DEPARTMENT OF HEALTH						DICARE & MEDICAID SERVICES		
	-		-		AND TRANSMITTAL	ID: 9DEF		
		TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00175		
1. MEDICARE/MEDICAID PROVIDER (L1) 245203	NO.	3. NAME AND AL (L3) THE VILLA				4. TYPE OF ACTION: <u>7 (</u> L8)		
2.STATE VENDOR OR MEDICAID NO	1	(L4) 275 PENN AVENUE NORTH				1. Initial 2. Recertification		
(L2) <b>1780028878</b>	-	(L5) MINNEAPO			(L6) <b>55405</b>	3. Termination     4. CHOW       5. Validation     6. Complaint		
5. EFFECTIVE DATE CHANGE OF OV	WNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9) <b>08/01/2013</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 11/18/2	<b>016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID				
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		·		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b) :			equirements		2. Technical Personnel	6. Scope of Services Limit		
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director		
12. Total Facility Beds	120 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	(F) 8. Patient Room Size		
13.Total Certified Beds	<b>120</b> (L17)	B. Not in Comp	liance with Progra	am	X_5. Life Safety Code	9. Beds/Room		
			and/or Applied V		* Code: A,5	(L12)		
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
120								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
			0.00.001.0					
Carrie Euerle, HFE N	EII	1	2/22/2016	(L19)	Mark Meath,	Enforcement Specialist 12/22/2016 (L20)		
PAR	Г II - ТО ВЕ	COMPLETED H	BY HCFA RE	GIONAI	OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILIT	Ϋ́		IPLIANCE WITH	H CIVIL		ncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Par	ticipate	RIGH	ITS ACT:		<ol> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
2. Facility is not Eligible					5. Bour of the ricove			
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	6 DATE	ENDING DA	ГЕ	VOLUNTARY 00	INVOLUNTARY		
10/01/1978					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ě		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	D. Descoind St	uspension Date:	(L44)			00-Active		
	D. Rescilla S	ispension Date.	(L45)					
28. TERMINATION DATE:	20	. INTERMEDIARY/	. ,		30. REMARKS			
20. TERMININGO DITE.	27		e. indulier no.		So. Alam nako			
	(1.28)	00270		(1.21)				
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(1.22)	09/19/2016		(122)				
	(L32)			(L33)	DETERMINATION APPI	XU VAL		

# 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

### 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 facility achieved and maintained compliance with Federal participation requirements, 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.



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



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

The Villa At Bryn Mawr December 22, 2016 Page 2

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

## **POST-CERTIFICATION REVISIT REPORT**

				DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245203 <sub>Y1</sub>	B. Wing	Y2	2.	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 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	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix F0309	Correction	ID Prefix F0322	Correction	ID Prefix	Correction
Reg. # 483.25	Completed	Reg. # 483.25	(g)(2) Completed	Reg. #	Completed
LSC	11/03/2016	LSC	11/03/2016	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	
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) GL/mm	<b>DATE</b> 12/22/2016	SIGNATURE OF SURVEYOR 31591		<b>DATE</b> 11/18/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY 8/5/2016	COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)		



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

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	SIT
00175 <sub>Y1</sub>	B. Wing	Y	′2	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).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20830	Correction	ID Prefix 2093	30	Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.0 Subp. 1	Completed	Reg. # Subp.	Rule 4658.0525 . 7 B.	Completed	Reg. #		Completed
LSC		11/03/2016			11/03/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC						LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
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		
REVIEW		REVIEWED BY (INITIALS) GL/mm	<b>DATE</b> 12/22/2016	SIGNATURE OF S	URVEYOR 315	91	<b>DATE</b> 11/18	/2016
REVIEW 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?					

