/06/16, triggered for Cognitive Loss/Dementia and indicated R20 had, "Decreased ability to make self understood or to understand others."	F 176		

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F 176	Continued From page 4 On 8/3/16, at 10:05 a.m. TMA-C stated the nurse came down from station 3 and did residents' tube feedings and insulins. TMA-C stated she was trained to pass medications and administer nebulizer treatments. At 10:26 a.m. TMA-C stated R20 got up for breakfast, had his morning medications and went back to bed. TMA-C stated R20 would put on the nebulizer mask himself. TMA-C stated she would go and take the mask off of R20. TMA-C stated she had not applied the nebulizer treatment for R20, that he must have put it on himself. At 10:33 a.m. TMA-C verified the nebulizer mask was on R20's face and that the machine was running, that the cylinder was partially full with medication and no steam was going into the mask. TMA-C stated she had not given R20 his nebulizer mask, nor had she filled the cylinder with medication. TMA-C verified written on the outside of the cylinder in black marker, "8/2/16, 2 p.m." TMA-C stated she had not been aware there was medication in the cylinder nor had she been aware that R20 had his nebulizer in place with the machine running. TMA-C stated R20 only received prn (as needed) nebulizer treatments and that she would call licensed practical nurse (LPN)-E to see if she had given R20 his treatment. TMA-C proceeded to call LPN-E and was told LPN-E had not applied R20's nebulizer treatment. TMA-C stated R20's machine must not be working since R20 had had his nebulizer treatment running for approximately half hour and was still only half full. TMA-C stated the cylinder was dated 8/2/16, 2 p.m. since cylinders were dated when changing out with a new one once a week. TMA-C stated she had not been the one that had written the date and time when the cylinder was replaced. TMA-C stated it would be the day nurse yesterday who would	F 176		

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F 176	Continued From page 5 have exchanged cylinders.TMA-C stated she did not know who gave the last nebulizer treatment to R20 as it had not been initialed in the TAR. TMA-C stated when she gave R20 a nebulizer treatment, she would put the medication in the cylinder and put the mask on R20's face and leave the room and come back when the treatment was finished. TMA-C stated she would come back in about 2-3 minutes as the treatment did not take long to run. TMA-C stated when giving R20 a nebulizer treatment she would initial on the front of the TAR and write on the back as it was a PRN treatment. TMA-C stated R20 was not supposed to do his own nebulizer treatment. On 8/3/16, at 2:30 p.m. LPN-I stated she had worked the previous evening, had not changed R20's cylinder at 2 p.m. and had not given R20 a nebulizer treatment. LPN-I stated when she gave R20 a nebulizer treatment she would have to stay in R20's room during the treatment as R20 would take the mask off and throw it on the floor. LPN-I stated R20 had severe chronic obstruction pulmonary disease (COPD). On 8/4/16 at 9:46 a.m. LPN-J stated she had replaced R20's tubing and cylinder and labeled the new cylinder 8/2/16, 2 p.m. as that was the date and time. LPN-J stated she had given R20 a nebulizer treatment as R20 was kind of wheezing and when he exerted himself. LPN-J stated she had checked R20's oxygen saturations and they had been a little low before applying the nebulizer treatment. LPN-J verified she had not documented anything about the PRN nebulizer treatment given to R20. LPN-J stated after 10 minutes there was still medication left in R20's	F 176		

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F 176	Continued From page 6 cylinder and she noticed the machine was not working correctly. She stated she had not known who to tell about the machine not working and had told the oncoming evening nurse about it. LPN-J stated she had not given a nebulizer treatment to R20 at 2 p.m. but at 10:00 a.m. and verified she had not documented it. LPN-J stated R20 will put his nebulizer mask on himself and when then, "asked if he wants a treatment will shake his head and say yes " LPN-J stated R20 will keep his mask on until she returns and LPN-J stated she thought R20 could be alone with his treatment as she thought a self-administration assessment had been completed on R20 in July. but had not seen the assessment or any indication of a self administration assessment in the resident's chart. On 8/4/16, at 10:40 a.m. LPN-E stated she had not given R20 a nebulizer the day before nor had TMA-C asked her to give one. LPN-E stated she normally left R20 alone in his room with the mask on as she believed R20 had an assessment completed at one time to self-administer but could not verify in the record one had been completed for R20. R20's August 2016 physician orders included: "Ipratropium-Albuterol 0.5-3 mg/3 Ampu-Neb Nebulize 1 vial by mouth every 4 hours as needed dated 7/16/16" and "Document Heart Rate Before And After Treatment, Document Respirations Before And After Treatment." R20's August MAR showed no initials by nurse or TMA regarding any nebulizer treatment given or any pre or post nebulizer treatment respiratory	F 176		

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F 176	Continued From page 7 assessments completed for R20. R20 ' s current care plan indicated, "The resident [R20] has a physician's order for supervised self-administration of the following medications: Nebs" date initiated 4/28/14 and also indicated for Goal, "The resident [R20] will take medications safely and as prescribed through the review date, " dated initiated 4/28/14 and also indicated, "Review medication self-administration with resident [R20] /monthly and as needed to reassess abilities," Dated initiated 4/28/14. On 8/4/16, at 10:47 a.m. ADON stated the facility had been talking about the self-administration assessments and would need to correct and educate staff regarding self-administration assessments. ADON stated there had to be an assessment completed to know the resident is safe to administer medication.	F 176		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 3 of 3 residents (R92, R52, R26) who were dependent on staff to provide activities, and were reviewed for activities.	F 248	F248: It is the policy of The Villa at Bryn Mawr to provide ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. Plan of correction for residents cited with this survey: For R92, R52, and R26, a review of activity assessments and care plans to include interventions, such as interests of residents. We will audit the participation of activities against the calendar. Education was provided on these three residents to activity staff to ensure we were holding activities to best meet their interests. The residents identified had no adverse effects noted as a result of the observations noted by the state. The attendance for these residents will be logged. Plan to address/prevent this deficiency for other residents: All residents in the facility will have a review of their activity assessments and care plans.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 8 Findings include: R92 was initially observed on 8/1/16, at 3:57 p.m. lying in bed sleeping soundly. Later, at 7:29 p.m. R92 was awake and was seated in a wheelchair in the dining area. No staff was interacting with the residents. On 8/3/16, at 2:46 p.m. R92 was lying in bed. Although the television was turned on, R92's bed was positioned adjacent to the television next to his head, where he could not see the screen. On 8/4/16, at 8:54 a.m. R92's room door was shut and the surveyor was told, "He is in bed sleeping still." At 9:47 a.m. R92 was assisted back to his room by nursing assistant (NA)-A. When asked where the "1:1 with Rec [recreation] staff" activity scheduled from 9:30 to 11:30 a.m. was usually held, NA-A walked to the white board listing activities and stated, "It's usually held in the dining room." NA-A then asked R92 if he wished to stay for the activity he replied, "Yes." NA-A wheeled R92 to a place at the dining room where a few other residents were seated. No activity was being held at that time. R92 sat calmly with no signs of agitation such as yelling or increased movement in his wheelchair. Twelve other residents were in the room as staff walked back and forth and the nurse passed medications in the dining room and no activity was held. At 10:20 a.m. a staff person stated the board game Yahtzee was being played on the third floor. No staff person offered to take R92 to the activity. R92's 8/6/15, annual Minimum Data Set (MDS) indicated the resident had moderately impaired cognition. The following activities were all somewhat important to the resident: having reading material, music, pets, keeping up on	F 248	Measures put in place to prevent recurrence: The activity calendar will be reviewed monthly to ensure we have activities that best meet the needs of all of our residents. The attendance for all residents will be logged. Education was provided to activity staff to ensure we were holding activities to best meet their interests. Plan to monitor: A random 10% audit of resident care plans and activity participation will be conducted the next 3 months to ensure we are holding activities on the calendar that best suit the needs of our residents. The results of the audit will be presented to at the QA Meetings with audits continuing as warranted. The QA Committee will monitor compliance, review trends and make recommendations as necessary. Responsible for maintaining compliance: Activity Director, Administrator Correction Date: 9/7/16	

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F 248	Continued From page 9 news, group activities, pets, going outside, and religious activity. A subsequent quarterly MDS dated 5/10/2016 indicated the resident had severely impaired cognition for decision making skills and had some difficulty focusing, however, a decline in mental status was not noted. The assessment indicated the resident had diagnoses including dementia, depression and psychosis. He was dependent on staff for mobility on/off the unit. He displayed verbal behaviors 1-3 days during the assessment period, however, mood indicators were not noted. R92's care plan dated 9/10/14, noted the resident was dependent on staff and his wife for meeting his emotional and social needs. Interventions directed staff to provide individual activities, assist with television, provide activity calendar, invite to scheduled activities, and thank resident for attending. During an interview with R92 on 8/3/16, at 2:47 p.m. he reported he did not attend activities, but enjoyed watching television in his room. R92 had difficulty speaking and was short of breath, so was unable to provide details as to why he did not attend activities. Licensed practical nurse (LPN)-A who routinely worked with R92 was interviewed on 8/3/16, at 2:48 p.m. LPN-A was unable to state R92's activity preferences, and referred the surveyor to the activity staff. NA-A then explained that when R92 was brought to an activity he would yell loudly and want to return to his room. When asked whether she had observed 1:1 visits/activities provided for R92 NA-A replied, "No."	F 248		

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F 248	Continued From page 10 On 8/3/16, at 3:09 p.m. Recreational Therapy Assistant (RTA)-A explained she had only been in her activities position for a month. RTA-A reported R92 enjoyed activities that required using the mind, such as spelling bees, old sayings and music. RTA-A explained that previously attendance was taken when residents attended activities, but that "fell to the wayside." RTA-A verified she did not document when a resident attended an activity or when a 1:1 visit was provided, and she was unable to produce an activity assessment since R92's admission. R92's activities participation notes revealed the following: 1) 8/9/15, R92 attended four structured programs in the past quarter; 2) 11/19/15, R92 attended Bible study, communion, and movie matinee; 3) 3/3/16, R92 attended social ball toss, old sayings and church; 4) No further entries were located in the record regarding activities R92 attended or declined. A review of the activity calendar for the months of July and August 2016, revealed numerous activities were provided for persons cognitively intact such as quiz challenge, hangman, spelling bee, jeopardy and horse racing. The facility's 10/09, Activity Assessment policy directed staff, "Within 14 days of a resident's admission to the facility, an activity assessment will be conducted to help develop an activities plan that reflects the choices and interests of the resident. The assessment will be conducted by the activity department staff and other staff employees input. The activity assessment will be part of the residents' medical record and updated	F 248		

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F 248	Continued From page 11 as needed and annually." R52 stated in an interview on 8/1/16, at 3:23 p.m., "I do not want to be here." R52 said he was just waiting for someone to tell him what to do and where to go. Although a television was on in the room, the resident stated he was not watching it. No other personal items were observed in the room except for clothing. The curtains were closed. R52 reported he used to be a carpenter and enjoyed hunting and fishing. On 8/3/16, at 2:17 p.m. R52 was seated in the dining room. He again reiterated his feelings about living at the facility. When asked what he would like to do at the facility he said he liked hunting and fishing and wanted to go outside. He then carried on a 10 minute conversation with the surveyor about fishing. A social services note dated 9/16/15, revealed R52 was severely cognitively impaired, had self-reported depression, spent some time watching television and lying in bed. R52 did not socialize or participate in activities; activity preferences were hunting and fishing. R52's care plan (9/5/16 goal date), indicated the resident had little or no activity involvement related to disinterest. The goal was, "The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date." Approaches included the resident's preference for old westerns and movies. His preferences were noted as listening to country music and watching western shows. Staff was to ensure he received daily opportunities for social contact and eat all meals in the dining room, attended daily activities of his	F 248		

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F 248	Continued From page 12 choice, and communicated his feelings regarding activities. Staff were to introduce the resident to others with similar background, interests and encourage/facilitate interaction and activity attendance. An activity assessment dated 6/15/16, indicated the resident had, ".. severe cognitive impairment related to dementia. Resident does not participate in activities secondary to lack of desire, only comes out for meals." R52's 6/23/16, annual Minimum Data Set included diagnoses of dementia, anxiety, and depression. Although the assessment indicated severely impaired cognition. It was "somewhat important" he do things with groups of people and go outside in nice weather. The assessment showed the resident did not display mood or behavioral indicators during the assessment period, but a new problem was that the resident experienced "little pleasure in doing things" every day or nearly every day. R52's care plan, however, did not incorporate these areas of importance to the resident or concerns with approaches to ensure his needs were met. On 8/4/16, at 11:55 a.m. R52's activity log for June 2016, revealed the resident attended movie and popcorn on 6/8/16 and Bingo on 6/27/16. During an interview with the Recreational Therapy Assistant-A (RTA-A) on 8/3/16, at 1:14 p.m. she reported R52 did not wish to attend activities. She described the resident as "disinterested in activities" and instead, the resident wanted his family to visit more often. He watched television or activities, but did not generally participate. He did attend food programs such as birthday	F 248		

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F 248	Continued From page 13 parties. RTA-A stated R52 would have benefited from more interaction with his family, and had made attempts to call them, but the phone numbers were no longer valid. R52 was not responsive to conversation and gave staff "the silent treatment." There were no current plans for the resident to move to a different location. He had not been attending his care conferences, but some magazines were provided for him in his room. RTA-A said she had no idea R52's previous occupation. The social worker (SW) was interviewed on 8/4/16, at 11:58 a.m. and described R52 as "unhappy" at the facility, and had not adjusted. He was encouraged to attend activities, and the staff allowed him space. The SW said they could have attempted other approaches with R52 to make his stay at the facility more satisfactory. The resident continued to say things were unacceptable and the SW said, "We may need to look at trying something new. He does consider this to be a prison." The SW reported he could utilize the patio, and said, "We will need to add outside to the care plan. There may be more opportunities that we need to consider for this resident." The SW explained they had noted traditional dementia symptoms with R52, such as what meal was being served. In addition, he often did not provide a reason why he did not wish to attend activities, just stated he did not wish to attend. R26, who had diagnoses that included brain injury, cognitive (thinking) problems, depression, stroke with left-sided paralysis was observed on 8/2/16, at 6:15 p.m. after being assisted out of bed for the evening meal. While trying to start a	F 248		

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F 248	Continued From page 14 conversation, R26 avoided eye contact and gave little response. The following morning at 8:25 a.m. the resident was up in a wheelchair in the bedroom. R26 was facing the television, which was off at the time. The resident made repetitive, nervous hand movements. R26 did not respond to two greetings by the surveyor. When asked if things were going okay, the response was "yah," and was barely audible. At 9:00 a.m. the resident was being assisted to eat breakfast in the dining room. At 9:30 a.m., still in the dining room, R26 sporadically looked at a morning television show between active looks around at the other residents in the room. At 10:24 a.m. the resident was lying awake in bed, and again did not respond to a greeting. During an interview on 8/2/16 at 4:13 p.m., NA-D indicated R26's morning routine was to be gotten up in a wheelchair, get washed up and then eat breakfast. NA-C was also present and added R26 was, "mostly in bed because of her bottom getting red in a short time, but that is better now." NA-D continued, "R26 does some activities, they try to get her to participate, movies...I'm not sure of any others." NA-E elaborated during an interview on 8/3/16, at 10:27 a.m.: "Her routine is that we get her cleaned up, then get her up for breakfast - she stays up an hour approximately. Then we put her back to bed and check her [skin], then check her again before we get her up at lunch. She's in bed a lot because of [skin issues] on her behind...that come and go." She doesn't do activities now, she doesn't follow - if she's left up longer her head	F 248		

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F 248	Continued From page 15 goes down, like this." During an interview on 8/3/16, at 10:36 a.m. registered nurse (RN)-G explained the wound nurse had requested R26 stay off from her buttocks due to her poor skin condition. RN-G said they occasionally included the resident in an activity, but she did not participate or attend to what was going on due to her cognition state. RN-G stated, "I'm not sure if she gets any 1:1 time from activities [staff]. You could ask our activities director." At 10:40 a.m. on 8/03/16 the Recreational Therapy Assistant (RTA-A) was observed just leading Bingo in the dining room - R26 was not there but in bed as previously observed. The current care plan for R26 indicated the resident had little or no activity involvement due to her limitations related to traumatic brain injury and a stroke. It was noted the resident was able to use some sensory skills such as hearing and vision. Interventions included a list of the resident's preferred activities: "Spiritual, cognitive, sensory, and a variety of programs on her floor. She does not tolerate being up for long periods of time. Resident watches TV in her room. Bible Study, Birthday Party, Manicures, church." An activities assessment for R26 was requested but not supplied by the facility. After she finished leading Bingo an interview was conducted with RTA-A. When asked what activity services existed for residents whose limitations prevented them attending scheduled activities, she answered she would individualize her interventions. For one resident she would bring a television into the bedroom and play movies. For another, she said, she would go in and read or	F 248		

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F 248	Continued From page 16 visit. "And I like to get them outside when possible." As to R26, RTA-A indicated she would read to her, "have conversations, tell her the weather." She added, "I'm a little bit of everywhere...I see everyone who needs a 1:1," She added, "I cover the whole facility so it takes more than 1 day [to see every resident who needs it]." She added, "Last week R26 played the Bingo."	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being for 1 of 1 resident (R52) who reported dissatisfaction with his life at the nursing home. Findings include: R52 stated in an interview on 8/1/16, at 3:23 p.m. he did not have any say in and/or was not informed of cares, treatments, or medications he was prescribed. When asked about how he was doing overall at the facility, he used an expletive and indicated, "I do not want to be here." R52 said he was just waiting for someone to tell him	F 250	**F250:** It is the policy of the Villa at Bryn Mawr that residents receive all necessary medically-related social services and that social service care plans are updated and reviewed in a timely manner. It is also the policy at the Villa at Bryn Mawr to make sure that residents and persons involved in a resident's care are updated in a timely manner. Plan of correction for residents cited with this survey: R52 had the psychosocial well-being care plan updated to reflect the care and services provided to attain or maintain the highest level of adjustment and	

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F 250	Continued From page 17 what to do and where to go. A social services note dated 9/16/15, revealed R52 was severely cognitively impaired, had self-reported depression, spent some time watching television and lying in bed. R52 did not socialize or participate in activities. A subsequent note dated 12/13/15, indicated R52 when asked to attend his quarterly care conference he declined stating, "'I don't even know you.'" The note indicated assessments had been completed and the resident had severely impaired decision making skills, and the physician recommended guardianship for the resident. The social worker (SW) documented difficulty finding a family member to assist with guardianship. It was noted R52 saw the in-house psychologist on 10/14/15, and the resident was not getting along with his roommate and was rejecting leg treatments. The SW noted she would continue to be available to meet the resident's psychosocial needs. On 12/17/15, the SW and nurse manager met for a care conference. The note did not indicate whether the resident was invited or declined or attended the conference. A SW note dated 6/14/16, indicated R52 had behaviors of refusing treatment and calling staff names, and had a need for a private room due to rummaging through others' belongings. The SW wrote, "Resident is dissatisfied with placement and desires to live in independent living, but doctor and IDT [interdisciplinary team] agree that community discharge is not appropriate due to resident's cognitive status. Plan of care to be discussed with guardian when guardian is appointed." Notes from the psychology clinic were not located	F 250	psychosocial well-being while residing in the nursing home. R52's family members have been found and appointed as legal decision makers for this resident. They have been updated about resident's cares and care plan. Social service will initiate a care conference with family and R52. Notes from Associated Clinic of Psychology (ACP) will also be added into R52's chart. Social service removed goal of having resident improve current level of cognitive function. The interdisciplinary team will implement behavior tracking to identify the frequency that he voices discontent with placement. Social service and IDT will implement interventions to help decrease resident's discontent. Social worker will meet with the resident on a weekly basis and talk about areas of interest. Resident has not demonstrated any adverse effects from the observations observed by MDH. Plan to address/prevent this deficiency for other residents: All residents will have their care plan reviewed and updated to ensure psychosocial needs are being met. Guidelines for care conference expectations has been updated and distributed to all relevant members of the	

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F 250	Continued From page 18 when R52's medical record was reviewed, although it was noted the resident was seen 4/6/16. A medication decrease in the resident's antidepressant was made and the note indicated he would be seen again in six months. An undated care conference summary form was found in R52's record when the record was reviewed on 8/3/16. The summary indicated R52 was invited but did not attend the conference, however, a reason was not noted. A conference note dated 3/16/16, indicated the resident was invited but did not attend his conference, and the facility had changed his bath to the morning to increase compliance with bathing. A conference form dated 6/30 lacked the year and did not indicate whether the resident was invited or attended or declined his conference. No other conference forms were located in the record. R52's 6/23/16, annual Minimum Data Set included diagnoses of dementia, anxiety, and depression. Although the assessment indicated severely impaired cognition, he was able to be interviewed for the assessment. The only area the resident reported as, "very important," was to have his family involved in discussions about his care. The assessment showed the resident did not display mood or behavioral indicators during the assessment period, but a new problem was that the resident experienced, "little pleasure in doing things," every day or nearly every day. R52's care plan, however, did not incorporate these areas of importance to the resident or concerns with approaches to ensure his needs were met. The 6/15/16, social services comprehensive Care Area Assessment (CAA) for mood/behavior annual review indicated "Resident	F 250	interdisciplinary team. The guidelines for care plan attendance will be updated to include the identification of resident and or family attendance. Measures put in place to prevent recurrence: The policy and procedure for revising the care plan has been reviewed and updated. The staff will be educated the proper care plan implementations to best meet the residents psychosocial needs. Plan to monitor: A random 10% audit of resident's care plans and care conference attendance will be conducted monthly for the next 3 months to ensure compliance. The results of the audit will be reported on at the QA Meeting with audits continuing as warranted. QA Committee will ensure ongoing compliance with F250 and make ongoing recommendations as needed. Responsible for maintaining compliance: Director of Social Services Correction Date: 9/7/16	

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F 250	Continued From page 19 states... that he would like to go home. IDT and physician agree that community placement is not appropriate." R52's care plan (goal date 9/5/16) indicated, "The resident is adjusting to a new routine and nursing home placement. Resident calls this place 'jail,' and would like to move to community, but has significant dementia." It also indicated the resident had impaired cognitive function/dementia or impaired thought processes related to short term memory loss/dementia. "Daughter has agreed to be resident's guardian, waiting on results of background check." The goal was, "The resident will improve current level of cognitive function through the review date." The care plan also noted the resident was adjusting to a new routine and nursing home placement, called the facility "jail" and would like to live in the community but had significant dementia. During an interview with RN-E on 8/4/2016 at 7:58 a.m. she stated that resident care conferences were sometimes a team, but it would depend on the resident. The adjustment part of the care plan was a team effort and varied depending on the resident. Initial care plans were started at the first referral which then triggered how it drove the care plan. Care conferences are primarily nursing and social services. There was also a process called Grand Rounds that occurs before the assessment period where additional staff gave input. During an interview with the recreational therapy assistant A (RTA-A) on 8/3/16, at 1:14 p.m. she described the resident as "disinterested in activities" and instead, wanted his family to visit more often. RTA-A said R52 would have benefited from more interaction with his family,	F 250		

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F 250	Continued From page 20 and had made attempts to call them, but the phone numbers were no longer valid. R52 was not responsive to conversation and gave staff "the silent treatment." There were no current plans for the resident to move to a different location. He and not been attending his care conferences. The SW was interviewed on 8/4/16, at 11:58 a.m. and said she and the nurse manager were the two staff who attended resident care conferences. Sometimes, the dietitian may attend, but the activity staff did not attend. She stated R52's daughter was appointed his guardian in 5/16. The SW described R52 as "unhappy" at the facility, and had not adjusted. The resident could not tolerate a roommate, as he was "unfriendly" toward them and they received a private room waiver for this reason. The staff had utilized the family to reach him and ensure he could do the best he could given the situation. The SW verified the care plan regarding adjusting to the nursing home including the problem statement, goal, and approaches, remained the same as when the resident was admitted more than a year prior. The SW said they could have attempted other approaches with R52 to make his stay at the facility more satisfactory. When asked if it was felt the plan was working, since the resident continued to express dissatisfaction with life at the facility, the SW replied, "We may need to look at trying something new. He does consider this to be a prison...There may be more opportunities that we need to consider for this resident." The SW explained they had noted traditional dementia symptoms with R52, such as what meal was being served. In addition, he did not provide a reason why he did not wish to attend his care conferences.	F 250		

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	245203	A. BUILDING _____ B. WING _____	08/05/2016

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care to adequately monitor and assess 1 of 3 residents (R63) in the sample, reviewed for non-pressure related skin conditions (bruising), failed to ensure 1 of 1 residents (R20) was supervised during nebulizer treatment, and failed to follow the care plan for 1 of 1 resident (47) receiving dialysis. Findings include: R63 did not receive skin monitoring and assessment as directed in the plan of care. The current plan of care, target date 7/8/16, identified R62 as a fall risk related to actual falls, unsteady gait, and failure to be cognoscente [sic] of deficits. The care plan directed staff to monitor, document, and report as needed for 72 hours to medical doctor for pain and bruises, however did not identify bruises or abrasions obtained on 7/22/16. R63 was observed on 8/1/16 to have a purple bruise on her right bicep area (inner, upper forearm). The areas to the edge of the bruise were lighter purple and the center was a deeper purple. She also had a scrape noted on the	F 282	F282: It is the policy at The Villa at Bryn Mawr that services provided or arranged by the facility must be provided by qualified person in accordance with each resident's written plan of care. Plan of correction for residents cited with this survey: R63 has been reassessed. Plan of care has been updated, and therapy has implemented new interventions, including a new walker. Resident has had no adverse effects identified. R20 has had SAM (Self Administration of Medication Assessment) of nebulizer treatment reassessed. R20 has had plan of care updated. Resident has had no adverse effects identified as a result of the observations by the survey. R47 has had self-administration of Lidoderm gel re-evaluated. The plan of care has been review, updated and revised. Resident has had no adverse effects identified as a result of the observations by the survey. The facility has contacted dialysis to update the care plan regarding appropriate dialysis interventions.	

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F 282	Continued From page 22 middle knuckle of her left hand. It was covered by a dry scab. When asked, R63 stated she had a fall while she was with her "companion" on a shopping trip and obtained both injuries at that time. The medication administration records (MAR) and the treatment administration records (TAR) for 7/2016 and 8/2016 lacked identification or monitoring of the bruise or the scrape. An Occurrence Report completed on 7/22/16, at 8:56 p.m. noted the following injuries: Bruise to the Right Upper Arm, near chest, purple, new looking bruise; Skin Tear to right middle Finger 3, scrape on knuckle of right middle finger. A treatment and measurements were not mentioned in the report. A skin /wound note on 7/23/16, the day after the occurrence, indicated R63 took a bed bath that night with extensive assistance of one staff and a complete skin assessment was completed. The skin was found to be dry, intact and no pressure areas or bruises were noted. A skin/wound note on 7/31/16, indicated R63 took a tub bath with extensive assistance of one staff. Her skin was dry and intact. No pressure areas or bruises were noted. During an interview on 8/3/16, at 1:31 p.m., a registered nurse (RN)-E stated all skin issues were to be monitored and tracked on the TAR, at least daily, until resolved as the policy indicated. She verified that R63's TAR for 6/2016, 7/2016 and 8/2016 lacked monitoring of non-pressure skin conditions	F 282	Plan to address/prevent this deficiency for other residents: A post-incident checklist and the skin conditions policy has been implemented at the facility. Nursing staff will complete the post-incident checklist at the time of an incident. Nursing staff will then turn the completed checklist into nursing management for review and further follow-up. The post-incident checklist will be completed after each incident occurrence. All residents will be audited for skin impairment documentation. Bruises to be identified on TAR (Treatment Administration Record) and monitored until resolved. The policy and procedures for skin impairment, dialysis treatments, self-administration of medication and nebulizers has been reviewed and updated. Measures put in place to prevent recurrence: All residents will be assessment for the self-administration of meds. Nursing staff will be educated on the self-administration of meds, nebulizer administration, pre and post assessment and appropriate functionality of equipment. Staff educated on the need to monitor all areas of skin impairment. All residents receiving dialysis will be	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 23 A policy to care plan for monitoring and assessing non-pressure skin conditions was requested but not provided. On 8/4/16, at 8:19 a.m. RN-E stated the facility did not have a system in place to monitor bruising and other non-pressure skin conditions. During an interview on 8/4/16, at 8:48 a.m., the director of nursing stated she expected staff to monitor bruising and care plan for all skin conditions. R20's current care plan indicated, "The resident [R20] has a physician's order for supervised self-administration of the following medications: Nebs," date initiated 4/28/14 and also indicated for Goal, "The resident [R20] will take medications safely and as prescribed through the review date," dated initiated 4/28/14 and also indicated, "Review medication self-administration with resident [R20] /monthly and as needed to reassess abilities." R20's quarterly Minimum Data Set dated 7/29/16, indicated R20 had short and long term memory problems, had severely impaired daily decision making skills, and had delirium present, which fluctuated. R20's Care Area Assessment (CAA) dated 4/06/16, triggered for Cognitive Loss/Dementia and indicated R20 had, "Decreased ability to make self understood or to understand others." R20 was observed on 8/3/16 at 10:01 a.m. lying on bed on right side, eyes open, with nebulizer	F 282	assessed and have care plans reviewed to ensure pre and post dialysis intentions are being implemented. Nursing staff were educated on appropriate dialysis follow up. Nursing staff educate on the need to ensure accurate assessments within the required time frames, the need to complete comprehensive care plans and the need to update NAR (Nursing Assistant Registered) care sheets. Staff educated on appropriate monitoring and coordination of care. Plan to monitor: To ensure compliance, the nursing management staff or designee will conduct audits of all of our dialysis residents on a monthly basis. All residents receiving nebulizer treatments will be reviewed. All residents with impaired skin will be reviewed. The results of the audit will be presented to at the QA Meetings with audits continuing as warranted. The QA Committee will monitor compliance, review trends and make recommendations as necessary. Responsible for maintaining compliance: Director of Nursing Correction Date: 9/7/16	

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F 282	Continued From page 24 mask over face, with machine running. During continuous observation at 10:07 a.m. R20 was observed with eyes closed, nebulizer mask still in place, machine running. One minute later trained medication assistant (TMA)-C walked down hall and looked in R20's room and then walked away. At 10:26 a.m. R20 was observed lying on right side with nebulizer mask on face, machine running with no steam going into the nebulizer mask. On 8/3/16, at 10:05 a.m. TMA-C stated the nurse would come down from station 3 and complete residents' tube feedings and insulins. TMA-C stated she was trained to pass medications and administer nebulizer treatments. At 10:26 a.m. TMA-C stated R20 got up for breakfast, had his morning medications and went back to bed. TMA-C stated R20 would put on the nebulizer mask himself. TMA-C stated she would go and take the mask off of R20. TMA-C stated she had not applied the nebulizer treatment for R20,that he must have put it on himself. At 10:33 a.m. TMA-C verified the nebulizer mask was on R20 ' s face and that the machine was running, that the cylinder was half full with medication and no steam was going into the mask. TMA-C stated she had not given R20 his nebulizer mask, nor had she filled the cylinder with medication. TMA-C verified that written on the outside o fthe cylinder in black marker was, "8/2/16, 2 p.m." TMA-C stated she had not been aware there was medication in the cylinder nor had she been aware that R20 had his nebulizer in place with the machine running. TMA-C stated R20 only received prn (as needed) nebulizer treatments and that she would call licensed practical nurse (LPN)-E to see if she had given R20 his treatment. TMA-C proceeded to call	F 282		

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F 282	Continued From page 25 LPN-E and was told LPN-E had not applied R20's nebulizer treatment. TMA-C stated R20 ' s machine must not be working since R20 had his nebulizer treatment running for approximately half hour and it was still half full. TMA-C stated the cylinder was dated 8/2/16, 2 p.m. since cylinders were dated when changing out with a new one once a week. TMA-C stated she had not been the one that had written the date and time when the cylinder was replaced. TMA-C stated it would be the day nurse yesterday who would have exchanged cylinders. TMA-C stated when R20 coughs a lot he can have a nebulizer treatment. TMA-C verified the medication administration record (MAR) Indicated a pre and post respiratory assessment was to be completed before and after the treatment but that she did not complete the assessments before applying nebulizer treatments. TMA -C stated she could give the nebulizer treatment if R20 coughed a lot or if the nurse told her to do it. TMA-C stated she had never been told to complete the pre and post respiratory assessments ordered. TMA-C stated she did not know who gave the last nebulizer treatment to R20 as it had not been initialed in the TAR. TMA-C stated when she gave R20 a nebulizer treatment she would put the medication in the cylinder apply on R20' s face and leave the room and come back when the treatment was finished. TMA-C stated she would come back in about 2-3 minutes as the treatment did not take long to run. TMA-C stated when giving R20 a nebulizer treatment she would initial on the front of the TAR and write on the back as it was a PRN treatment. TMA-C stated R20 is not supposed to do his own nebulizer treatment. On 8/3/16, at 2:30 p.m. LPN-I stated she had worked last evening, had not changed R20 ' s	F 282		

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F 282	Continued From page 26 cylinder at 2 p.m. and not given R20 a nebulizer treatment. LPN-I stated when she gave R20 a treatment she would initial on the front of the TAR and write on the back of the MAR. LPN-I stated when she gave R20 a nebulizer treatment she would have to stay in R20's room during the treatment as R20 would take the mask off and throw it on the floor. LPN-I stated R20 had severe chronic obstruction pulmonary disease (COPD). LPN-I stated she had not observed R20's nebulizer machine the previous evening as R20 breathed adequately that evening. The following morning at 9:46 a.m. LPN-J stated she had replaced R20's tubing and cylinder with new and labeled the cylinder 8/2/16, 2 p.m. as that was the date and time. LPN-J stated she had given R20 a nebulizer treatment as R20 was kind of wheezing when he exerted himself. LPN-J verified she had not documented anything anywhere about the PRN nebulizer treatment given to R20 nor any of the pre or post respiratory assessments. LPN-J stated after 10 minutes there was still medication left in R20 ' s cylinder and she noticed the machine was not working correctly. She had not known who to tell about the machine not working and had told the oncoming evening nurse about it. LPN-J stated R20 will put his nebulizer mask on himself and when then asked if he wanted a treatment would shake his head and say, "yes." LPN-J stated R20 would keep his mask on until she returned and stated she thought R20. could be alone with his treatment as she thought a self-administration assessment had been completed on R20 in July. LPN-J stated R20 had asthma and COPD (lung disease). LPN-J stated by her not documenting on the TAR the oncoming nurse would not know if	F 282		

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F 282	Continued From page 27 and when she could give R20 a PRN nebulizer treatment. LPN-J stated she had been really busy that day as she had been going back and forth between two floors and could forget things then like she did with the nebulizer treatment. On 8/4/16, at 10:40 a.m. LPN-E stated she had not given R20 a nebulizer the day before nor had TMA-C asked her to give one. LPN-E stated she normally left R20 alone in his room with the mask on as she believed R20 had an assessment completed at one time to self-administer but could not verify in the record one had been completed for R20. R20's August 2016 physician orders included: "Ipratropium-Albuterol 0.5-3 mg/3 Ampu-Neb Nebulize 1 vial by mouth every 4 hours as needed dated 7/16/16" and " Document Heart Rate Before And After Treatment, Document Respirations Before And After Treatment " R20's August MAR showed no initials by nurse or TMA regarding any nebulizer treatment given or any pre or post nebulizer treatment respiratory assessments completed for R20. On 8/4/16, at 10:47 a.m. ADON stated the facility had been talking about the self administration assessments and would need to correct and educate staff regarding self-administration assessments. ADON stated there had to be an assessment completed to know the resident is safe to administer medication. Although the resident was left alone with his nebulizer treatment at times, facility staff had different understandings as to his abilities to	F 282		

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F 282	Continued From page 28 safely administer the nebulizer treatments when he was left alone and there was no evidence he was assessed/reassessed for his self adminsitration abilities. R47's quarterly Minimum Data Set (MDS) dated 6/25/16, indicated R47 was cognitively intact, displayed no behaviors of refusal of cares and required staff supervision at times or was independent with personal hygiene. R47 had diagnoses of dementia, depression and schizophrenia. R47's care plan dated 6/23/15, indicated R47 required dialysis related to renal failure. Staff interventions included to check and change dressing daily, monitor signs and symptoms of infections at access site and document on treatment sheets. During an interview on 8/2/16, at 4:15 p.m. R47 stated he went to dialysis on Mondays, Wednesdays and Fridays. R47 expressed concerns he had about the care he was receiving at the facility. R47 stated, "the nursing staff here does nothing for my dialysis access site." R47 explained, "Before I go to my dialysis appointment the nurse is to put on a numbing medication (lidocaine 2.5%) cream to my access site 1 hour before my appointment time. This never happens. I have to do it." R47 stated, "I have the numbing cream in the drawer by my bed. I put the cream on my dialysis access site and the nurse brings me a dressing to cover it. I don't know why I have to do this, nursing should be doing this, but they don't, it's been going on like this for some time now." R47 stated when he was done with dialysis the nurse at dialysis put a bandage on his arm and he removed it later in	F 282		