DEPARTMENT OF HEALTH	. –					DICARE & MEDICAID SERVICES		
					ND TRANSMITTAL	ID: 9DEF		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00175		
1. MEDICARE/MEDICAID PROVIDE	R NO.	3. NAME AND AL				4. TYPE OF ACTION: $\underline{7}$ (L8)		
(L1) <b>245203</b>		(L3) THE VILLA				1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID N (L2) 1780028878	0.	(L4) 275 PENN A		IH	(L6) <b>55405</b>	3. Termination 4. CHOW		
(12) 1780028878		(L5) MINNEAPO	olis, mn		(L0) 55405	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF C	WNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey After Complaint		
(L9) <b>08/01/2013</b>		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. Fun Survey Arter Compraint		
6. DATE OF SURVEY <b>10/05</b> /		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID				
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia			And/Or Approved Waivers Of	The Following Requirements:		
To (b):		•	quirements		2. Technical Personnel	0		
		Compliance	Based On:		3. 24 Hour RN	7. Medical Director		
		1. A	cceptable POC		4. 7-Day RN (Rural SN			
12.Total Facility Beds	120 (L18)	**			X 5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	<b>120</b> (L17)	X B. Not in Con Requirements	pliance with Prog and/or Applied V	-	* Code: <b>B</b> , 5	(L12)		
14. LTC CERTIFIED BED BREAKDO	J/N	requirements	and/or Applied v	varvers.	* Code: <b>B</b> , 5 15. FACILITY MEETS	(E12)		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
120	19 5141	ici	IID		1801 (c) (1) 01 1801 (j) (1).	(2.2)		
(L37) (L38)	(L39)	(L42)	(L43)					
16 CTATE OLIDARY A CENCY DEMA			NCELLATION	DATE).				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LIC CA	INCELLATION I	DALE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Mary Bruess, HFE NEII		1	0/27/2016		mark mark	, Enforcement Specialist 11/23/2016		
				(L19)		(L20)		
PAR	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILI	TY		PLIANCE WITH	I CIVIL		ncial Solvency (HCFA-2572)		
<b>X</b> 1. Facility is Eligible to Pa	articipate	RIGE	ITS ACT:		<ol> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
2. Facility is not Eligible						·		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNINC	G DATE	ENDING DAT	ГЕ	VOLUNTARY _00	INVOLUNTARY		
10/01/1978					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n OTHER		
		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
			(L44)			00-Active		
(L27)	B. Rescind St	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		00270						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539								
	32	2. DETERMINATION	OF APPROVAL	DATE				
	32 (L32)	2. DETERMINATION 09/19/2016	OF APPROVAL	(L33)	DETERMINATION APPI	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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.



#### 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

DEPAR	<b>FMENT OF HEALTH</b>	AND HUMAN SERVICES		P	RINTED: 10/19/2 FORMAPPRO
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	•		MB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245203	B. WING	· · · · · · · · · · · · · · · · · · ·	R 10/05/2016
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE VIL	LA AT BRYN MAWR		2	75 PENN AVENUE NORTH	
			N	IINNEAPOLIS, MN 55405	
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{F 000}	INITIAL COMMEN	rs	{F 000}	F000	
{F 309} SS=D	completed on Octo deficiencies found orevisit can be found Deficiencies found onsite PCR are dile 2567. Investigation of con which was substant the survey, was fou Investigation of con which was substant the survey, was fou 483.25 PROVIDE O HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care.	receive and the facility must $\chi$ ary care and services to attain ( nest practicable physical,	{F 309} 0( pteto y farin y for 211	<ul> <li>Please accept the following as the facilities credible allegation of compliance.</li> <li>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-compliant with any State or Federal standard, requirements or regulations.</li> <li>F309</li> <li>R47 was reviewed by IDT.</li> <li>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 and a bases and a submitted of the surveyors. All residents and a base and a base and b</li></ul>	d ce
	review, the facility	alled to ensure care was ely and services were 2 resident (R47) receiving		currently receiving dialysis had their care plans reviewed and updated as warranted to ensure	
	Findings include:			compliance. The policy and	
ABORATORY	DIRECTOR'S ON PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE

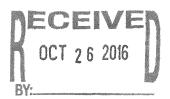
Any deficiency statement ending with abusterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