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F 282	Continued From page 29 the evening after it stopped bleeding. When R47 was asked if the facility ever educated him on safety or looking for signs of infections, R47 replied, "No, the staff here has never taught me how or what to look for, how to change my dressing on my arm they [nursing] never done any monitoring of my skin." During an interview on 8/3/16, at 7:15 a.m. licensed practical nurse (LPN)-H stated she had been R47's nurse for a long time and checked and removed R47 dressing from dialysis around 2-3 p.m. but did not document that she had done this. Review of R47's medication administration record (MAR) and treatment administration record (TAR) for the month of 7/2016, revealed there was no indication for nursing to check and change R47's dialysis dressing or to monitor for bleeding and signs of infection. However, after it was brought to the nurse manager's attention, these intervention were added to R47's 8/2016 MAR on 8/4/16. During an interview on 8/4/16, at 2:14 p.m. with the administrator and registered nurse (RN)-E, both verified R47 should have had dressing changes and monitoring for signs and symptoms of infection on his MAR/TAR. RN-C stated that nursing should be documenting when the resident's dressing was last changed. A policy and procedure was requested but not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	F309: It is the policy of The Villa at Bryn Mawr that residents are provided the necessary care and service to attain or maintain the highest practicable well-being. Plan of correction for residents cited with this survey: R63 has been reassessed. Plan of care has been updated, and therapy has implemented new interventions, including a new walker. Resident has had no adverse effects identified. R20 has had self-administer medications (SAM) of nebulizer treatment reassessed. R20 has had plan of care updated. Resident has	

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F 309	Continued From page 30 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: ~~Based on observation, interview and document~~ review, the facility failed to monitor and assess 1 of 3 residents (R63) in the sample, reviewed for non-pressure related skin conditions (bruising) and failed to ensure care was provided appropriately, and services coordinated for 1 of 1 resident (R47)receiving dialysis. Findings include: ~~R63 was observed on 8/1/16 to have a purple~~ bruise on her right bicep area (inner, upper forearm). The areas to the edge of the bruise were lighter purple and the center was a deeper purple. She also had a scrape noted on the middle knuckle of her left hand. It was covered by a dry scab. When asked, R63 stated she had a fall while she was with her "companion" on a shopping trip and obtained both injuries at that ~~time.~~ A nurse's progress note on 7/22/16, at 8:24 p.m. described a fall during an outing. R62 tripped while getting into a car. The nurse did a body check and noted a "scrape right middle knuckle and bruising present on the right arm near the chest that seemed new." The medication administration records (MAR) and the treatment administration record (TAR) for 7/2016 and 8/2016 lacked identification or monitoring of the bruise or the scrape.	F 309	had no adverse effects identified as a result of the observations by the survey. R47 has had self-administration of Lidoderm gel reevaluated. The plan of care has been review, updated and revised. Resident has had no adverse effects identified as a result of the observations by the survey. The facility has contacted dialysis to update the care plan regarding appropriate dialysis interventions. ~~Plan to address/prevent this deficiency for~~ other residents: A post-incident checklist and the skin conditions policy has been implemented at the facility. Nursing staff will complete the post-incident checklist at the time of an incident. Nursing staff will then turn the completed checklist into nursing management for review and further follow-up. The post-incident checklist will be completed after each incident occurrence. All residents will be audited for skin impairment documentation. Bruises to be identified on TAR (Treatment Administration Record) and monitored until resolved. The policy and procedures for skin impairment, dialysis treatments, self-administration of medication and nebulizers has been reviewed and updated.	

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F 309	Continued From page 31 A skin /wound note on 7/23/16, the day after the resident's injury, stated R63 took a bed bath tonight with extensive assistance of one staff and a complete skin assessment was done. The skin was found to be dry, intact and no pressure areas or bruises noted. A skin/wound note on 7/31/16 stated R63 took a tub bath with extensive assistance of one staff. Her skin was dry and intact. No pressure areas or bruises were noted. During an interview on 8/3/16, at 1:31 p.m., a registered nurse (RN)-E stated all skin issues were to be monitored and tracked on the TAR, at least daily, until resolved as the policy indicates. She verified that R63's TAR for 6/2016, 7/2016 and 8/2016 lacked monitoring of non-pressure skin conditions An Occurrence Report completed on 7/22/16, at 8:56 p.m. noted the following injuries: Bruise to the Right Upper Arm, near chest, purple, new looking bruise; Skin Tear to right middle Finger 3, scrape on knuckle of right middle finger. A treatment and measurements were not mentioned in the report. A list of current orders lacked direction to monitor and treat current non-pressure skin conditions. The current plan of care, target date 7/8/16, identified R62 as a fall risk related to actual falls, "Unsteady gait, Poor Balance, and failure to be cognoscente [sic] of deficits." The care plan directed staff to monitor, document, and report as needed for 72 hours to medical doctor for	F 309	Measures put in place to prevent recurrence: All residents will be assessment for the self-administration of meds. Nursing staff will be educated on the self-administration of meds, nebulizer administration, pre and post assessment and appropriate functionality of equipment. Staff educated on the need to monitor all areas of skin impairment. All residents receiving dialysis will be assessed and have care plans reviewed to ensure pre and post dialysis intentions are being implemented. Nursing staff were educated on appropriate dialysis follow up. Nursing staff educate on the need to ensure accurate assessments within the required time frames, the need to complete comprehensive care plans and the need to update NAR care sheets. Staff educated on appropriate monitoring and coordination of care. Plan to monitor: To ensure compliance, the nursing management staff or designee will conduct audits of all of our dialysis residents on a monthly basis. All residents	

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F 309	Continued From page 32 pain and bruises. A policy to monitor and assess non-pressure skin conditions was requested however a policy regarding Suspected Abuse and Neglect -Clinical Protocol Injury, Fractures, Bruises and Skin Tears of unknown origin, revised June 2014) was provided. The policy did not address monitoring or assessing non-pressure skin conditions. On 8/4/16, at 8:19 a.m. RN-E stated the facility did not have a system in place to monitor bruising and other non-pressure skin conditions. She stated the facility's only policy to monitor these non-pressure alterations in skin integrity was the Abuse/Neglect policy that was provided. She verified the policy and procedure did not direct staff to ensure complete and standardized monitoring of these skin conditions. RN-E explained she did not expect staff to take an initial measurement of a bruise or an abrasion or to monitor for changes in size or color and considered weekly body audits as an effective monitoring system. During an interview on 8/4/16, at 8:48 a.m., the director of nursing stated she expects staff to monitor bruising at least daily, if not every shift. She stated the medical doctor, nurse practitioner or wound nurse should be notified if increase in size, color or pain was noted. She further stated an initial measurement and other identifying information such as color, area and presence of pain should be obtained. The DON further stated she did not consider weekly body audits as an adequate system to monitor bruises, abrasions and other non-pressure related skin conditions.	F 309	receiving nebulizer treatments will be reviewed. All residents with impaired skin will be reviewed. The results of the audit will be presented to at the QA meetings with audits continuing as warranted. The QA Committee will monitor compliance, review trends and make recommendations as necessary. Responsible for maintaining compliance: Director of Nursing Correction Date: 9/7/16	

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F 309	Continued From page 33 R47 was interviewed on 8/2/16, at 4:15 p.m. R47 stated he attended renal dialysis on Mondays, Wednesdays and Fridays. At that time, R47 expressed concerns he had about his dialysis care by the facility staff stating, "the nursing staff here does nothing for my dialysis access site." R47 explained that one hour prior to dialysis the nurse was supposed to apply a numbing medication, Lidocaine, to his access site. He stated, "this never happens. I have to do it." R47 stated, "I don't know why I have to do this. Nursing should be doing this, but they don't. It's been going on like this for some time now." R47 explained that the dialysis nurse put a bandage on his arm after the run was completed, and he removed the bandage himself in the evening after it stopped bleeding. The resident also indicated that facility nursing staff did not monitor his dialysis access site. On 8/3/16, at 1:02 p.m. R47 stated his dialysis run went well today. When R47 was asked about any paperwork that was given to him, he replied "I didn't get any paperwork back from dialysis I might get paperwork once a month." A Quarterly Review Minimum Data Set (MDS) dated 6/16/2016 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 indicating a good memory. The MDS indicated the resident was receiving dialysis treatments. The resident was able to communicate needs. The resident's current care plan dated 6/25/2015 indicated facility staff were to complete dialysis access site care/assessment daily. Licensed practical nurse (LPN)-H who routinely worked with R47 was interviewed on 8/3/16, at 1:07 p.m. LPN-H verified R47 self-administered the Lidocaine cream prior to dialysis. She explained that the dialysis clinic had provided the	F 309		

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F 309	Continued From page 34 resident with a tube of the cream, the facility provides the bandage, and he performed the treatment "himself." LPN-H stated she used to help the resident when his dialysis appointments were at 10:00 a.m. adding the resident's appointment time was now earlier and she was not yet in the facility to help him. LPN-H explained when R47 leaves for his appointment we [nurses] send paperwork with him, but when he comes back he does not give it to us." Registered nurse (RN)-A stated at 1:10 p.m. on 8/3/16, she was unaware R47 was applying prescribed topical medication to his dialysis access site. RN-A said sometimes the resident does not give his paperwork to the facility nurse upon returning from dialysis. RN-A stated when R47 has been given a prescription in the past he has kept or has lost them, "so we have asked the dialysis clinic that any prescriptions be called directly to the pharmacy." RN-A stated she was unsure why R47 did not have a physician order in his medical chart for the Lidocaine, "I will have to call the dialysis clinic for the order." At 1:25 p.m. RN-A stated she had spoken to the dialysis nurse who had informed her the clinic had contacted the facility on 12/20/15, to notify them R47 had been prescribed Lidocaine cream which had been filled by the dialysis clinic, with directions to apply 1 hour prior to his appointment time. On 8/3/16 at approximately 3 p.m., R47's dialysis nurse (RN-C) was interviewed by telephone. She verified R47 had received an order for Lidocaine cream from the dialysis center, which was to be applied to the access site one hour prior to his appointments. RN-C stated, "I don't think the facility looks at the information sheets we send back with him after each dialysis run. We [dialysis nurses] have found that if we have something that really needs to be addressed or changed, we	F 309		

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F 309	Continued From page 35 have to call the facility directly." On 8/4/16, at 10:38 a.m. R47 stated he had just been moved to a new room the previous evening. When asked if he had the Lidocaine cream he replied, "Yes, I will show you." However, when R47 opened the drawer he could not find the cream. RN-D, a nurse on the resident's current unit, was notified and was also unable to locate the Lidocaine cream. RN-D said it could have been left in the treatment cart on R47's previous living unit. At 12:58 p.m. LPN-H reported they'd found the lidocaine cream. R47's dialysis communication book was reviewed on 8/4/16. On top of the book was a note to the dialysis center that included: "Dear dialysis care team, we put this book together to improve the communication and should travel to/from with him. Feel free to review, suggest changes and add data to assist our team." However, the book only contained a face sheet dated 7/25/16 ,and very little other information. A review of R47's medical record revealed a lack of documented communication between the dialysis clinic and the facility. There was no documentation at all found in the resident's records related to the dialysis treatment runs. On 8/4/16, at 1:31 p.m. RN-E provided pages of R47's dialysis run results. When asked where the documents had come from, RN-E said she'd had the dialysis clinic fax them over. RN-E confirmed there had been no other dialysis run notes in R47's chart. During an interview on 8/4/16, at 2:14 p.m. the administrator and RN-E both verified R47 should have had dressing changes and monitoring for signs and symptoms of infection included on his MAR/TAR. RN-C stated nursing staff should be documenting when the resident's dressing was last changed. In addition, they both	F 309		

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F 309	Continued From page 36 acknowledged that if R47 does not take or bring back his paperwork from dialysis, the nursing staff should be calling the dialysis clinic and asking for a faxed copy of the run for the day. A policy and procedure was requested but not provided.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - ~~RESTORE EATING SKILLS~~ Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper care and monitoring was provided for 1 of 1 resident (R149) reviewed for use of a tube feeding, to ensure the resident received adequate nutritional	F 322	F322: It is the policy of The Villa at Bryn Mawr to provide guidelines for the safe administration of medications through an enteral tube. Plan of correction for residents cited with this survey: Nursing staff completed hydration risk assessments on R149. R149 incurred no adverse effects as a result of observation. Dietician has evaluated the resident to ensure appropriate nutritional interventions are implemented. A care conference was held with resident and IDT to ensure her care concerns were being met. Resident has now been receiving bolus tube feeding with increased compliance. Resident voiced satisfaction with the changes to her care plans.	

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F 322	Continued From page 37 intake. Findings include: R149's physician's order sheet on 8/2/16, indicated R149 was to receive peptamen 1.5 (a liquid high-calorie nutritional supplement) at 105 milliliters per hour (ml/hr) from 12:00 a.m. (midnight) to 9:00 a.m. with 120 ml free water flushes at 12am, 3am, 6am, 9am, 3pm and 8pm per registered dietitian. A nutrition/dietary progress note dated 8/3/16, confirmed the orders on 8/2/16, with the addition that R149's calculated nutritional needs were 1000-1400 kilocalorie, 40-60 grams protein and 1000-1400 ml fluids. R149's care plan dated 7/25/16, indicated R149 had a nutritional problem with a weight loss of estimated 19% loss in 180 days and was on tube feedings to provide adequate calories and fluids. Staff interventions were to provide tube feedings as ordered and maintain hydration status. On 8/3/16, at 7:37 a.m. the surveyor observed R149 asleep in her room which is the first room by the nursing station. R149's nutritional supplement was hanging on an IV pole with approximately 250-400 ml of nutritional supplement left in the bag, the end of nutritional supplement tubing was hanging down not attached to R149 while she slept. During an interview on 8/3/16, at 8:45 a.m. licensed practical nurse (LPN)-D stated R149 returned from the hospital yesterday bcause her G-Tube (a tube surgically placed into the stomach to provide nutritional support) was clogged. LPN-D explained R149 will shut off her tube during the night when she goes to the	F 322	Plan to address/prevent this deficiency for other residents: The facility has implemented a policy and procedure for naso-gastric and gastrostomy tube care. Hydration risk assessments are completed on all residents quarterly, annually and PRN. If a resident is deemed at risk for dehydration, nursing management and the registered dietician consult for new hydration interventions. Nursing staff has been educated on the policy and procedure for naso-gastric and gastrostomy tube care. Measures put in place to prevent recurrence: Nursing staff has completed hydration risk assessments on all current residents with naso-gastric or gastrostomy tubes. All residents deemed at risk for dehydration have been reviewed with the registered dietician and appropriate interventions have been put in place. Staff will be trained on appropriate care and flushing of tubes.	

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F 322	Continued From page 38 bathroom and not tell anyone she has done this. LPN-D stated "I went into her room at 7:45 a.m. and it was off [the G-tube pump]. LPN-D stated R149 gets all her nutritional needs via the G-tube and receives 30 ml flushed before and after any medication given to her. LPN-D verified R149 does not get any extra flushes throughout the day. During an interview the same day at 2:57 p.m. R149 explained she was in the hospital the previous day because her G-tube was clogged. She said the G-tube was now unclogged but her J-tube was stilled clogged. R149 explained she does take out her tubing when she goes to smoke or to the bathroom but will put her light on and let staff know when she is back in her room. "I am aware I get my nutrition from this [pointing to her nutritional supplement fluid in the bag hanging on the IV pole] however my G-tube keeps clogging during the night and it takes staff awhile to come in, each time it stops I don't get all the nutrition I need, "look there is still nutritional supplement left in my bag." The resident indicated she had been in the hospital for a clogged tube. On 8/4/16 at 4:20 p.m., R149 explained that she has been managing the G-tube on her own for a long time before coming to this facility. "I have asked staff to teach me about this G-tube because it's different than the one I have at home, but they have never done any training with me." During an interview on 8/4/16, at 6:48 a.m. (LPN)-C verified he works the night shift and has been working with R149 the last two nights. LPN-C explained R149 would come out of her room and not let staff know when she disconnected her G-tube so LPN-C kept peeking	F 322	Plan to monitor: DON or designee will conduct audits on all residents monthly with naso-gastric or gastrostomy tubes for the next 90 days. The results of the audits will be presented at the QA Meetings with audits continuing as warranted. QA Committee will ensure ongoing compliance with F322 and make ongoing recommendations as needed. Responsible for maintaining compliance: Director of Nursing and Director of Dietary Services Correction Date: 9/7/16	

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F 322	Continued From page 39 in on her often to see if her nutritional supplement was still running. LPN-C stated R149 gets a whole bag of nutritional supplement. While talking with LPN-C at the nursing station, at 6:48 a.m. R149 came out of her room with the G-tube disconnected and told LPN-C she was going out to smoke. The surveyor interviewed R149 in the smoking courtyard. R149 said, "I do tell staff when I unplug my G-tube, but they [staff] don't come back to hook it up. R149 explained that the previous night the nurse came in to hook up her G-tube, but he wanted to put on the same nutritional supplement that had been hanging in the room all day. "I told him that I should get fresh nutrition that stuff has been sitting there all day and it will make me sick." He put a new bag on. The resident stated, "I am very worried about the cares I'm getting here. A review of R149's medication administration record (MAR) for the month of 8/2016, revealed R149 was to receive nutritional support of peptamen 1.5 at 80 ml/hr from 8pm to 8am then was changed on 8/2/16, to 105 ml/hr from 12am (midnight) to 9 am. The MAR indicated no documention the resident received any of her nutritional support on 8/2 or 8/3. Staff did not initial the MAR as being given nor did staff document on the back of the MAR reasons why not given for two times. Review of nursing notes indicated one note that on 8/2/16, at 21:40 the resident, "refused her tube feeding at 8PM but allowed staff to hook it up at 9:30 pm." No documentaion was noted as to how much nutritional supplement she received daily. A policy and procedure was requested for G-Tube care but was not provided.	F 322		

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F 371 F 371 SS=F	Continued From page 40 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and ~~(2) Store, prepare, distribute and serve food~~ under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper dietary sanitation practices. This had the potential to affect all 110 residents who were served food from the kitchen. Findings include: An initial tour of the kitchen was conducted with the certified dietary manager (CDM) on 8/1/16, at ~~12:36 p.m. The following concerns were noted:~~ Cook-A was prepping food for the noon meal. The gloves he was wearing had large holes that exposed his fingers as he touched lettuce cheese, and tortillas. Cook-A explained the available gloves were too small and larger gloves had not been provided. The CDM then confirmed the gloves cook-A was wearing were too small, resulting in holes from use. Cereal bowls filled with dry cereal were stacked three-high on the counter. The cook also	F 371 F 371	F371: It is the policy of The Villa at Bryn Mawr to store, prepare, distribute and service food under sanitary conditions. <u>Plan of correction for residents cited with this survey</u>: No residents were harmed by this practice. <u>Plan to address/prevent this deficiency for other residents</u>: 1. Educate staff on proper glove use and handwashing policy/procedure. 2. New meal service provided that eliminates the need for so many tray carts. New service involves serving from steam tables on each station with the exception of the locked unit of station 3, which will continue getting tray line service. 3. Staff will be educated on proper cereal storage procedures. 4. Chipped/cracked floor tiles will be repaired or replaced. 5. Compressor of the reach-in white cooler will be cleaned. The painted surface will be removed or replaced with a cleanable surface. 6. All equipment will be inspected and repairs made as needed.	

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F 371	Continued From page 41 explained the stacked cereal bowls had been prepared for residents as an alternative to the lunch menu. They would either get put away or be disposed of not served at the noon meal. The dish room area was crowded. Carts with trays being readied to deliver to dining rooms also occupied the space. Staff were required to cross over between the carts and clean dishes used for tray set up to reach the dirty dish area. The CDM stated dirty dishes came into the dish room to the right, were sent through the dish machine, and then stored in the clean dish area on the back wall. The CDM explained that five carts went out with trays at every meal. Floor tiles in the preparation and serving area were chipped and cracked and parts of tile were missing. There was a heavy black build-up in the cracks and missing tile areas. There was a heavy layer of dust/dirt on the compressor of the reach-in white cooler. The surface of the cooler had been painted white and the surface was uneven. Dark finger prints surrounded the edges of refrigerators. A freezer had food smudges and finger prints, as well as white substance smeared across the front doors. The three-door reach in freezer's bottom gasket was cracked and broken on the edge (although closed tightly). The sides of the chrome preparation counter had been painted blue and corroded, blackened areas were not cleanable. The sliding door tracks had a black build-up along the doors and drawers. Chips and cracks were noted in the painted interior of three drawers where scoops and other utensils were stored. The outside edges of the	F 371	7. Painted prep surfaces, drawers, and sliding door tracks will be removed or replaced with cleanable surfaces. 8. Staff will be re-educated on dishwashing procedures and general kitchen sanitation guidelines including not crossing between dirty and clean areas and prevention of overspray from the dish room into the clean area. 9. Ice chests will have removable/cleanable liners with ice scoop holders installed. 10. Staff educated on the proper delivery of cold items on an ice bath and the proper disposal of items not kept to adequate temperature. 11. Staff will be re-educated on the proper cleaning policy/procedure for the can opener. 12. Janitor closet door will be cleaned and/or repaired. <u>Measures put in place to prevent recurrence</u>: 1. Ensure all necessary glove sizes are in stock for employee use. 2. Cleaning schedules are posted monthly with the expectation that staff are cleaning their assigned areas daily.	

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F 371	Continued From page 42 drawers had black track marks, chipped and peeling paint, and were soiled at the handles. More than half of the door to the janitor closet was splattered with a brown unknown substance. Splatters were also noted on cork bulletin board. Food tray preparation was observed on 8/2/16, at 11:12 a.m. While the trays were being prepared, a staff person was pre-spraying dishes prior to the dish machine wash cycle. A second staff person was preparing the clean tray carts with trays, silverware and other items. The door on the tray cart faced the back wall toward the dish machine, approximately three to four feet from the dish sprayer. Mist from the spray reached the cart during the clean tray set-up process. The following day on 8/3/16, at 7:05 a.m. the dining areas were toured with the CDM and registered dietitian. The CDM explained nurses were responsible for delivering ice water to residents as they requested. Carts in four of five dining areas contained ice stored in a plastic bag in a chest cooler. An ice machine was also located on the first floor. All ice chests were kept locked. The four ice coolers and the ice machine contained ice scoops or a plastic cup to remove ice that was resting on the ice itself or in melted water. The CDM stated on 8/4/16 at 2:39 p.m. the facility used four ice coolers on the units. The night nursing staff were responsible for replacing the ice in the coolers. The CDM verified that during the tour the ice was observed to have melted, and scoops and cups were being stored in the ice. When asked if the practice was considered acceptable she replied, "Definitely not. We are taking it over from nursing." Going forward, the plan was for dietary staff to take	F 371	3. Commercial can opener cleaning will be done each shift with the complete disassembly of the blade each time. 4. Ice bins will have covered scoops separated from the ice and the kitchen staff will run scoops and holders through dish machine daily. DDS will check the ice bins on a weekly basis to ensure adherence to guidelines. 5. Staff will be re-educated on maintaining a separation of dirty and clean items in the dish room. Staff will be educated on appropriate kitchen sanitation to avoid the prevention of food borne illness. 6. DDS (Director of Dietary Services) will do weekly rounds checking kitchen cleanliness and sanitation. Plan to monitor: DDS will do weekly rounds and will audit the cleaning schedules, ice bins, staff adherence, maintenance of items listed above, and forward the audits to the QA Committee. QA Committee will ensure ongoing compliance with F371 and make ongoing recommendations as needed.	

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	245203	A. BUILDING _____ B. WING _____	08/05/2016

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F 371	Continued From page 43 responsibility for ensuring ice was changed in the coolers. The CDM was unsure whether the facility had a related policy. On 8/3/16, at 7:30 a.m. a cart containing coffee and several one half gallon plastic bottles of milk was at the unit 2 nursing station. The milk was not stored on ice and it was unclear when it had been delivered. At 8:13 a.m. a dietary assistant wheeled the cart to the unit two dining room. The milk had been without cooling or refrigeration for over 40 minutes. At 8:42 a.m. milk was poured for residents and distributed to residents. A dietary assistant (DA)-C stated she brought the milk to the unit between 7:15 and 7:30 a.m. that morning. DA-C explained that the nurses were supposed to have stored the milk in the refrigerator but, "that did not happen today." DA-C said any remaining milk at the end of the meal would be discarded, "it is too warm ...I only serve and do not do the milk, so I really do not know." At 8:49 a.m. LPN-B said the milk was supposed to come up from the kitchen on ice and then be placed into the refrigerator. LPN-B stated, "There was not ice today." At 8:53 a tub of ice was delivered and the milk was placed on the ice. DA-B stated at 8:57 a.m. dietary staff brought milk to the units from the kitchen, and it should have been placed in a bin of ice. On 8/4/16, at 1:55 p.m. The CDM reported milk needed to leave the kitchen on ice, and should have then been refrigerated or otherwise kept cool. Milk was sent to the units at each meal, and after the meal unused portions were refrigerated. The CDM did not know why milk had been delivered the previous morning without ice, but she instructed staff to provide a bin of ice as soon as she became aware of the issue. The nurses were to refrigerate the milk when it arrived on the units, and if it came back to	F 371	Responsible for maintain compliance: Director of Dietary Services Correction Date: 9/7/16	

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F 371	Continued From page 44 the kitchen and was still cold, it was marked and kept in a bin. If not, it was disposed of. Sanitation concerns were noted in the kitchen during observations on 8/4/16, at 9:15 a.m. The sides of the chrome preparation counter had been painted blue. The paint was chipped and bubbling and had black corroded areas that were not cleanable. The sliding door tracks had a black build up along the doors and drawers. Chips and cracks were noted on the painted exterior and interior of three drawers that store utensils, and was soiled at the handles. The plate cart was not clean and had food spills on the lower bar. The tray cart was also not clean and had blackened wheels. Metal shavings and black build-up was observed near the blade of the can opener. Cook-A reported the blade was changed "last week" and the opener was cleaned weekly. Cook-A had not noticed the metal shavings. DA-A then explained, "The blade was just changed and is part of my cleaning schedule." DA-A said the cleaning schedule included cleaning the can opener and was due that day. Cook-A took it to the dish room and instructed DA-A to rinse it and put it through the dish machine. Following this process, DA-A showed the surveyor, who pointed out that the metal shavings and black build up remained near the blade. DA-A then used a butter knife to scrape the blade as well as a scrubber to wash the sides, and put it through the dish washer a second time. DA-A then rinsed it with the sprayer on the dirty side of the dish room to remove the "disinfectant residue" and returned it to the kitchen for use.	F 371		

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F 371	Continued From page 45 DA-A then proceeded to rinse dirty dishes and pans on the right side of the dish machine. As the clean dishes came out of the machine, she reached for the sprayer with her right hand and sprayed off the disinfectant residue from the clean dishes. DA-A pointed out residue on the stainless steel, clean side of dish room counter and explained she would not want that on her dishes. Instead of performing hand washing, she rinsed her hands using the dirty sprayer, and then moved to the clean side of the dish room. DA-A did not wear gloves or wash her hands during the process. She proceeded to the rack where chemicals were stored, obtained a blue cloth and used it to wipe two trays. The cloth was then placed on a shelf over the clean dishes. She moved two clean trays back to the dirty side of the dish room. She then moved two clean, but still wet pans to the conveyor line in the kitchen. DA-A then wiped down carts with a cloth. When asked about hand washing DA-A responded, "Yes, we wash our hands between clean and dirty. We are very good at washing our hands. It is required." It was 9:50 a.m. when DA-A first approached a sink and rinsed her hands, but did not wash using soap. DA-A then for the first time, applied gloves and went to the dirty side of the dish machine. Dishes were sprayed on the dirty side of the sink and then set in racks which were moved through the dish washer. After the rinse cycle, racks were pulled using her left hand and without touching the dishes. The gloves were removed at 10:00 a.m. and using the sprayer, DA-A again sprayed her hands and the counter. She proceeded to move clean plates and plate covers to the racks. She took the blue cloth and began to wipe the clean dishes. When finished wiping the dishes, DA-A wiped her hands on the towel and placed it back on the shelf above the clean dishes. DA-A	F 371		

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F 371	Continued From page 46 then applied gloves and returned to washing dirty dishes. She then rinsed her hands at the hand washing sink, but again did not use soap. She stacked clean plates and bowls, shaking them prior to stacking. DA-A placed two trays in the tray rack, retrieved an orange towel from the bin on the chemical rack and wiped the trays dry. DA-A handled the dirty pots and pans on numerous occasions, ran them through the dishwasher, and then rinsed them off with the dirty sprayer. The CDM stated in an interview on 8/4/16, at 1:55 p.m. hand washing was "an expectation." The CDM reported she had made similar observations and hand provided education for DA-A. She confirmed staff were not to go between dirty and clean dishes/ processes without washing hands. She did not consider rinsing hands with the sprayer on the dirty side of the sink consistent with hand washing. The CDM explained, "The sanitizer is meant to sit on the dishes and not be rinsed off." Dishwashing and tray set up should not have occurred at the same time, according to the CDM. The CDM also verified there were surfaces that were no longer cleanable in the kitchen and preparation area. She verified some of the paint was bubbled and peeled. The CDM said she had attempted to clean the splatters off the janitor door, but it would not come clean. Can openers were supposed to be run through the dishwasher after each use in order for food residue to be removed. There should have been no evidence of any food debris or metal shavings on the opener. The CDM verified she had changed the blade last week. The CDM confirmed they needed to blow out the compressor vent on the reach-in cooler.	F 371		

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F 371	Continued From page 47 The facility's undated Sanitization policy directed staff as follows: "All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair." Additionally, "All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions ...Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy. " The facility's undated Dishwashing Machine Use directed staff to, "Wash hands before and after running dishwashing machine, and frequently during the process."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	F 425: It is the policy of The Villa at Bryn Mawr to provide routine drugs and biologicals to its residents.	

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F 425	Continued From page 48 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmaceutical services were secured, including routine medications and biologicals as ordered for 4 of 8 residents (R2, R120, R145 and R149), reviewed for missed medication doses due to medications not being available for administration. Findings include: During an observation of medication administration, on 8/1/16, at 7:07 p.m. a trained medication aid (TMA)-B was unable to locate Depakote (a medication used to decrease seizure activity but has also been used to stabilize mood and behavior) for R2. R2's diagnoses included schizophrenia and major depression. TMA-B advised a licensed practical nurse (LPN)-G who was also unable to locate the medication in the nursing medication cart and the medication room. LPN-G then stated he would order the medication from the pharmacy. The assistant director of nursing (ADON), at 7:15 p.m., explained the process for reordering medications to ensure availability was to pull the label on the medication card when there were approximately 7 pills left and fax it to the pharmacy. She said it was important to allot	F 425	Plan of correction for residents cited with this survey: R2 has now received Depakote and Clozapine. Resident has had behaviors assessed and no adverse effects identified as a result of the survey. R120 has received Oxycodone. Resident has had pain assessment reviewed and updated. No adverse effects have been identified as a result of the observation by the survey. R145 has been discharged from the facility. Prior to discharge, she did receive Trazadone Requip. No adverse effects have been identified as a result of the observation by the survey. R149 has received her Ferrous Sulfate and Gabapentin. The resident has had a care conference with staff and has had no adverse effects identified as a result of the observation by the survey. Consultation with pharmacist regarding policy and procedure with medication administration. Plan to address/prevent this deficiency for other residents: Nursing is reviewing all of the MARs (Medication Administration Records) for	

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F 425	Continued From page 49 adequate time in case the medication was not able to be reordered due to insurance or other reasons. She explained if it was a necessary medication, it would be ordered "stat" and would be expected on the next run from the pharmacy. The facility would pick up the expense for any or these reasons. It was the responsibility of the nurses or TMAs that were administering the medications to ensure it had been reordered and available for the residents. A review of the medication administration records (MAR) revealed the medication Depakote was initialed and circled on 8/1/16, at 8:00 p.m. No explanation was documented on either side of the MAR or in the nursing progress notes as to why the initials were circled.. A physician's order, written on 1/26/16, directed staff to administer Depakote ER (extended release) 2000 milligrams (mg) by mouth (po) every bedtime. R2's care plan, target date 10/17/16, identified R2 as having mood and behavior problems, grandiose delusions, active hallucinations and depression and the potential for self-harm related paranoid schizophrenia. The care plan directed staff to administer medications as ordered. A physician's order written on 1/26/16 directed staff to administer Clozapine 400 mg at bedtime A Heath Status Note written 7/23/16 indicated R2 did not have any antipsychotic medication, Clozapine, used to treat schizophrenia and lower suicidal behavior, stating at present time it was unavailable and was being processed by the VA (veterans' administration) pharmacy. A review of the July 2016, MAR revealed R2 did	F 425	all of the residents and comparing them to the physician's orders. Nursing staff is being educated on proper medication administration, reordering and follow up on missing meds. Measures put in place to prevent recurrence: Facility will complete a MAR to cart medication audit by September 7th. Facility will do random audits of nursing staff with medication administration, 10 times per month, ongoing. Pharmacist consultant will do audits of nursing medication distribution practices and technique. Plan to monitor: All audits will be referred to QA Committee. QA Committee will ensure ongoing compliance with F425 and make ongoing recommendations as needed. Responsible for maintain compliance: Director of Nursing or designee Correction Date: 9/7/16	

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F 425	Continued From page 50 not receive Clozapine 400 mg at bedtime on 7/23/16 and 7/24/16. During an initial interview on 8/2/16, at 10:51 a.m., R120 stated he frequently had pain in his left shoulder and had an order for Oxycodone to manage it. He explained, however, the facility often ran out of the medication and he had to take Tylenol as an alternate, "They are so slow getting medications here. They are always running out because they don't order in time." In a follow-up conversation on 8/4/16, at 2:40 p.m., R120 stated he did not receive Oxycodone on 8/1/16 and 8/2/16 because there was no stock available in the facility. He explained, although he received Tylenol, it did not manage his pain to the level of the Oxycodone. He again stated this happened, "way too often," and, "they just don't reorder the medications when they should." Diagnoses for R120 included Cervicalgia (neck pain that occurs toward the rear or the side of the cervical vertebrae) and low back pain. A physician's order written on 7/21/16 directed staff to administer Oxycodone HCL 5 mg every 6 hours prn (as needed) for pain. A review of the MAR revealed R120 was administered 2 tablets of Oxycodone HCL 5 mg on 8/1/16, at 8:00 a.m. and did not receive another dose until 8/2/16, at 4:45 p.m. The individual narcotic record, page 77, showed that after the 8/1/16 dose that was given at 8:00 a.m., the Oxycodone HCL 5 mg supply for R120 was depleted. A care plan, initiated 6/27/16, Identified R120 with actual and potential leg pain and chronic low back pain and to monitor and document side effects, increased pain, new onset of signs and	F 425		

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F 425	Continued From page 51 symptoms of pain or behavior, and to update the physician if interventions were not successful or if a significant change in status was observed. On 8/4/16, at 3:00 p.m. R145 approached the nurses' station located on unit 1 in the facility. She asked the staff, "Can someone please make sure my Trazadone (an anti-depressant medication also used to treat insomnia) is ordered? I haven't had it in 2 nights and I didn't sleep at all last night." During a follow-up interview the next day at 7:53 a.m. R145 stated she had not received her trazadone again on 8/4/16. She explained it was the third night in a row and it was, "messing with my bipolar and my emotions are unstable." She stated that it was hard to manage stress when she didn't get any sleep. She stated she was restless and got up several times during the night and when she was given Trazadone she, "slept like a rock." She continued, "If I have to go through another night like this, it won't be good. I don't want to end up like a basket case. I feel like I am on the edge. I have been stable for a long time and I don't need this, I really don't." She then explained she had not received her Requip (a medication used to treat restless leg syndrome) for several days. At 8:02, TMA-D stated R2's Trazadone was not found in the cart or the medication room. She verified the last dose of Trazadone 200mg was given on 8/1/16, at 8:00 p.m. The TMA further acknowledged Requip was not given from 8/1/16 through 8/4/16. At 8:17 a.m. LPN-G reported that he located R2's Requip and Trazadone in the bottom drawer of	F 425		

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F 425	Continued From page 52 the medication cart. The medications had been filled by Omni pharmacy on 8/2/16 but had not yet been dispensed to R145. Diagnoses for R145 included Bipolar disorder, major depression and insomnia. The physician orders directed staff to administer Trazadone, 200 mg prn at bedtime for insomnia and Requip HCL 3 mg every bedtime. A review of the MARs revealedl Trazadone was not given 8/2/16, 8/3/16 or 8/4/16 and Requip was not administered for five days between 7/31/16 and 8/4/16. The care plan, initiated 7/1/16, indicated R145 was to use psychotropic medication to treat insomnia and depression and directed staff to administer psychotropic medication, including Trazadone, as ordered by the physician and to monitor for side effects including insomnia, depression and suicidal ideation. During an observation of medication administration, on 8/3/16, at 8:44 a.m. a licensed practical nurse (LPN)-D was unable to locate ferrous sulfate (a medication used to treat iron deficiency anemia) and gabapentin gel (a pain medication) for R149. R149's diagnoses included acute kidney injury and altered mental status. LPN-D stated "the medications are not in the cart so I will not be able to give them, I will have to order them from the pharmacy." A review of R149's physicians orders dated 8/2/16, indicated R149 was to receive ferrous sulfate 220 milligrams per 5 milligrams (mg/ml) three times a day and gabapentin 8% gel topically every 8 hours. R149 medication administration record (MAR) for 8/2016 indicated the medication ferrous sulfate was not initialed as being administered twice on 8/3/16, and her gabapentin	F 425		