PRINTED: 10/19/2016

		& MEDICAID SERVICES			C		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	03/2016
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			,	N	MINNEAPOLIS, MN 55405		
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{F 309}	Continued From pa	ge 1 <sub>.</sub>	{F 3	09}	procedure for dialysis		
					communication was		
		dialysis on 10/5/16, at 1:39 e reported he went to dialysis			reviewed and remains		
2		eek on Monday, Wednesday			current. Licensed nursing		
		an undated dressing in place			staff have been in-serviced		
		tal space. R47 further d not feel staff was providing			on the policy and procedur	re	
		lated to his dialysis. Examples			for residents receiving		
		his blood pressure when he			dialysis services. In servicin	g	
		sis, not applying Lidocaine (a tion) regularly to his dialysis			completed by the Director	of	
	site as ordered, and	providing no care related to			Nursing (DON)/ or designed		
		aid the dialysis put on the s itnobody does anything			The facility also implement	ed	
	here. I just take it o	ff myself when I know the			the use of an electronic		
	bleeding has stopp	ed." He denied carrying			medication and treatment		
		tion report sheets between sis center explaining that they			administration system. A		
		ports back and forth.			weekly audit of all resident:	s ,	
	A physician's order	written for R47 dated			receiving dialysis services w		
	11/16/15, directed s	taff to check blood pressure			be conducted for the next a		
		(Monday, Wednesday, Friday) cation administration sheets			months to ensure		
		tment administration sheets			compliance. Audits to be		
	(TAR) indicated a b	lood pressure was taken only			completed by the DON/	*	
	once since the facil	ity's correction date of 9/7/16.			designee. The results of the		
		2/16, directed staff to check			audits will be reviewed in th		
		nsure fistula access site			monthly QA meetings and	:	
	the MAR and TAR r	and as needed. Review of revealed the order was not			audits will continue as		
	followed as written.				warranted. The DON will be		
	An order written 0/1	2/16, directed staff to apply a			responsible for maintaining		
	small amount of Lic	locaine cream 2.5% to skin			compliance. Compliance da		
	three times weekly dialysis. The MAR a	as directed 60 minutes prior to and TAR were not signed off eived the cream as ordered.			11/03/2016.		
				]		ana ana ang	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00175



PRINTED: 10/19/2016

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES			F	NTED: 10/19/201 FORM APPROVE
STATEMEN'	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	l'	B NO. 0938-039 (3) DATE SURVEY COMPLETED
		245203	B. WING			R
NAME OF	PROVIDER OR SUPPLIER		. I.	STREET ADDRESS, CITY, STATE, ZI	P CODE	10/05/2016
THE VIL	LA AT BRYN MAWR			275 PENN AVENUE NORTH		
				MINNEAPOLIS, MN 55405		
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{F 309}	Continued From pa	ige 2	{F 30	9}		
	The physician's ord and TAR, lacked di R47's dialysis dress	ler sheet, as well as the MAR rection regarding care of sing.				
	physician, the MAR weigh R47 on dialys weights had been d correction date. In monitored for signs shift, however the d	vas not written by the and TAR directed staff to sis days. A total of three ocumented since the facility's addition, the site was to be of infection or bleeding every ocumentation lacked oring was consistently being				
	R47's nursing progr documentation cond assessments from t present.	ess notes lacked cerning dialysis care and he correction date through				
	when going to dialys communication she dialysis center to fill current dialysis run i stated communication dialysis center. The it,fill out, and fax bac chart (date initiated i plan directs staff to	an initiated 6/23/15 stated sis, R47 will bring a dialysis et in an envelope for the out and return with the results. The care plan further on forms will be faxed to dialysys center will review okto be entered in the resident 8/5/16). In addition, the care dressing daily ataccess site				
	per dialysis instructionsheets. -obtain weight three days. -after dialysis, check infection and or s/s subleeding.	ons. Document on treatment times each week on dialysis t the site and monitor for Digns and symptoms) of				
		bruit qevery shift and as				
RM CMS-250	67(02-99) Previous Versions (	Obsolete Event ID: 9DEF12	F	Facility ID: 00175	16	

Facility ID: 00175

If continuation sheet Page 3 of 8

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES			FORM	: 10/19/2016 APPROVED
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{F 322} SS=D	Infection to the accel warmth or drainage During an interview director of nursing (I care and services w regular basis for R4 the physician's order followed to obtain the minimize risks for R was no physician's or dialysis dressing. In that although the dial being faxed to and fit had actually only tak further stated that sh pressure to be taken return from dialysis. The facility's 10/f0, H policy directed the st resident's medical re location of the cather if dialysis was done or report from dialysis in given and observation 483.25(g) (2) NG TRE RESTORE EATING and Based on the compre- resident, the facility in (1) A resident who ha alone or with assistan- tube unless the resident	report as needed any s/s of ass site (redness, swelling, on 10/5/15, at 1:44 p.m. the DON) verified that dialysis ere not being provided on a 7. She stated she expected rs and the care plan be e maximum benefits and 47. She further verified there order or monitoring of the addition, the DON explained dysis report sheets were om the facility to dialysis, this en place two-times. She he expected R47's blood hwithin 60 minutes upon demodialysis Access Care aff to document in the cord every shift as follows: ter, condition of the dressing, during the shift, any part of nurse post-dialysis being ns post dialysis. EATMENT/SERVICES - SKILLS	{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.		