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F 425	Continued From page 53 was not administered once the same day. No explanations were documented on either side of the MAR or in the nursing progress notes as to why the initials were circled. During an interview on 8/5/16, at 9:57 a.m. the assistant director of nursing (ADON) verified R149 did not received her 8am or noon medication of ferrous sulfate and her 8am medication of gabapentin gel on 8/3/16. On 8/5/16, at 9:57 a.m. the ADON and surveyor reviewed R149 MAR and noted both of her medications was initialed as being given by LPN-D, however when the ADON looked into the medication cart she could not find either one of the medications. The same day at 10:50 a.m. the ADON verified that both medication are still not available. The ADON explained R149 received the medication ferrous sulfate in a pill form instead of liquid and for R149 gabapentin the facility needs to obtains a new prescription for the physician before the pharmacy will refill it. During a telephone conversation on 8/5/16, at 9:34 a.m. the Omni Pharmacy consultant stated he would expect a new medication order to be filled and delivered the same day. If a refill, it might take 2 or 3 days so therefore he would expect the facility staff to reorder when 3 to 5 days of medication were left for the resident. That would ensure ample time availability of the medication. He further stated it was, "concerning, " when Trazadone or other antipsychotic medications were not given for 3 or more days. He further explained, "Medications are ordered for a reason. If they are ordered, they should be administered. They are ordered because they are needed."	F 425		

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 _____	08/05/2016

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 425	Continued From page 54 The Omnicare of Minnesota Pharmacy Ordering Schedule, revised 1/1/13, indicated the pharmacy and facility should coordinate to determine delivery days and times as soon as possible after the execution of the Pharmacy Services Agreement or Pharmacy Consultant Agreement. The policy did not address the procedure when re-ordering medications. During an interview on 8/5/16, at 10:25 a.m. the director of nursing (DON) stated she expected staff to reorder residents' medications when a 4-day supply was left and to contact the pharmacy if the medication was not delivered to find out the reason.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	08/02/2016

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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 8, 2016. At the time of this survey, The Villa at Bryn Mawr was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	**APPROVED** Thm & Linhoff **By Tom Linhoff at 3:49 pm, Sep 01, 2016** RECEIVED SEP - 1 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/1/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/02/2016

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

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K 000	Continued From page 1 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 3 story building was constructed in 1967 and was determined to be of Type II(222) construction. In 1969, a 3 story addition was constructed to the West that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 109 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/02/2016**

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
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all 268 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on August 08, 2016, observation revealed that the ventilation system for the corridors appears to be utilizing the egress corridor as an air plenum for the resident rooms. This deficient practice was verified by the Administrator at the time of the inspection.	K 067	**K-067 Please see attached waiver.**	

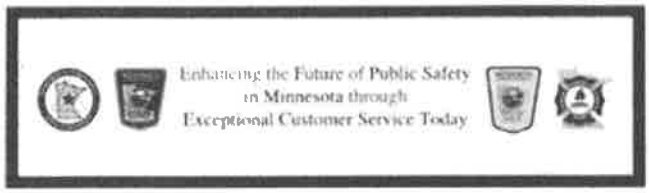
Whitney, Marian (DPS)

From: Linhoff, Tom (DPS)
Sent: Thursday, September 01, 2016 4:00 PM
To: rochi_lsc@cms.hhs.gov; Dehler, Robert (MDH); Dietrich, Shellae (MDH); Henderson, Mary (MDH); Fiske-Downing, Kamala (MDH); Johnston, Kate (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Whitney, Marian (DPS)
Subject: The Villa of Bryn Mawr - annual waiver for K-067. Previously Approved - No Changes
Attachments: The Villa of Bryn Mawr K-084 Annual Waiver.pdf; POC The Villa at Bryn Mawr-signed.pdf

This is to inform you that I am accepting the annual waiver report for The Villa of Bryn Mawr 245203 regarding K-0067. No changes.
The exit date of the survey was 08/02/2016.

Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office phone: 651-201-7205
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.fire.state.mn.us



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 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. 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)* THOMAS LINHOFF 12424	Title FIRE SAFETY SUPV	Office STATE FIRE MARSHAL	Date 09-01-2016

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 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. 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 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
THOMAS LINKHOFF 12424	FIRE SAFETY SUPV	STATE FIRE MARSHAL	09-01-2016

GILBERT

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

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

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

Proposal

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

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

Amount: $259,000.00 (budget price)

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

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5575

August 22, 2016

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

Re: State Nursing Home Licensing Orders-Project Numbers: S5203025, H5203050,H5203051 H5203053

Dear Ms. Krebs:

The above facility was surveyed on August 1, 2016 through August 5, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate the following complaint numbers:

H5203050, found substantiated at MN Rule 4658.0525 Subp. 7B (tag 2 930)
H5203051, found to be substantiated at MN Rule 4658.1325 Subp. 1 (tag 21550)
H5203053, 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at:

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 Gayle Lantto at the phone number or email detailed above.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Licensing and Certification Program / Program Assurance Unit
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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 _____	08/05/2016

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: On 8/1/16 through 8/5/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Licensing and Certification Program; P.O. Box	2 000	RECEIVED SEP 01 2016 (via email) COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 64900, Saint Paul, MN 55164-0900. In addition to the recertification survey, complaints were investigated. H5203050 was substantiated at State Order 0930; H5203051 was substantiated at State Order 1550; H5203053 was unsubstantiated.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease or related disorders as required. This had the potential to affect all residents in the facility. Findings include: During a review of the facility's Alzheimer's training program, evidence was lacking to show consumers had been provided in written or electronic format, a description of an Alzheimer's training program, the categories of employees trained, the frequency of training and the basic topics covered as required. At the time of the survey, the facility had residents with diagnoses of Alzheimer's disease or other dementia.	2 302		

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	00175	A. BUILDING: _____ B. WING _____	08/05/2016

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2 302	Continued From page 3 When interviewed on 8/5/16, at 11:15 a.m., the administrator stated information provided to consumers was unavailable,stating the facility did not provide to the public any detailed information related to Alzheimer's disease or related disorder training in any form including written or electronic. She further indicated the facility did not have a policy related to required dementia training. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of the information. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care to adequately monitor and assess 1 of 3 residents (R63) reviewed for non-pressure related skin conditions (bruising) and failed to ensure 1 of 2 residents observed for self administrating medications (R20) careplan was followed during	2 565		

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2 565	Continued From page 4 nebulizer treatment and failed to provide access site care for 1 of 1 resident (47) who was receiving dialysis treatments. Findings included: The current plan of care, target date 7/8/16, identified R62 as a fall risk related to actual falls, unsteady gait, and failure to be cognoscente of deficits and directs staff to monitor, document, and report as needed for 72 hours to medical doctor for pain and bruises, hoever did not identify bruises or abrasions obtained from a obtained 7/22/16. R63 was observed on 8/1/16 to have a purple bruise on her right bicep area (inner, upper forearm). The areas to the edge of the bruise were lighter purple and the center was a deeper colored purple. She also had a scrape noted on the middle knuckle of her left hand. It was covered by a dry scab. When asked, R63 stated she had a fall while she was with her "companion" on a shopping trip and obtained both injuries at that time. The medication administration records (MAR) and the treatment administration record (TAR) for 7/2016 and 8/2016 lacked identification or monitoring of the bruise or the scrape. A skin /wound note on 7/23/16 stated R63 took a bed bath tonight with extensive assistance of one staff and a complete skin assessment was done. The skin was found to be dry, intact and no pressure areas or bruises noted. A skin/wound note on 7/31/16 stated R63 took a tub bath with extensive assistance of one staff.	2 565		

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2 565	Continued From page 5 Her skin was dry and intact. No pressure areas or bruises were noted. During an interview on 8/3/16, at 1:31 p.m., a registered nurse (RN)-E stated all skin issues were to be monitored and tracked on the TAR, at least daily, until resolved as the policy indicates. She verified that R63's TAR for 6/2016, 7/2016 and 8/2016 lacked monitoring of non-pressure skin conditions An Occurrence Report completed on 7/22/16, at 8:56 p.m. noted the following injuries: Bruise to the Right Upper Arm, near chest, purple, new looking bruise; Skin Tear to right middle Finger 3, scrape on knuckle of right middle finger. A treatment and measurements were not mentioned in the report. A policy to care plan for monitoring and assessing non-pressure skin conditions was requested but not provided. On 8/4/16, at 8:19 a.m. RN-E stated the facility did not have a system in place to monitor bruising and other non-pressure skin conditions. During an interview on 8/4/16, at 8:48 a.m., the director of nursing (DON) stated she expected staff to monitor bruising and care plan for all skin conditions. R20's current care plan indicated "The resident [R20] has a physician's order for supervised self-administration of the following medications: Nebs" date initiated 4/28/1,4 and also indicated for Goal "The resident [R20] will take medications safely and as prescribed through the review date"	2 565		

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2 565	Continued From page 6 dated initiated 4/28/14, and also indicated "Review medication self-administration with resident [R20] /monthly and as needed to reassess abilities." Dated initiated 4/28/14. R20's quarterly Minimum Data Set dated 7/29/16, indicated 20 had short and long term memory problems, had severely impaired daily decision making skills, and had delirium present, which fluctuated. R20's Care Area Assessment (CAA) dated 4/06/16, triggered for Cognitive Loss/Dementia and indicated R20 had "Decreased ability to make self understood or to understand others." R20 was observed on 8/3/16, at 10:01 a.m. lying on bed on right side, eyes open, with nebulizer mask over face, with machine running. During continuous observation at 10:07 a.m. R20 was observed with eyes closed nebulizer mask still in place, machine running. One minute later trained medication assistant (TMA)-C walked down hall and looked in R20's room and then walked away. At 10:26 a.m. R20 was observed lying on right side with nebulizer mask on face, machine running with no steam coming into mask. On 8/3/16, at 10:05 a.m. TMA-C stated the nurse comes down from station 3 and does residents ' tube feedings and insulins. TMA-C stated she was trained to pass medications and nebulizer treatments. At 10:26 a.m. TMA-C stated R20 got up for breakfast, had his morning medications and went back to bed. TMA-C stated R20 would put on the nebulizer mask himself. TMA-C stated she would go and take the mask off of R20. TMA-C stated she had not applied the nebulizer treatment for R20,that he must have put on himself.	2 565		

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2 565	Continued From page 7 At 10:33 a.m. TMA-C verified the nebulizer mask was on R20 ' s face and that the machine was running, that the cylinder was ½ full with medication and no steam was going into the mask. TMA-C stated she had not given R20 his nebulizer mask, nor had she filled the cylinder with medication. TMA-C verified the cylinder had written on the outside of cylinder in black marker " 8/2/16, 2 p.m. " TMA-C stated she had not been aware there was medication in the cylinder nor had she been aware that R20 had his nebulizer in place with the machine running. TMA-C stated R20 only prn (as needed) nebulizer treatments and that she would call licensed practical nurse (LPN)-E to see if she had given R20 his treatment. TMA-C proceeded to call LPN-E and was told LPN-E had not applied R20 ' s nebulizer treatment. TMA-C stated R20 ' s machine must not be working since R20 had had his nebulizer treatment running for approximately half hour and was still only half full. TMA-C stated the cylinder was dated 8/2/16, 2 p.m. since cylinders were dated when changing out with a new one once a week. TMA-C stated she had not been the one that had written the date and time when the cylinder was replaced. TMA-C stated it would be the day nurse yesterday who would have exchanged cylinders. TMA-C stated when R20 coughs a lot he can have a nebulizer treatment. TMA-C verified the medication administration record (MAR) indicated a pre and post respiratory assessment was to be completed before and after the treatment but that she did not complete the assessments before applying nebulizer treatments. TMA -C stated she could give the nebulizer treatment if R20 coughed a lot or if the nurse told her to do it. TMA-C stated she had never been told to complete the pre and post respiratory assessments ordered. TMA-C stated she did not know who gave the last nebulizer	2 565		

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2 565	Continued From page 8 treatment to R20 as it had not been initialed in the TAR and written on the back as instructed to do. TMA-C stated when she gave R20 a nebulizer treatment she would put the medication in the cylinder apply on R20 ' s face and leave the room and come back when the treatment was finished. TMA-C stated she would come back in about 2-3 minutes as the treatment did not take long to run. TMA-C stated when giving R20 a nebulizer treatment she would initial on the front of the TAR and write on the back as it was a PRN treatment. TMA-C stated R20 is not supposed to do his own nebulizer treatment. On 8/3/16, at 2:30 p.m. LPN-I stated she had worked last evening, had not changed R20 ' s cylinder at 2 p.m. and not given R20 a nebulizer treatment. LPN-I stated R20 had had pneumonia in July and when she gave R20 a treatment she would initial on the front of the TAR and write on the back of the MAR. LPN-I stated she gave R20 nebulizer treatment when he wheezed. LPN-I stated R20 would put his nebulizer mask on and she would ask him if he want a nebulizer treatment and " he would shake his head yes " . LPN- stated when she gave R20 a nebulizer treatment she would have to stay in R20 ' s room during the treatment as R20 would take the mask off and throw on the floor. LPN-I stated R20 had severe chronic obstruction pulmonary disease (COPD). LPN-I stated she had not observed R20 ' s nebulizer machine last evening as R20 breathed adequately last evening and walked around. LPN-I stated LPN-J worked yesterday at 2 p.m. and had not told LPN-I at report that she had given R20 a nebulizer treatment that day. LPN-I stated normally after R20 ' s nebulizer treatment is completed the nurse or TMA would wash, rinse and drip dry the cylinder.	2 565		

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2 565	Continued From page 9 The following morning at 9:46 a.m. LPN-J stated she had replaced R20 ' s tubing and cylinder with new and labeled the cylinder 8/2/16, 2 p.m. as that was the date and time. LPN-J stated she had given R20 a nebulizer treatment as R20 was kind of wheezing and that when R20 he exerts himself. LPN-J stated she had checked R20 ' s oxygen saturations and they had been a little low before applying the nebulizer treatment. LPN-J verified she had not documented anything anywhere about the PRN nebulizer treatment given to R20 nor any of the pre or post respiratory assessments. LPN-J stated after 10 minutes there was still medication left in R20 ' s cylinder and noticed the machine was not working correctly and stated she had not known who to tell about the machine not working and had told the oncoming evening nurse about it. LPN-J stated she had not given a nebulizer treatment to R20 at 2 p.m. but at 10:00 a.m. and verified she had not documented it. LPN-J stated R20 will put his nebulizer mask on himself and when then " asked if he wants a treatment will shake his head and say yes. " LPN-J stated R20 will keep his mask on until she returns to R20 and LPN-J stated she thought R20 could be alone with his treatment as she thought a self-administration assessment had been completed on R20 in July but had not seen the assessment or any indication of one in the chart. Assistant Director of Nursing (ADON) standing nearby stated LPN-J should have called the supervisor to inform about the faulty nebulizer machine and stated she would check the supply room for another machine for R20. LPN-J stated she had been really busy that day she last gave R20 a nebulizer treatment. LPN-J stated R20 had asthma and COPD (lung disease). LPN-J stated by her not documenting on the TAR the oncoming nurse	2 565		

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2 565	Continued From page 10	2 565		

would not know if and when she could give R20 a PRN nebulizer treatment. LPN-J stated she had been really busy that day as she had been going back and forth between two floors and could forget things then like she did with the nebulizer treatment.

On 8/4/16, at 10:40 a.m. LPN-E stated she had not given R20 a nebulizer the day before nor had TMA-C asked to give one. LPN-E stated she normally left R20 alone in his room with the mask on as she believed R20 had had an assessment completed at one time to self-administer but could not verify in the record one had been completed for R20.

R20 ' s nursing progress note dated 8/3/16, at 10:08 p.m. by LPN-I indicated " Resident ' s [R20] prn sats [saturations] were 89%. During the evening, he appeared to have more difficulty breathing and vitals were done ... 73% R.A. (Room Air). A duoneb was immediately done and he [R20] was put on 2.5 L (liters) O2 (oxygen). Within fifteen minutes, sats were up to 94% on O2. Lung sounds are very diminished. "

R20 ' s August 2016 physician orders included: " Ipratropium-Albuterol 0.5-3 mg/3 Ampu-Neb Nebulize 1 vial by mouth every 4 hours as needed dated 7/16/16 " and " Document Hart Rate Before And After Treatment, Document Respirations Before And After Treatment "

R20 ' s August MAR showed no initials by nurse or TMA regarding any nebulizer treatment given or any pre or post nebulizer treatment respiratory assessments completed for R20.