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Facility ID: 00175

If continuation sheet Page 4 of 8

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T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
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PROVIDER OR SUPPLIER		4			<u>  1(</u>	0/05/2016
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	1	ı IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
unavoidable; and (2) A resident who is gastrostomy tube re- treatment and servic pneumonia, diarrhe metabolic abnormal ulcers and to restore skills. This REQUIREMEN by: Based on observati review, the facility fa according to physicia (R70) whose medica	s fed by a naso-gastric or eceives the appropriate ces to prevent aspiration a, vomiting, dehydration, ities, and nasal-pharyngeal e, if possible, normal eating T is not met as evidenced on, interview and document iled to administer medication an orders for 1 of 3 residents ation administration via	{F 3:	22)	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		
10/5/16, at 9:38 a.m (LPN)-G. LPN-G ent began setting up R70 provides feeding thro stomach) tube feeding the physician orders donned gloves. LPN was viable for 24 hou medication cups on a liquid medication and medications in water	bý licensed practical nurse ered the resident's room and D's gastrostomy (G-tube that bugh a tube inserted into the ng. LPN-G double checked and sanitized hand and G date the bag explaining it urs. LPN-G set two a washcloth, one containing a t the other crushed (also known as cocktailing					
	RS FOR MEDICARE         T OF DEFICIENCIES         OF CORRECTION         PROVIDER OR SUPPLIER         LA AT BRYN MAWR         SUMMARY STA         (EACH DEFICIENCY         REGULATORY OR L3         Continued From pa         unavoidable; and         (2) A resident who is         gastrostomy tube ret         treatment and servid         pneumonia, diarrhes         metabolic abnormal         ulcers and to restore         skills.         This REQUIREMEN         by:         Based on observation         review, the facility fa         according to physicia         (R70) whose medication ad         10/5/16, at 9:38 a.m.         (LPN)-G. LPN-G ent         began setting up R/m         provides feeding there         stomach) tube feeding         the physician orders,         donned gloves. LPN-W         was viable for 24 hou         medication sin water         medications in water	OF CORRECTION       IDENTIFICATION NUMBER:         245203         PROVIDER OR SUPPLIER         LA AT BRYN MAWR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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.	RS FOR MEDICARE & MEDICAID SERVICES         TOF DEFICIENCIES         OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245203         ROVIDER OR SUPPLIER         LA AT BRYN MAWR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Interforming         Continued From page 4       {F 3         Unavoidable; and       {F 3         (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 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	RS FOR MEDICARE & MEDICAID SERVICES         TOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIA A BUILDIN         245203       B. WING         PROVIDER OR SUPPLIER       245203       B. WING         LAAT BRYN MAWR       Image: Construction of Deficiences       Image: Construction of Deficiences       Image: Construction of Deficiences         REGULATORY OR LSC IDENTIFYING INFORMATION)       PAEFIX       TAG         Continued From page 4       (F 322)         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, diarthea, 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.         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LPN-G then explained and checked	RS FOR MEDICARE & MEDICARD SERVICES       O         OF OF DEFICIENCY       (X1) PHOVIDEFIGUEPRIEPCIENCIA DOBATECATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         PROVIDER OR SUPPLER       245203       B       WING         PROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE       275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER PLAN OF CORRECTIVE ATION SPLUEN (EACH CORRECTIVE ACTION SPLUEN REGULATION OF USC DENTIFYING INFORMATION)         Continued From page 4 unavoidable; and       ID       PROVIDER PLAN OF CORRECTIVE ATION SPLUEN (EACH CORRECTIVE ATION SPLUENCY)         Continued From page 4 unavoidable; and       (F 322)       implemented the use of an electronic medications and treatment and services the appropriate froatment and services the appropriate froatment and services the appropriate froatment and services and nasa-plaryngeal ulcers and to restore, if possible, normal eating skills.       (F 322)         This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administration via gastrostomy tube was observed.       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 datu 11/03/2016.         Findings include:       R70's medication administration via gastrostomy tube feeding. LPN-G ducb thecked       11/03/2016.         Findings include:       R70's medication administration via gastrostom	RS FOR MEDICARE & MEDICATO SERVICES     OND NO       OF OF PERCENCIONS     (C) PROVIDERSUPPLIERLY     A BULLING       A BULLING     A BULLING       245203     e. wing       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZP CODE       2AAT BRYN MAWR     ZF PENN VIENUE NORTH       MINNEAPOLIS, MI SSAOS     PROVIDERS PLAN OF CONFICTION       SUMMARY STATEMENT OF DEFIDENCIES     PROVIDERS PLAN OF CONFICTION       (2A T BRYN MAWR     ZF PENN VIENUE NORTH       MINNEAPOLIS, MI SSAOS     PROVIDERS PLAN OF CONFICTION       (2A T BRICH WIN IS INFORMATION)     PROVIDERS PLAN OF CONFICTION       (2) A resident who is fad by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.     (F 322)       This REQUIREMENT is not met as evidenced by:     Street Addits will be done by the DON/designee       The results of the audits will cortinue as warranted. The DON or designee will be responsible for maintaining compliance. Audits will be done by the Goding LPN-G double checked in the results of the audits will continue as warranted. The DON or designee will be responsible for maintaining compliance. Compliance date 11/03/2016.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00175