On 8/4/16, at 10:47 a.m. Assistant Director of Nursing (ADON) stated the facility had been

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2 565	Continued From page 11 talking about these assessments and would need to correct and educate staff regarding self-administration assessments. ADON stated there had to be an assessment completed to know the resident is safe to administer medication. R47's quarterly Minimum Data Set (MDS) dated 6/25/16, indicated R47 was cognitively intact, displayed no behaviors of refusal of cares and required staff supervision at times or was independent with personal hygiene. R47 had diagnoses of dementia, depression and schizophrenia. R47's care plan dated 6/23/15, indicated R47 required dialysis related to renal failure. Staff interventions included to check and change dressing daily, monitor signs and symptoms of infections at access site and document on treatment sheets. During an interview on 8/2/16, at 4:15 p.m. R47 stated he went to dialysis on Mondays, Wednesdays and Fridays. R47 expressed concerns he had about the care he was receiving at the facility. R47 stated, "the nursing staff here does nothing for my dialysis access site." R47 explained, "Before I go to my dialysis appointment the nurse is to put on a numbing medication (lidocaine 2.5%) cream to my access site 1 hour before my appointment time. This never happens. I have to do it." R47 stated, "I have the numbing cream in the drawer by my bed. I put the cream on my dialysis access site and the nurse brings me a dressing to cover it. I don't know why I have to do this, nursing should be doing this, but they don't, it's been going on like this for some time now." R47 stated when he was done with dialysis the nurse at dialysis put a bandage on his arm and he removed it later in	2 565		

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2 565	Continued From page 12	2 565		

the evening after it stopped bleeding. When R47 was asked if the facility ever educated him on safety or looking for signs of infections, R47 replied, "No, the staff here has never taught me how or what to look for, how to change my dressing on my arm they [nursing] never done any monitoring of my skin."
During an interview on 8/3/16, at 7:15 a.m. licensed practical nurse (LPN)-H stated she had been R47's nurse for a long time and checked and removed R47 dressing from dialysis around 2-3 p.m. but did not document that she had done this.
Review of R47's medication administration record (MAR) and treatment administration record (TAR) for the month of 7/2016, revealed there was no indication for nursing to check and change R47's dialysis dressing or to monitor for bleeding and signs of infection. However, after it was brought to the nurse manager's attention, these intervention were added to R47's 8/2016 MAR on 8/4/16.
During an interview on 8/4/16, at 2:14 p.m. with the administrator and registered nurse (RN)-E, both verified R47 should have had dressing changes and monitoring for signs and symptoms of infection on his MAR/TAR. RN-C stated that nursing should be documenting when the resident's dressing was last changed.
A policy and procedure was requested but not provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the nursing staff to ensure accurate assessments within the required time frames to ensure complete and comprehensive care plans, update the nursing assistant care sheets and then could educate staff. The DON or designee could also perform audits of the assessments,

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2 565	Continued From page 13 the care plans and nursing assistant care sheets to ensure all sources of information are consistent and complete. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
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 monitor and assess 1 of 3 residents (R63) in the sample, reviewed for non-pressure related skin conditions (bruising) and failed to ensure care was provided appropriately, and services coordinated for 1 of 1 resident (R47)receiving dialysis. Findings included: R63 was observed on 8/1/16 to have a purple bruise on her right bicep area (inner, upper	2 830		

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2 830	Continued From page 14 forearm). The areas to the edge of the bruise were lighter purple and the center was a deeper colored purple. She also had a scrape noted on the middle knuckle of her left hand. It was covered by a dry scab. When asked, R63 stated she had a fall while she was with her "companion" on a shopping trip and obtained both injuries at that time. A nurse's progress note on 7/22/16, at 8:24 p.m. described a fall during an outing. R62 tripped while getting into a car. The nurse did a body check and noted a "scrape right middle knuckle and bruising present on the right arm near the chest that seemed new." The medication administration records (MAR) and the treatment administration record (TAR) for 7/2016 and 8/2016 lacked identification or monitoring of the bruise or the scrape. A skin /wound note on 7/23/16 stated R63 took a bed bath tonight with extensive assistance of one staff and a complete skin assessment was done. The skin was found to be dry, intact and no pressure areas or bruises noted. A skin/wound note on 7/31/16 stated R63 took a tub bath with extensive assistance of one staff. Her skin was dry and intact. No pressure areas or bruises were noted. During an interview on 8/3/16, at 1:31 p.m., a registered nurse (RN)-E stated all skin issues were to be monitored and tracked on the TAR, at least daily, until resolved as the policy indicates. She verified that R63's TAR for 6/2016, 7/2016 and 8/2016 lacked monitoring of non-pressure skin conditions	2 830		

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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

(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
2 830	Continued From page 15 An Occurrence Report completed on 7/22/16, at 8:56 p.m. noted the following injuries: Bruise to the Right Upper Arm, near chest, purple, new looking bruise; Skin Tear to right middle Finger 3, scrape on knuckle of right middle finger. A treatment and measurements were not mentioned in the report. A list of current orders lacks direction to monitor and treat current non-pressure skin conditions. The current plan of care, target date 7/8/16, identified R62 as a fall risk related to actual falls, unsteady gait, and failure to be cognoscente of deficits and directs staff to monitor, document, and report as needed for 72 hours to medical doctor for pain and bruises. A policy to monitor and assess non-pressure skin conditions was requested however a policy regarding Suspected Abuse and Neglect -Clinical Protocol Injury, Fractures, Bruises and Skin Tears of unknown origin, revised June 2014) was provided. The policy did not address monitoring or assessing non-pressure skin conditions. On 8/4/16, at 8:19 a.m. RN-E stated the facility did not have a system in place to monitor bruising and other non-pressure skin conditions. She stated the facility's only policy to monitor these non-pressure alterations in skin integrity was the Abuse/Neglect policy that was provided. She verified the policy and procedure did not direct staff to ensure complete and standardized monitoring of these skin conditions. RN-E explained she did not expect staff to take an initial measurement of a bruise or an abrasion or to monitor for changes in size or color and considered weekly body audits as an effective monitoring system.	2 830		

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2 830	Continued From page 16 During an interview on 8/4/16, at 8:48 a.m., the director of nursing stated she expects staff to monitor bruising at least daily, if not every shift. She stated the medical doctor, nurse practitioner or wound nurse should be notified if increase in size, color or pain was noted. She further stated an initial measurement and other identifying information such as color, area and presence of pain should be obtained. The DON further stated she did not consider weekly body audits as an adequate system to monitor bruises, abrasions and other non-pressure related skin conditions. R47 was interviewed on 8/2/16, at 4:15 p.m. R47 stated he attended renal dialysis on Mondays, Wednesdays and Fridays. At that time, R47 expressed concerns he had about his dialysis care by the facility staff stating, "the nursing staff here does nothing for my dialysis access site." R47 explained that one hour prior to dialysis the nurse was supposed to apply a numbing medication, Lidocaine, to his access site. He stated, "this never happens. I have to do it." R47 stated, "I don't know why I have to do this. Nursing should be doing this, but they don't. It's been going on like this for some time now." R47 explained that the dialysis nurse put a bandage on his arm after the run was completed, and he removed the bandage himself in the evening after it stopped bleeding. The resident also indicated that facility nursing staff did not monitor his dialysis access site.	2 830		

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2 830	Continued From page 17 On 8/3/16, at 1:02 p.m. R47 stated his dialysis run went well today. When R47 was asked about any paperwork that was given to him, he replied "I didn't get any paperwork back from dialysis I might get paperwork once a month." A Quarterly Review Minimum Data Set (MDS) dated 6/16/2016 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 indicating a good memory. The MDS indicated the resident was receiving dialysis treatments. The resident was able to communicate needs. The resident's current care plan dated 6/25/2015 indicated facility staff were to complete dialysis access site care/assessment daily. Licensed practical nurse (LPN)-H who routinely worked with R47 was interviewed on 8/3/16, at 1:07 p.m. LPN-H verified R47 self-administered the Lidocaine cream prior to dialysis. She explained that the dialysis clinic had provided the resident with a tube of the cream, the facility provides the bandage, and he performed the treatment "himself." LPN-H stated she used to help the resident when his dialysis appointments were at 10:00 a.m. adding the resident's appointment time was now earlier and she was not yet in the facility to help him. LPN-H explained when R47 leaves for his appointment we [nurses] send paperwork with him, but when he comes back he does not give it to us." Registered nurse (RN)-A stated at 1:10 p.m. on 8/3/16, she was unaware R47 was applying prescribed topical medication to his dialysis access site. RN-A said sometimes the resident does not give his paperwork to the facility nurse upon returning from dialysis. RN-A stated when R47 has been given a prescription in the past he has kept or has lost them, "so we have asked the dialysis clinic that any prescriptions be called directly to the pharmacy." RN-A stated she was unsure why R47 did not have a physician order in	2 830		

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2 830	Continued From page 18	2 830		

his medical chart for the Lidocaine, "I will have to call the dialysis clinic for the order." At 1:25 p.m. RN-A stated she had spoken to the dialysis nurse who had informed her the clinic had contacted the facility on 12/20/15, to notify them R47 had been prescribed Lidocaine cream which had been filled by the dialysis clinic, with directions to apply 1 hour prior to his appointment time.
On 8/3/16 at approximately 3 p.m., R47's dialysis nurse (RN-C) was interviewed by telephone. She verified R47 had received an order for Lidocaine cream from the dialysis center, which was to be applied to the access site one hour prior to his appointments. RN-C stated, "I don't think the facility looks at the information sheets we send back with him after each dialysis run. We [dialysis nurses] have found that if we have something that really needs to be addressed or changed, we have to call the facility directly."
On 8/4/16, at 10:38 a.m. R47 stated he had just been moved to a new room the previous evening. When asked if he had the Lidocaine cream he replied, "Yes, I will show you." However, when R47 opened the drawer he could not find the cream. RN-D, a nurse on the resident's current unit, was notified and was also unable to locate the Lidocaine cream. RN-D said it could have been left in the treatment cart on R47's previous living unit. At 12:58 p.m. LPN-H reported they'd found the lidocaine cream.
R47's dialysis communication book was reviewed on 8/4/16. On top of the book was a note to the dialysis center that included: "Dear dialysis care team, we put this book together to improve the communication and should travel to/from with him. Feel free to review, suggest changes and add data to assist our team." However, the book only contained a face sheet dated 7/25/16 ,and very little other information. A review of R47's medical record revealed a lack of documented

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2 830	Continued From page 19 communication between the dialysis clinic and the facility. There was no documentation at all found in the resident's records related to the dialysis treatment runs. On 8/4/16, at 1:31 p.m. RN-E provided pages of R47's dialysis run results. When asked where the documents had come from, RN-E said she'd had the dialysis clinic fax them over. RN-E confirmed there had been no other dialysis run notes in R47's chart. During an interview on 8/4/16, at 2:14 p.m. the administrator and RN-E both verified R47 should have had dressing changes and monitoring for signs and symptoms of infection included on his MAR/TAR. RN-C stated nursing staff should be documenting when the resident's dressing was last changed. In addition, they both acknowledged that if R47 does not take or bring back his paperwork from dialysis, the nursing staff should be calling the dialysis clinic and asking for a faxed copy of the run for the day. A policy and procedure was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure that all residents have adequate monitoring and coordination of care. The DON or designee could educate all appropriate staff on the appropriate methods to monitor snd to ensure coordinated care.. The DON or designee could develop a monitoring systems to ensure ongoing compliance and present those findings to the quality assurance committee. . TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 930	Continued From page 20	2 930		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper care and monitoring was provided for 1 of 1 resident (R149) reviewed for use of a tube feeding, to ensure the resident received adequate nutritional intake. Findings include: R149's physicians order sheet on 8/2/16, indicated R149 was to receive peptamen 1.5 (a liquid high-calorie nutritional supplement) at 105 milliliters per hour (ml/hr) from 12:00 a.m. (midnight) to 9:00 a.m. with 120 ml free water flushes at 12am, 3am, 6am, 9am, 3pm and 8pm per registered dietitian. A nutrition/dietary progress note dated 8/3/16, confirmed the orders on 8/2/16, with the addition that R149's calculated nutritional needs were 1000-1400 kilocalorie,	2 930		

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2 930	Continued From page 21 40-60 grams protein and 1000-1400 ml fluids. R149's care plan dated 7/25/16, indicated R149 had a nutritional problem with a weight loss of estimated 19% loss in 180 days and was on tube feedings to provide adequate calories and fluids. Staff interventions were to provide tube feedings as ordered and maintain hydration status. On 8/3/16, at 7:37 a.m. the surveyor observed R149 asleep in her room which is the first room by the nursing station. R149's nutritional supplement was hanging on an IV pole with approximately 250-400 ml of nutritional supplement left in the bag, the end of nutritional supplement tubing was hanging down not attached to R149 while she slept. During an interview on 8/3/16, at 8:45 a.m. licensed practical nurse (LPN)-D stated R149 returned from the hospital yesterday due to her G-Tube (a tube surgically placed into the stomach to provide nutritional support) was clogged. LPN-D explained R149 will shut off her tube during the night when she goes to the bathroom and not tell anyone she has done this. LPN-D stated "I went into her room at 7:45 a.m. and it was off [the G-tube pump]. LPN-D stated R149 gets all her nutritional needs via the G-tube and receives 30 ml flushed before and after any medication given to her. LPN-D verified R149 does not get any extra flushes throughout the day. During an interview the same day at 2:57 p.m. R149 explained she was in the hospital the previous day because her G-tube was clogged. The G-tube was now unclogged but her J-tube was stilled clogged. R149 explained she does take out her tubing when she goes to smoke or to	2 930		

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2 930	Continued From page 22	2 930		

the bathroom but will put her light on and let staff know when she is back in her room. "I am aware I get my nutrition from this [pointing to her nutritional supplement fluid in the bag hanging on the IV pole] however my G-tube keep clogging during the night and it takes staff awhile to come in, each time it stop I don't get all the nutrition I need. "look there is still nutritional supplement left in my bag." The resident indicated she had been in the hospital for a clogged tube. On 8/4/16 at 4:20 p.m. R149 explained that she has been managing a G-tube on her own for a long time before coming to this facility. "I have asked staff to teach me about this G-tube because it's different than the one I have at home, but they have never done any training with me."

During an interview on 8/4/16, at 6:48 a.m. (LPN)-C verified he works the night shift and has been working with R149 the last two nights. LPN-C explained R149 would come out of her room and not let staff know when she disconnected her G-tube so LPN-C kept peeking in on her often to see if her nutritional supplement was still running. LPN-C stated R149 gets a whole bag of nutritional supplement. While talking with LPN-C at the nursing station, at 6:48 a.m. R149 came out of her room with the G-tube disconnected and told LPN-C she was going out to smoke. The surveyor interviewed R149 in the smoking courtyard. R149 said, "I do tell staff when I unplug my G-tube, but they[staff] don't come back to hook it up. R149 explained that the previous night the nurse came in to hook up her G-tube, but he wanted to put on the same nutritional supplement that had been hanging in the room all day. "I told him that I should get fresh nutrition that stuff has been sitting there all day and it will make me sick." He put a new bag on. The resident stated, "I am very worried about

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2 930	Continued From page 23 the cares I'm getting here. A review of R149's medication administration record (MAR) for the month of 8/2016, revealed R149 was to receive nutritional support of peptamen 1.5 at 80 ml/hr from 8pm to 8am then was changed on 8/2/16, to 105 ml/hr from 12am (midnight) to 9 am. The MAR indicated no documention the resident received any of her nutritional support on 8/2 or 8/3. Staff did not initial the MAR as being given nor did staff document on the back of the MAR reasons why not given for two times. Review of nursing notes indicated one note that on 8/2/16, at 21:40 the resident, "refused her tube feeding at 8PM but allowed staff to hook it up at 9:30 pm." No documentaion was noted as to how much nutritional supplement she received daily. A policy and procedure was requested for G-Tube care but was not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could train and educate staff and complete audits to ensure monitoring and compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand	21000		

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21000	Continued From page 24 washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper dietary sanitation practices. This had the potential to affect all 110 residents who were served food from the kitchen. Findings include: An initial tour of the kitchen was conducted with the certified dietary manager (CDM) on 8/1/16, at 12:36 p.m. The following concerns were noted: Cook-A was prepping food for the noon meal. The gloves he was wearing had large holes that exposed his fingers as he touched lettuce cheese, and tortillas. Cook-A explained the available gloves were too small and larger gloves had not been provided. The CDM then confirmed the gloves cook-A was wearing were too small, resulting in holes from use. Cereal bowls filled with dry cereal were stacked three-high on the counter. The cook also explained the stacked cereal bowls had been prepared for residents as an alternative to the lunch menu. They would either get put away or be disposed of not served at the noon meal. The dish room area was crowded. Carts with trays being readied to deliver to dining rooms also	21000		

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21000	Continued From page 25 occupied the space. Staff were required to cross over between the carts and clean dishes used for tray set up to reach the dirty dish area. The CDM stated dirty dishes came into the dish room to the right, were sent through the dish machine, and then stored in the clean dish area on the back wall. The CDM explained that five carts went out with trays at every meal. DA-A then proceeded to rinse dirty dishes and pans on the right side of the dish machine. As the clean dishes came out of the machine, she reached for the sprayer with her right hand and sprayed off the disinfectant residue from the clean dishes. DA-A pointed out residue on the stainless steel, clean side of dish room counter and explained she would not want that on her dishes. Instead of performing hand washing, she rinsed her hands using the dirty sprayer, and then moved to the clean side of the dish room. DA-A did not wear gloves or wash her hands during the process. She proceeded to the rack where chemicals were stored, obtained a blue cloth and used it to wipe two trays. The cloth was then placed on a shelf over the clean dishes. She moved two clean trays back to the dirty side of the dish room. She then moved two clean, but still wet pans to the conveyor line in the kitchen. DA-A then wiped down carts with a cloth. When asked about hand washing DA-A responded, "Yes, we wash our hands between clean and dirty. We are very good at washing our hands. It is required." It was 9:50 a.m. when DA-A first approached a sink and rinsed her hands, but did not wash using soap. DA-A then for the first time, applied gloves and went to the dirty side of the dish machine. Dishes were sprayed on the dirty side of the sink and then set in racks which were moved through the dish washer. After the rinse cycle, racks were pulled using her left hand and without touching	21000		

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21000	Continued From page 26	21000		

the dishes. The gloves were removed at 10:00 a.m. and using the sprayer, DA-A again sprayed her hands and the counter. She proceeded to move clean plates and plate covers to the racks. She took the blue cloth and began to wipe the clean dishes. When finished wiping the dishes, DA-A wiped her hands on the towel and placed it back on the shelf above the clean dishes. DA-A then applied gloves and returned to washing dirty dishes. She then rinsed her hands at the hand washing sink, but again did not use soap. She stacked clean plates and bowls, shaking them prior to stacking. DA-A placed two trays in the tray rack, retrieved an orange towel from the bin on the chemical rack and wiped the trays dry. DA-A handled the dirty pots and pans on numerous occasions, ran them through the dishwasher, and then rinsed them off with the dirty sprayer.

The CDM stated in an interview on 8/4/16, at 1:55 p.m. hand washing was "an expectation." The CDM reported she had made similar observations and hand provided education for DA-A. She confirmed staff were not to go between dirty and clean dishes/ processes without washing hands. She did not consider rinsing hands with the sprayer on the dirty side of the sink consistent with hand washing. The CDM explained, "The sanitizer is meant to sit on the dishes and not be rinsed off." Dishwashing and tray set up should not have occurred at the same time, according to the CDM.

The facility's undated Dishwashing Machine Use directed staff to, "Wash hands before and after running dishwashing machine, and frequently during the process."

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee

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21000	Continued From page 27 could develop, review or revise policies, and provide education for staff regarding appropriate sanitation in the kitchen to ensure prevention of food borne illness. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426		

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facility failed to screen 3 of 5 newly admitted residents (R19, R79, R124) for tuberculosis (TB) and failed to document the results of the 2nd step Mantoux (TST, tuberculin skin test) results for 4 of 5 residents (R19, R76, R79, R124). In addition the facility failed to provide the 2nd step TST for 1 of 5 newly hired employees (E-1). This had the potential to affect all 110 residents residing in the facility.

Findings include:

R19 was admitted to the facility on 3/4/16. R19's medical record revealed a TB screening had not been completed at the time of admission. R19's medication administration record (MAR) for the month of 3/2016, indicated R19 had received first and second step TSTs. Although the first step TST was identified as 0 millimeters (mm) induration, there had been no documentation as to whether the TST was positive or negative. In addition, there was no documented measurement of induration for the second step, nor documentation of whether the test was positive or negative.

R76 was admitted to the facility on 2/10/16. R76's MAR for the month of 2/2016, indicated R76 received the first and second step TST, where staff recorded on the MAR the first and second step TST as having zero mm for induration, however R76's MAR lacked any documentation that his first or second step TST was positive or negative.

R79 was admitted to the facility on 2/19/16. R79's medical record revealed the TB screening had not been completed on the date of admission. R79's MAR for the month of 2/2016, indicated R79 received his first TST, however

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there was no documentation to indicate whether R79 ever received the second step.

R124 was admitted to the 3/1/16. R124 medical record revealed the TB screening had not been completed on the date of admission. R124's MAR for the month of 6/2016, indicated R124 first step TST was given and recorded as negative no induration noted. R124 MAR lacked any documentation that she was given the second step TST.

E1 was newly hired on 5/23/16. E1's health file was reviewed on 8/5/16, and indicated E1 had not received a second step TST as required.

During an interview on 8/5/16, at approximately 11:00 a.m. registered nurse (RN)-E. RN-E stated she is in charge of doing the infection control training and documentation for the facility. RN-E verified R19, R79, R124 did not have symptom screen done for TB at time of hire, R19, R76, R79, R124 did not have correct documentaion for the first and second step TST, not did E1 have a second step TST done. RN-E verified she has only been with the facility for a short time and when she started she became aware of staff and resident were not up-to-date with current documention on TST results and symptoms screens for TB. RN-E explained over the last several months she and the medical director are working on a program to get all employees and resident current in TB documentation.

The facility's policy and procedure titled "Tuberculosis Infections Control Plan" revised date 7/11/16, indicated "The infections Control Nurse/Infection Control Designee is responsible for developing, implementing, and monitoring the TB Control Program in collaboration with the

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21426	Continued From page 30 Administrator, Medical Director, Director of Nursing and Assistant Director(s) of Nursing." The facility indicated they are a medium risk health care facility. The facility will implement that all healthcare workers and residents received two step TST and be assessed for current symptoms of active TB upon hire and/or admission. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents are receiving tuberculosis screening according to the CDC guidelines including reading mantoux results correctly. The DON or designee could conduct resident screening audits, interventions and monitoring to ensure residents are free from communicable disease. The DON or designee could randomly audit resident's documents to ensure adequate documentation for induration. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and	21435		

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21435	Continued From page 31 recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 3 of 3 residents (R92, R52, R26) who were dependent on staff to provide activities, and were reviewed for activities. Findings include: R92 was initially observed on 8/1/16, at 3:57 p.m. lying in bed sleeping soundly. At 7:29 p.m. R92 was awake and was seated in a wheelchair in the dining area. No staff was interacting with the residents. On 8/3/16, at 2:46 p.m. R92 was lying in bed. Although the television was turned on, R92's bed was positioned adjacent to the television next to his head, where he could not see the screen. On 8/4/16, at 8:54 a.m. R92's room door was shut and the surveyor was told, "He is in bed sleeping still." At 9:47 a.m. R92 was assisted back to his room by nursing assistant (NA)-A. When asked where the "1:1 with Rec [recreation] staff" activity scheduled from 9:30 to 11:30 a.m. was usually held, NA-A walked to the white board listing activities and stated, "It's usually held in the dining room." NA-A then asked R92 if he wished to stay for the activity he replied, "Yes." NA-A wheeled R92 to a place at the dining room where a few other residents were seated. No activity was being held at that time. R92 sat calmly with no signs of agitation such as yelling or increased movement in his wheelchair. Twelve other residents were in the room as staff walked back and forth and the nurse passed medications in the dining room and no activity was held. At 10:20 a.m. a staff person stated the board game	21435		

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21435	Continued From page 32 Yahtzee was being played on the third floor. No staff person offered to take R92 to the activity. R92's 8/6/15, annual Minimum Data Set (MDS) indicated the resident had moderately impaired cognition. The following activities were all somewhat important to the resident: having reading material, music, pets, keeping up on news, group activities, pets, going outside, and religious activity. A subsequent quarterly MDS dated 5/10/2016 indicated the resident had severely impaired cognition for decision making skills and had some difficulty focusing, however, a decline in mental status was not noted. The assessment indicated the resident had diagnoses including dementia, depression and psychosis. He was dependent on staff for mobility on/off the unit. He displayed verbal behaviors 1-3 days during the assessment period, however, mood indicators were not noted. R92's care plan dated 9/10/14, noted the resident was dependent on staff and his wife for meeting his emotional and social needs. Interventions directed staff to provide individual activities, assist with television, provide activity calendar, invite to scheduled activities, and thank resident for attending. During an interview with R92 on 8/3/16, at 2:47 p.m. he reported he did not attend activities, but enjoyed watching television in his room. R92 had difficulty speaking and was short of breath, so was unable to provide details as to why he did not attend activities. Licensed practical nurse (LPN)-A who routinely worked with R92 was interviewed on 8/3/16, at 2:48 p.m. LPN-A was unable to state R92's activity preferences, and referred the surveyor to the activity staff. NA-A then explained that when R92 was brought to an activity he would yell loudly and want to return to his room. When asked whether she had observed 1:1	21435		

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21435	Continued From page 33 visits/activities provided for R92 NA-A replied, "No." On 8/3/16, at 3:09 p.m. Recreational Therapy Assistant (RTA)-A explained she had only been in her activities position for a month. RTA-A reported R92 enjoyed activities that required using the mind, such as spelling bees, old sayings and music. RTA-A explained that previously attendance was taken when residents attended activities, but that "fell to the wayside." RTA-A verified she did not document when a resident attended an activity or when a 1:1 visit was provided, and she was unable to produce an activity assessment since R92's admission. R92's activities participation notes revealed the following: 1) 8/9/15, R92 attended four structured programs in the past quarter; 2) 11/19/15, R92 attended Bible study, communion, and movie matinee; 3) 3/3/16, R92 attended social ball toss, old sayings and church; 4) No further entries were located in the record regarding activities R92 attended or declined. A review of the activity calendar for the months of July and August 2016, revealed numerous activities were provided for persons cognitively intact such as quiz challenge, hangman, spelling bee, jeopardy and horse racing. The facility's 10/09, Activity Assessment policy directed staff, "Within 14 days of a resident's admission to the facility, an activity assessment will be conducted to help develop an activities plan that reflects the choices and interests of the resident. The assessment will be conducted by the activity department staff and other staff employees input. The activity assessment will be part of the residents' medical record and updated as needed and annually." R52 stated in an interview on 8/1/16, at 3:23 p.m.,	21435		

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21435	Continued From page 34 "I do not want to be here." R52 said he was just waiting for someone to tell him what to do and where to go. Although a television was on in the room, the resident stated he was not watching it. No other personal items were observed in the room except for clothing. The curtains were closed. R52 reported he used to be a carpenter and enjoyed hunting and fishing. On 8/3/16, at 2:17 p.m. R52 was seated in the dining room. He again reiterated his feelings about living at the facility. When asked what he would like to do at the facility he said he liked hunting and fishing and wanted to go outside. He then carried on a 10 minute conversation with the surveyor about fishing. A social services note dated 9/16/15, revealed R52 was severely cognitively impaired, had self-reported depression, spent some time watching television and lying in bed. R52 did not socialize or participate in activities; activity preferences were hunting and fishing. R52's care plan (9/5/16 goal date), indicated the resident had little or no activity involvement related to disinterest. The goal was, "The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date." Approaches included the resident's preference for old westerns and movies. His preferences were noted as listening to country music and watching western shows. Staff was to ensure he received daily opportunities for social contact and eat all meals in the dining room, attended daily activities of his choice, and communicated his feelings regarding activities. Staff were to introduce the resident to others with similar background, interests and encourage/facilitate interaction and activity attendance.	21435		

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21435	Continued From page 35 An activity assessment dated 6/15/16, indicated the resident had, "... severe cognitive impairment related to dementia. Resident does not participate in activities secondary to lack of desire, only comes out for meals." R52's 6/23/16, annual Minimum Data Set included diagnoses of dementia, anxiety, and depression. Although the assessment indicated severely impaired cognition. It was "somewhat important" he do things with groups of people and go outside in nice weather. The assessment showed the resident did not display mood or behavioral indicators during the assessment period, but a new problem was that the resident experienced "little pleasure in doing things" every day or nearly every day. R52's care plan, however, did not incorporate these areas of importance to the resident or concerns with approaches to ensure his needs were met. On 8/4/16, at 11:55 a.m. R52's activity log for June 2016, revealed the resident attended movie and popcorn on 6/8/16 and Bingo on 6/27/16. During an interview with the Recreational Therapy Assistant-A (RTA-A) on 8/3/16, at 1:14 p.m. she reported R52 did not wish to attend activities. She described the resident as "disinterested in activities" and instead, the resident wanted his family to visit more often. He watched television or activities, but did not generally participate. He did attend food programs such as birthday parties. RTA-A stated R52 would have benefited from more interaction with his family, and had made attempts to call them, but the phone numbers were no longer valid. R52 was not responsive to conversation and gave staff "the silent treatment." There were no current plans for the resident to move to a different location. He had not been attending his care conferences, but some magazines were provided for him in his	21435		

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room. RTA-A said she had no idea R52's previous occupation.

The social worker (SW) was interviewed on 8/4/16, at 11:58 a.m. and described R52 as "unhappy" at the facility, and had not adjusted. He was encouraged to attend activities, and the staff allowed him space. The SW said they could have attempted other approaches with R52 to make his stay at the facility more satisfactory. The resident continued to say things were unacceptable and the SW said, "We may need to look at trying something new. He does consider this to be a prison." The SW reported he could utilize the patio, and said, "We will need to add outside to the care plan. There may be more opportunities that we need to consider for this resident." The SW explained they had noted traditional dementia symptoms with R52, such as what meal was being served. In addition, he often did not provide a reason why he did not wish to attend activities, just stated he did not wish to attend.

R26, who had diagnoses that included brain injury, cognitive (thinking) problems, depression, stroke with left-sided paralysis was observed on 8/2/16, at 6:15 p.m. after being assisted out of bed for the evening meal. While trying to start a conversation, R26 avoided eye contact and gave little response.

The following morning at 8:25 a.m. the resident was up in a wheelchair in the bedroom. R26 was facing the television, which was off at the time. The resident made repetitive, nervous hand movements. R26 did not respond to two greetings by the surveyor. When asked if things were going okay, the response was "yah," and was barely audible. At 9:00 a.m. the resident was being

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21435	Continued From page 37 assisted to eat breakfast in the dining room. At 9:30 a.m., still in the dining room, R26 sporadically looked at a morning television show between active looks around at the other residents in the room. At 10:24 a.m. the resident was lying awake in bed, and again did not respond to a greeting. During an interview on 8/2/16 at 4:13 p.m., NA-D indicated R26's morning routine was to be gotten up in a wheelchair, get washed up and then eat breakfast. NA-C was also present and added R26 was, "mostly in bed because of her bottom getting red in a short time, but that is better now." NA-D continued, "R26 does some activities, they try to get her to participate, movies...I'm not sure of any others." NA-E elaborated during an interview on 8/3/16, at 10:27 a.m.: "Her routine is that we get her cleaned up, then get her up for breakfast - she stays up an hour approximately. Then we put her back to bed and check her [skin], then check her again before we get her up at lunch. She's in bed a lot because of [skin issues] on her behind...that come and go." She doesn't do activities now, she doesn't follow - if she's left up longer her head goes down, like this." During an interview on 8/3/16, at 10:36 a.m. registered nurse (RN)-G explained the wound nurse had requested R26 stay off from her buttocks due to her poor skin condition. RN-G said they occasionally included the resident in an activity, but she did not participate or attend to what was going on due to her cognition state. RN-G stated, "I'm not sure if she gets any 1:1 time from activities [staff]. You could ask our activities director."	21435		

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21435	Continued From page 38 At 10:40 a.m. on 8/03/16 the Recreational Therapy Assistant (RTA-A) was observed just leading Bingo in the dining room - R26 was not there but in bed as previously observed. The current care plan for R26 indicated the resident had little or no activity involvement due to her limitations related to traumatic brain injury and a stroke. It was noted the resident was able to use some sensory skills such as hearing and vision. Interventions included a list of the resident's preferred activities: "Spiritual, cognitive, sensory, and a variety of programs on her floor. She does not tolerate being up for long periods of time. Resident watches TV in her room. Bible Study, Birthday Party, Manicures, church." An activities assessment for R26 was requested but not supplied by the facility. After she finished leading Bingo an interview was conducted with RTA-A. When asked what activity services existed for residents whose limitations prevented them attending scheduled activities, she answered she would individualize her interventions. For one resident she would bring a television into the bedroom and play movies. For another, she said, she would go in and read or visit. "And I like to get them outside when possible." As to R26, RTA-A indicated she would read to her, "have conversations, tell her the weather." She added, "I'm a little bit of everywhere...I see everyone who needs a 1:1," She added, "I cover the whole facility so it takes more than 1 day [to see every resident who needs it]." She added, "Last week R26 played the Bingo." SUGGESTED METHOD OF CORRECTION: Activity Director or designee could train and	21435		

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21435	Continued From page 39 educate staff regarding residents activities' and complete audits to ensure monitoring and compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being for 1 of 1 resident (R52) who reported dissatisfaction with his life at the nursing home. Findings include: R52 stated in an interview on 8/1/16, at 3:23 p.m. he did not have any say in and/or was not informed of cares, treatments, or medications he was prescribed. When asked about how he was doing overall at the facility, he used an expletive and indicated, "I do not want to be here." R52 said he was just waiting for someone to tell him	21475		

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21475	Continued From page 40 what to do and where to go. A social services note dated 9/16/15, revealed R52 was severely cognitively impaired, had self-reported depression, spent some time watching television and lying in bed. R52 did not socialize or participate in activities. A subsequent note dated 12/13/15, indicated R52 when asked to attend his quarterly care conference he declined stating, "'I don't even know you.'" The note indicated assessments had been completed and the resident had severely impaired decision making skills, and the physician recommended guardianship for the resident. The social worker (SW) documented difficulty finding a family member to assist with guardianship. It was noted R52 saw the in-house psychologist on 10/14/15, and the resident was not getting along with his roommate and was rejecting leg treatments. The SW noted she would continue to be available to meet the resident's psychosocial needs. On 12/17/15, the SW and nurse manager met for a care conference. The note did not indicate whether the resident was invited or declined or attended the conference. A SW note dated 6/14/16, indicated R52 had behaviors of refusing treatment and calling staff names, and had a need for a private room due to rummaging through others' belongings. The SW wrote, "Resident is dissatisfied with placement and desires to live in independent living, but doctor and IDT [interdisciplinary team] agree that community discharge is not appropriate due to resident's cognitive status. Plan of care to be discussed with guardian when guardian is appointed." Notes from the psychology clinic were not located when R52's medical record was reviewed, although it was noted the resident was	21475		

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seen 4/6/16. A medication decrease in the resident's antidepressant was made and the note indicated he would be seen again in six months.

An undated care conference summary form was found in R52's record when the record was reviewed on 8/3/16. The summary indicated R52 was invited but did not attend the conference, however, a reason was not noted. A conference note dated 3/16/16, indicated the resident was invited but did not attend his conference, and the facility had changed his bath to the morning to increase compliance with bathing. A conference form dated 6/30 lacked the year and did not indicate whether the resident was invited or attended or declined his conference. No other conference forms were located in the record.

R52's 6/23/16, annual Minimum Data Set included diagnoses of dementia, anxiety, and depression. Although the assessment indicated severely impaired cognition, he was able to be interviewed for the assessment. The only area the resident reported as, "very important," was to have his family involved in discussions about his care. The assessment showed the resident did not display mood or behavioral indicators during the assessment period, but a new problem was that the resident experienced, "little pleasure in doing things," every day or nearly every day. R52's care plan, however, did not incorporate these areas of importance to the resident or concerns with approaches to ensure his needs were met. The 6/15/16, social services comprehensive Care Area Assessment (CAA) for mood/behavior annual review indicated "Resident states... that he would like to go home. IDT and physician agree that community placement is not appropriate."
R52's care plan (goal date 9/5/16) indicated, "The

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21475	Continued From page 42 resident is adjusting to a new routine and nursing home placement. Resident calls this place 'jail,' and would like to move to community, but has significant dementia." It also indicated the resident had impaired cognitive function/dementia or impaired thought processes related to short term memory loss/dementia. "Daughter has agreed to be resident's guardian, waiting on results of background check." The goal was, "The resident will improve current level of cognitive function through the review date." The care plan also noted the resident was adjusting to a new routine and nursing home placement, called the facility "jail" and would like to live in the community but had significant dementia. During an interview with RN-E on 8/4/2016 at 7:58 a.m. she stated that resident care conferences were sometimes a team, but it would depend on the resident. The adjustment part of the care plan was a team effort and varied depending on the resident. Initial care plans were started at the first referral which then triggered how it drove the care plan. Care conferences are primarily nursing and social services. There was also a process called Grand Rounds that occurs before the assessment period where additional staff gave input. During an interview with the recreational therapy assistant A (RTA-A) on 8/3/16, at 1:14 p.m. she described the resident as "disinterested in activities" and instead, wanted his family to visit more often. RTA-A said R52 would have benefited from more interaction with his family, and had made attempts to call them, but the phone numbers were no longer valid. R52 was not responsive to conversation and gave staff "the silent treatment." There were no current plans for the resident to move to a different location. He and not been attending his care	21475		

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21475	Continued From page 43 conferences. The SW was interviewed on 8/4/16, at 11:58 a.m. and said she and the nurse manager were the two staff who attended resident care conferences. Sometimes, the dietitian may attend, but the activity staff did not attend. She stated R52's daughter was appointed his guardian in 5/16. The SW described R52 as "unhappy" at the facility, and had not adjusted. The resident could not tolerate a roommate, as he was "unfriendly" toward them and they received a private room waiver for this reason. The staff had utilized the family to reach him and ensure he could do the best he could given the situation. The SW verified the care plan regarding adjusting to the nursing home including the problem statement, goal, and approaches, remained the same as when the resident was admitted more than a year prior. The SW said they could have attempted other approaches with R52 to make his stay at the facility more satisfactory. When asked if it was felt the plan was working, since the resident continued to express dissatisfaction with life at the facility, the SW replied, "We may need to look at trying something new. He does consider this to be a prison...There may be more opportunities that we need to consider for this resident." The SW explained they had noted traditional dementia symptoms with R52, such as what meal was being served. In addition, he did not provide a reason why he did not wish to attend his care conferences. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement policies and procedures related to social services and educate all staff. Then	21475		

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21475	Continued From page 44 develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21475		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmaceutical services were secured, including routine medications and biologicals as ordered for 4 of 8 residents (R2, R120, R145 and R149), reviewed for missed medication doses due to medications not being available for administration. Findings include: During an observation of medication administration, on 8/1/16, at 7:07 p.m. a trained medication aid (TMA)-B was unable to locate Depakote (a medication used to decrease seizure activity but has also been used to stabilize mood and behavior) for R2. R2's diagnoses included schizophrenia and major depression. TMA-B advised a licensed practical nurse (LPN)-G who was also unable to locate the medication in the nursing medication cart and the medication room.	21550		

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21550	Continued From page 45 LPN-G then stated he would order the medication from the pharmacy. The assistant director of nursing (ADON), at 7:15 p.m., explained the process for reordering medications to ensure availability was to pull the label on the medication card when there were approximately 7 pills left and fax it to the pharmacy. She said it was important to allot adequate time in case the medication was not able to be reordered due to insurance or other reasons. She explained if it was a necessary medication, it would be ordered "stat" and would be expected on the next run from the pharmacy. The facility would pick up the expense for any or these reasons. It was the responsibility of the nurses or TMAs that were administering the medications to ensure it had been reordered and available for the residents. A review of the medication administration records (MAR) revealed the medication Depakote was initialed and circled on 8/1/16, at 8:00 p.m. No explanation was documented on either side of the MAR or in the nursing progress notes as to why the initials were circled.. A physician's order, written on 1/26/16, directed staff to administer Depakote ER (extended release) 2000 milligrams (mg) by mouth (po) every bedtime. R2's care plan, target date 10/17/16, identified R2 as having mood and behavior problems, grandiose delusions, active hallucinations and depression and the potential for self-harm related paranoid schizophrenia. The care plan directed staff to administer medications as ordered. A physician's order written on 1/26/16 directed staff to administer Clozapine 400 mg at bedtime	21550		

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A Heath Status Note written 7/23/16 indicated R2 did not have any antipsychotic medication, Clozapine, used to treat schizophrenia and lower suicidal behavior, stating at present time it was unavailable and was being processed by the VA (veterans' administration) pharmacy.