If continuation sheet Page 5 of 8

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 10/19/2016
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					MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
	administered the liq cc's of water. LPN-C medication that may to continue to flow in then recapped the fir reduced the amount system. LPN-G ther syringe to stir medic said the cup contain medications in wate medications and wa pour the cocktailed r of the syringe, with g down the tube into F used another 30 cc's and proceeded with physician orders. R70's 10/16, physicia- Provide Isosource including at 10:00 a. -100 milliliters (cc's) feeding -Check placement of food or medications -Do not cocktail med -Check residual ever Medication orders fo -Amlodipine besylate (Norvasc) 1 tab via g hypertension -Atenolol 25 mg tab, morning for hyperten Certavite-Antioxidan morning for osteopor	water into the tube and uid medication, followed by 30 G explained this allowed the y have been stuck in the tube nto R70 for absorption. LPN-G eeding tube, stating this t of air flowing into R70's n used the open end of the pations in the second cup, and ted several crushed r. After stirring the ter, the nurse proceeded to medications into the open end gravity pulling the mediation R70's system. LPN-G then is of water to flush the tube the enteral feeding per an orders directed staff to: 1.5 1 box six times daily m. water flush before and after if tube prior to administering lications ry shift and enter amount r 10/16 included: 10 milligram (mg) tab i-tube every morning for 1 tab via g-tube every sion it 1 tab via g-tube every rosis	{F 3;	22)			
-		ab, 1 tab every morning for					

FORM CMS-2567 (02-99) Previous Versions Obsolete

Facility ID: 00175

If continuation sheet Page 6 of 8

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P	RINTE	D: 10/19/201	16
CENTE	<b>RS FOR MEDICARE</b>	& MEDICAID SERVICES				FOR	MAPPROVE	D
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) D	O <u>. 0938-039</u> ATE SURVEY DMPLETED	<u>11</u>
		245203	B. WING	;			R	
NAME OF	PROVIDER OR SUPPLIER	I	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1	0/05/2016	
THE VIL	LA AT BRYN MAWR				275 PENN AVENUE NORTH			
	······				MINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	-clonidine HCL 0.1 r morning for hyperte -lisinopril 20 mg, 1 t for hypertension -loratadine (Claritin) daily for allergic rhin -gabapentin 400 mg three times daily for R70's annual Minim 7/13/16, indicated R Nutritional Care Plan nutritional problem a g-tube for total muta dysphagia (swallowi interventions directe medications as orde for side effects and c and provide Isosourc The care plan also d medications. On 10/5/16, at 10:58 (DON) stated an ord Medications" referred medication could hav then flushed and and one medication shou On 10/5/16, at 11:02 white binder book will stated he had crushe certavite, citalopram, and gabapentin into a adminsitered the med specifically about the	ng tab 1 tab via g-tube every nsion ab via g-tube every morning 10 mg tab, 1 tab via g-tube itis capsule, 1 cap via g-tube pain um Data Set (MDS) dated 70 had a feeding tube. A n indicated R70 had a und used had tube feeding via tional/fluid intake due to ng disorder). Care Plan d staff to administer red and to monitor/document effectiveness and to provide ce 1.5 and flush as ordered. irected staff to not cocktail a.m. the director of nursing er that read "Do Not Cocktail d to both liquid and crushed N explained that one ve been mixed with water, other given, but no more than Id have been given at a time. a.m. LPN-G referred to a th tube feeding orders and ed atenolol, Norvasc, clonidine, lisinopril, Claritin one cup, added water and dicaiton to R70. When asked "Do Not Cocktail .PN-G stated the order	{F 3:	22}				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00175