A review of the July 2016, MAR revealed R2 did not receive Clozapine 400 mg at bedtime on 7/23/16 and 7/24/16.

During an initial interview on 8/2/16, at 10:51 a.m., R120 stated he frequently had pain in his left shoulder and had an order for Oxycodone to manage it. He explained, however, the facility often ran out of the medication and he had to take Tylenol as an alternate, "They are so slow getting medications here. They are always running out because they don't order in time."

In a follow-up conversation on 8/4/16, at 2:40 p.m., R120 stated he did not receive Oxycodone on 8/1/16 and 8/2/16 because there was no stock available in the facility. He explained, although he received Tylenol, it did not manage his pain to the level of the Oxycodone. He again stated this happened, "way too often," and, "they just don't reorder the medications when they should."

Diagnoses for R120 included Cervicalgia (neck pain that occurs toward the rear or the side of the cervical vertebrae) and low back pain. A physician's order written on 7/21/16 directed staff to administer Oxycodone HCL 5 mg every 6 hours prn (as needed) for pain. A review of the MAR revealed R120 was administered 2 tablets of Oxycodone HCL 5 mg on 8/1/16, at 8:00 a.m. and did not receive another dose until 8/2/16, at 4:45 p.m. The individual narcotic record, page 77, showed that after the 8/1/16 dose that was

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21550	Continued From page 47 given at 8:00 a.m., the Oxycodone HCL 5 mg supply for R120 was depleted. A care plan, initiated 6/27/16, Identified R120 with actual and potential leg pain and chronic low back pain and to monitor and document side effects, increased pain, new onset of signs and symptoms of pain or behavior, and to update the physician if interventions were not successful or if a significant change in status was observed. On 8/4/16, at 3:00 p.m. R145 approached the nurses' station located on unit 1 in the facility. She asked the staff, "Can someone please make sure my Trazadone (an anti-depressant medication also used to treat insomnia) is ordered? I haven't had it in 2 nights and I didn't sleep at all last night." During a follow-up interview the next day at 7:53 a.m. R145 stated she had not received her trazadone again on 8/4/16. She explained it was the third night in a row and it was, "messing with my bipolar and my emotions are unstable." She stated that it was hard to manage stress when she didn't get any sleep. She stated she was restless and got up several times during the night and when she was given Trazadone she, "slept like a rock." She continued, "If I have to go through another night like this, it won't be good. I don't want to end up like a basket case. I feel like I am on the edge. I have been stable for a long time and I don't need this, I really don't." She then explained she had not received her Requip (a medication used to treat restless leg syndrome) for several days. At 8:02, TMA-D stated R2's Trazadone was not found in the cart or the medication room. She verified the last dose of Trazadone 200mg was	21550		

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21550	Continued From page 48 given on 8/1/16, at 8:00 p.m. The TMA further acknowledged Requip was not given from 8/1/16 through 8/4/16. At 8:17 a.m. LPN-G reported that he located R2's Requip and Trazadone in the bottom drawer of the medication cart. The medications had been filled by Omni pharmacy on 8/2/16 but had not yet been dispensed to R145. Diagnoses for R145 included Bipolar disorder, major depression and insomnia. The physician orders directed staff to administer Trazadone, 200 mg prn at bedtime for insomnia and Requip HCL 3 mg every bedtime. A review of the MARs revealedl Trazadone was not given 8/2/16, 8/3/16 or 8/4/16 and Requip was not administered for five days between 7/31/16 and 8/4/16. The care plan, initiated 7/1/16, indicated R145 was to use psychotropic medication to treat insomnia and depression and directed staff to administer psychotropic medication, including Trazadone, as ordered by the physician and to monitor for side effects including insomnia, depression and suicidal ideation. During an observation of medication administration, on 8/3/16, at 8:44 a.m. a licensed practical nurse (LPN)-D was unable to locate ferrous sulfate (a medication used to treat iron deficiency anemia) and gabapentin gel (a pain medication) for R149. R149's diagnoses included acute kidney injury and altered mental status. LPN-D stated "the medications are not in the cart so I will not be able to give them, I will have to order them from the pharmacy." A review of R149's physicians orders dated 8/2/16, indicated R149 was to receive ferrous sulfate 220 milligrams per 5 milligrams (mg/ml)	21550		

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three times a day and gabapentin 8% gel topically every 8 hours. R149 medication administration record (MAR) for 8/2016 indicated the medication ferrous sulfate was not initialed as being administered twice on 8/3/16, and her gabapentin was not administered once the same day. No explanations were documented on either side of the MAR or in the nursing progress notes as to why the initials were circled.

During an interview on 8/5/16, at 9:57 a.m. the assistant director of nursing (ADON) verified R149 did not received her 8am or noon medication of ferrous sulfate and her 8am medication of gabapentin gel on 8/3/16. On 8/5/16, at 9:57 a.m. the ADON and surveyor reviewed R149 MAR and noted both of her medications was initialed as being given by LPN-D, however when the ADON looked into the medication cart she could not find either one of the medications. The same day at 10:50 a.m. the ADON verified that both medication are still not available. The ADON explained R149 received the medication ferrous sulfate in a pill form instead of liquid and for R149 gabapentin the facility needs to obtains a new prescription for the physician before the pharmacy will refill it.

During a telephone conversation on 8/5/16, at 9:34 a.m. the Omni Pharmacy consultant stated he would expect a new medication order to be filled and delivered the same day. If a refill, it might take 2 or 3 days so therefore he would expect the facility staff to reorder when 3 to 5 days of medication were left for the resident. That would ensure ample time availability of the medication. He further stated it was, "concerning, " when Trazadone or other antipsychotic medications were not given for 3 or more days. He further explained, "Medications are ordered

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21550	Continued From page 50 for a reason. If they are ordered, they should be administered. They are ordered because they are needed." The Omnicare of Minnesota Pharmacy Ordering Schedule, revised 1/1/13, indicated the pharmacy and facility should coordinate to determine delivery days and times as soon as possible after the execution of the Pharmacy Services Agreement or Pharmacy Consultant Agreement. The policy did not address the procedure when re-ordering medications. During an interview on 8/5/16, at 10:25 a.m. the director of nursing (DON) stated she expected staff to reorder residents' medications when a 4-day supply was left and to contact the pharmacy if the medication was not delivered to find out the reason. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or pharmacist could educate all staff responsible for medicaiton administration to ensure residents received their medication as ordered by the physician.. The DON or designee could complete audits to ensure monitoring and compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and	21565		

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21565	Continued From page 51 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents who self-administered medications had been assessed and/or reassessed as safe to do so for 2 of 2 residents (R47, R20) reviewed for self administration of medications. Findings include: R47 was interviewed on 8/2/16, at 4:15 p.m. R47 stated he attended renal dialysis on Mondays, Wednesdays and Fridays. At that time, R47 expressed concerns he had about his dialysis care by the facility staff stating, "the nursing staff here does nothing for my dialysis access site." R47 explained that one hour prior to dialysis the nurse was suppose to apply a numbing medication Lidocaine, to his access site. He stated, "this never happens. I have to do it." R47 said the cream was stored in a drawer in his room, and the nurse provided the resident with gauze to cover the site. R47 stated, "I don't know why I have to do this. Nursing should be doing this, but they don't. It's been going on like this for some time now." R47 explained that the dialysis nurse put a bandage on his arm after the run was completed, and he removed the bandage himself in the evening after it stopped bleeding. When asked if anyone had ever observed him apply the Lidocaine to determine if he correctly used the medication he replied, "No, I keep the cream in my top drawer in my room." R47 was outside on 8/3/16, at 1:02 p.m. when he called for the surveyor. His access site was bandaged. The resident informed the surveyor, "I went to dialysis today and again the nurse did not put the numbing cream on. I had to do myself."	21565		

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21565	Continued From page 52 R47 explained the dialysis clinic ordered the cream, but the nurse placed a bandage over the cream prior to his appointment. A Quarterly Review Minimum Data Set (MDS) dated 6/16/2016 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 15 indicating a good memory. The resident was able to communicate needs. The resident's current care plan dated 6/25/2015 indicated facility staff were to complete dialysis access site care daily. Licensed practical nurse (LPN)-H who routinely worked with R47 was interviewed on 8/3/16, at 1:07 p.m. LPN-H verified R47 self-administered the Lidocaine cream prior to dialysis. She explained that the dialysis clinic had provided the resident with a tube of the cream and a bandage, and he performed the treatment "himself." LPN-H stated she used to help the resident when his dialysis appointments were at 10:00 a.m. adding, "now he goes before I start work." Registered nurse (RN)-A stated at 1:10 p.m. she was unaware R47 was applying prescribed topical medication to his dialysis access site. She verified anyone taking or applying medications should have been assessed as safe to do so by a nurse, and R47 had not been assessed for medication self-administration. RN-A reported to the surveyor that in 12/15, R47 was sent back an order from the dialysis clinic to apply Lidocaine to the access site one hour prior to his appointment. RN-A said sometimes the resident did not give the paperwork to the facility nurse upon returning from dialysis. Later that day R47's dialysis nurse (RN-C) was interviewed by telephone. She verified R47 obtained the order for Lidocaine cream from the dialysis center, which was to be applied to the access site one hour prior to his appointments. RN-C stated, "I don't think the facility looks at the information sheets we send back with him after	21565		

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	00175	A. BUILDING: _____ B. WING _____	08/05/2016

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

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each dialysis run. We [dialysis nurses] have found out that if we have something that really needs to be addressed or changed. we have to call the facility directly." RN-C restated, "I really don't think the facility looks at the sheets we send back with [R47]."
On 8/4/16, at 10:38 a.m. R47 stated he had just been moved to a new room last evening. When asked if he had the Lidocaine cream he replied, "Yes--come, I will show you." However, when R47 opened the drawer he could no find the cream. RN-D who worked on the resident's new unit could not locate the Lidocaine cream in the treatment cart. RN-D said it would have been left in the treatment cart on the unit where R47 resided until last evening. At 12:58 p.m. however, LPN-H reported she was unable to find the cream."
Later, at 2:14 p.m. the administrator and RN-E verified R47 should have been assessed prior to self-administering medication.
R20
R20 was observed on 8/3/16, at 10:01 a.m. lying on bed on right side, eyes open, with nebulizer mask over face, with machine running. During continuous observation at 10:07 a.m. R20 was observed with eyes closed nebulizer mask still in place, machine running. One minute later trained medication assistant (TMA)-C walked down the hall and looked in R20's room and then walked away. At 10:26 a.m. R20 was observed lying on the right side with the nebulizer mask on face, machine running with no steam going into the mask.

R20's quarterly Minimum Data Set dated 7/29/16, indicated R20 had short and long term memory problems, had severely impaired daily decision making skills, and had delirium present, which fluctuated. R20's Care Area Assessment (CAA)

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21565	Continued From page 54 dated 4/06/16, triggered for Cognitive Loss/Dementia and indicated R20 had, "Decreased ability to make self understood or to understand others." On 8/3/16, at 10:05 a.m. TMA-C stated the nurse came down from station 3 and did residents' tube feedings and insulins. TMA-C stated she was trained to pass medications and administer nebulizer treatments. At 10:26 a.m. TMA-C stated R20 got up for breakfast, had his morning medications and went back to bed. TMA-C stated R20 would put on the nebulizer mask himself. TMA-C stated she would go and take the mask off of R20. TMA-C stated she had not applied the nebulizer treatment for R20, that he must have put it on himself. At 10:33 a.m. TMA-C verified the nebulizer mask was on R20's face and that the machine was running, that the cylinder was partially full with medication and no steam was going into the mask. TMA-C stated she had not given R20 his nebulizer mask, nor had she filled the cylinder with medication. TMA-C verified written on the outside of the cylinder in black marker, "8/2/16, 2 p.m." TMA-C stated she had not been aware there was medication in the cylinder nor had she been aware that R20 had his nebulizer in place with the machine running. TMA-C stated R20 only received prn (as needed) nebulizer treatments and that she would call licensed practical nurse (LPN)-E to see if she had given R20 his treatment. TMA-C proceeded to call LPN-E and was told LPN-E had not applied R20's nebulizer treatment. TMA-C stated R20's machine must not be working since R20 had had his nebulizer treatment running for approximately half hour and was still only half full. TMA-C stated the cylinder was dated 8/2/16, 2 p.m. since cylinders were dated when changing out with a new one once a week. TMA-C stated she had not	21565		

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been the one that had written the date and time when the cylinder was replaced. TMA-C stated it would be the day nurse yesterday who would have exchanged cylinders.TMA-C stated she did not know who gave the last nebulizer treatment to R20 as it had not been initialed in the TAR.

TMA-C stated when she gave R20 a nebulizer treatment, she would put the medication in the cylinder and put the mask on R20's face and leave the room and come back when the treatment was finished. TMA-C stated she would come back in about 2-3 minutes as the treatment did not take long to run. TMA-C stated when giving R20 a nebulizer treatment she would initial on the front of the TAR and write on the back as it was a PRN treatment. TMA-C stated R20 was not supposed to do his own nebulizer treatment.

On 8/3/16, at 2:30 p.m. LPN-I stated she had worked the previous evening, had not changed R20's cylinder at 2 p.m. and had not given R20 a nebulizer treatment. LPN-I stated when she gave R20 a nebulizer treatment she would have to stay in R20's room during the treatment as R20 would take the mask off and throw it on the floor. LPN-I stated R20 had severe chronic obstruction pulmonary disease (COPD).

On 8/4/16, at 9:46 a.m. LPN-J stated she had replaced R20's tubing and cylinder and labeled the new cylinder 8/2/16, 2 p.m. as that was the date and time. LPN-J stated she had given R20 a nebulizer treatment as R20 was kind of wheezing and when he exerted himself. LPN-J stated she had checked R20's oxygen saturations and they had been a little low before applying the nebulizer treatment. LPN-J verified she had not documented anything about the PRN nebulizer treatment given to R20. LPN-J stated after 10

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21565	Continued From page 56 minutes there was still medication left in R20's cylinder and she noticed the machine was not working correctly. She stated she had not known who to tell about the machine not working and had told the oncoming evening nurse about it. LPN-J stated she had not given a nebulizer treatment to R20 at 2 p.m. but at 10:00 a.m. and verified she had not documented it. LPN-J stated R20 will put his nebulizer mask on himself and when then, "asked if he wants a treatment will shake his head and say yes " LPN-J stated R20 will keep his mask on until she returns and LPN-J stated she thought R20 could be alone with his treatment as she thought a self-administration assessment had been completed on R20 in July. but had not seen the assessment or any indication of a self administration assessment in the resident's chart. On 8/4/16, at 10:40 a.m. LPN-E stated she had not given R20 a nebulizer the day before nor had TMA-C asked her to give one. LPN-E stated she normally left R20 alone in his room with the mask on as she believed R20 had an assessment completed at one time to self-administer but could not verify in the record one had been completed for R20. R20's August 2016 physician orders included: "Ipratropium-Albuterol 0.5-3 mg/3 Ampu-Neb Nebulize 1 vial by mouth every 4 hours as needed dated 7/16/16" and "Document Heart Rate Before And After Treatment, Document Respirations Before And After Treatment." R20's August MAR showed no initials by nurse or TMA regarding any nebulizer treatment given or any pre or post nebulizer treatment respiratory assessments completed for R20.	21565		

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21565	Continued From page 57 R20's current care plan indicated, "The resident [R20] has a physician's order for supervised self-administration of the following medications: Nebs" date initiated 4/28/14, and also indicated for Goal, "The resident [R20] will take medications safely and as prescribed through the review date, " dated initiated 4/28/14 and also indicated, "Review medication self-administration with resident [R20] /monthly and as needed to reassess abilities," Dated initiated 4/28/14. On 8/4/16, at 10:47 a.m. ADON stated the facility had been talking about the self-administration assessments and would need to correct and educate staff regarding self-administration assessments. ADON stated there had to be an assessment completed to know the resident is safe to administer medication. SUGGESTED METHOD OF CORRECTION: The DON or designee could train and educate staff regarding Self Administration of Medication assessments for residents. They could conduct random audits of resident assessments to ensure appropriateness to self administer medication. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		