If continuation sheet Page 7 of 8

	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			OMB NC	1 APPROVE ). 0938-039
	F CORRECTION	IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	- (X3) DATE SURVEY COMPLETED	
		245203	B. WING		10	R / <b>05/2016</b>
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP C	ODE	00/2010
	A AT BRYN MAWR			275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID Prefix Tag				PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{F 322}	Continued From pa	ge 7	{F 322]	}		
	(RN)-E stated an or Medications" mean medications and giv confirmed that putti medications into on	D a.m. registered nurse der of "Do Not Cocktail t they were not to co-mingle ve them together. She ng multiple crushed e medication cup, stirring, and ner was considered cocktailing				
	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.		-			
		<u>N</u>				
	87 (02-99) Previous Versions (	Dbsolete Event ID:9DEF12		cility ID: 00175		

## **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245203 <sub>Y1</sub>	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	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		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. #	(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) GL/mm	<b>DATE</b> 10/19/2016	SIGNATURE OF SURVEYOR 330	)43		те )/05/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DA	TE
FOLLOWUP TO SURVE	COMPLETED ON		R ANY UNCORRECTED DEFICIEN TED DEFICIENCIES (CMS-2567)	NCIES. WAS SENT TO TH		YES 🗌 NO



### 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 <u>\$700.00</u> per day beginning on the day you receive this notice.

The Villa At Bryn Mawr November 21, 2016

Page 2

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

Minneso	ta Department of He	alth			T OT MIT AT THOTED
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00175	B. WING		R 10/05/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
THE VILI	_A AT BRYN MAWR		NAVENUE NO POLIS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{2 000}	Initial Comments		{2 000}		
	*****ATTEI	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the	nether a violation has been			
	comply with any of lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.			
	Minnesota Departm on-site revisit to foll issued as a result o August 5, 2016. Du determined that the	TS: 5, 2016, surveyors of the hent of Health completed an ow up on licensing orders f a survey completed on ring this onsite visit it was following corrections orders 1 and 4658.0525 Subpart 7B			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
					10/	05/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
THE VILI	A AT BRYN MAWR		NAVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 000}	Continued From pa	ge 1	{2 000}			
	will be reviewed at	ders will remain in effect and the next onsite visit. Also will be reviewed for possible				
	the State Licensing federal software. Ta assigned to Minnes nursing homes. The appears in the far le Tag." The state stat corresponding text compliance is listed of Deficiencies" coll Comply" portion of column also include violation of the state "This Rule is not me the surveyors finding	hent of Health is documenting Correction Orders using the ag numbers have been sota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule number and the of the state statute/rule out of d in the "Summary Statement umn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidenced by." Following ngs are the Suggested Method ne Time Period for Correction.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
{2 830}	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	{2 830}			
	receive nursing car	general. A resident must e and treatment, personal and supervision based on				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED
		00175	D. WING		10/	05/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
THE VILI	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
{2 830}	Continued From pa	ge 2	{2 830}			
	individual needs an	d preferences as identified in				
		resident assessment and				
		scribed in parts 4658.0400 and				
		ing home resident must be out				
		possible unless there is a				
		he attending physician that the				
		in in bed or the resident				
	prefers to remain in	ı bed.				
	This MN Requirem	ent is not met as evidenced				
	by:					
		on, interview and document				
		ailed to ensure care was				
	provided appropriat	ely and services were				
		f 1 resident (R47) receiving				
	dialysis.					
	Findings include:					
	R47 returned from	dialysis on 10/5/16, at 1:39				
		e reported he went to dialysis				
		eek on Monday, Wednesday				
		an undated dressing in place				
		ital space. R47 further				
		id not feel staff was providing				
		lated to his dialysis. Examples				
		his blood pressure when he				
		sis, not applying Lidocaine (a				
		tion) regularly to his dialysis d providing no care related to				
		aid the dialysis put on the				
		is it-nobody does anything				
		ff myself when I know the				
		ed." He denied carrying				
		tion report sheets between				
		sis center explaining that they				
	instead faxed the re	eports back and forth.				

	a Department of He				1	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING			R 0 <b>5/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	A AT BRYN MAWR		N AVENUE NO			
			POLIS, MN 55		000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 3	{2 830}			
	11/16/15, directed s three times weekly however,r the medi (MAR) and the trea (TAR) indicated a b once since the facil An order written 9/2 thrill and bruit (to er function) every shift the MAR and TAR r followed as written. An order written 9/1 small amount of Lic three times weekly dialysis. The MAR a to indicate R47 rece The physician's ord and TAR, lacked dia R47's dialysis dress Although an order w physician, the MAR weigh R47 on dialys weights had been d correction date. In monitored for signs shift, however the o	<ul> <li>12/16, directed staff to apply a docaine cream 2.5% to skin as directed 60 minutes prior to and TAR were not signed off eived the cream as ordered.</li> <li>ler sheet, as well as the MAR rection regarding care of sing.</li> <li>was not written by the a and TAR directed staff to sis days. A total of three documented since the facility's addition, the site was to be of infection or bleeding every documentation lacked oring was consistently being</li> </ul>				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00175		CONSTRUCTION	(X3) DATE SURVE COMPLETED R 10/05/201	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		10,	
			N AVENUE NO			
THE VILI	LA AT BRYN MAWR		POLIS, MN 55			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC			
{2 830}	Continued From pa	ge 4	{2 830}			
	director of nursing ( care and services w regular basis for R4 the physician's orde followed to obtain the minimize risks for F was no physician's dialysis dressing. In that although the di being faxed to and had actually only ta further stated that se pressure to be take return from dialysis The facility's 10/10, policy directed the se resident's medical n location of the cather if dialysis was done	Hemodialysis Access Care staff to document in the record every shift as follows: eter, condition of the dressing, during the shift, any part of nurse post-dialysis being				
2 930	-	5 Subp. 7 B. Rehab -	2 930			
	and feeding syringes. Based o	ric tubes, gastrostomy tubes, n the comprehensive resident sing home must ensure that:				
	gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab	who is fed by a nasogastric or r feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, olic abnormalities, and lcers and to restore, if eding function.				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	СОМ	E SURVEY PLETED R
		00175	B. WING		10/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		275 PEN	N AVENUE NO	DRTH		
	LA AT BRYN MAWR	MINNEA	POLIS, MN 55	5405		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLET DATE
TAG			TAG	DEFICIENC		
2 930	Continued From no	~~ F	2 930			
2 930	Continued From pa	ige 5	2 930			
		ent is not met as evidenced				
	by:	ent is not met as evidenced				
		on, interview and document				
		ailed to administer medication				
		ian orders for 1 of 3 residents				
		ation administration via				
	gastrostomy tube w	vas observed.				
	Findings include:					
	DZ0la madiaatian a	desiriate ation was also an ed ar				
		dministration was observed or n. by licensed practical nurse	1			
		itered the resident's room and				
		70's gastrostomy (G-tube that				
		rough a tube inserted into the				
		ling. LPN-G double checked				
		s, and sanitized hand and				
		N-G date the bag explaining it				
	was viable for 24 ho	ours. LPN-G set two				
		a washcloth, one containing a	a			
		nd the other crushed				
		er (also known as cocktailing				
	,	G then explained and checked				
		70's feeding tube. LPN-G then				
		water into the tube and				
		uid medication, followed by 30 G explained this allowed the	)			
		y have been stuck in the tube				
		nto R70 for absorption. LPN-G				
		feeding tube, stating this				
		it of air flowing into R70's				
		n used the open end of the				
		cations in the second cup, and				
		ned several crushed				
	medications in wate					
	medications and wa	ater, the nurse proceeded to				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED R
		00175	B. WING		10/05/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
HE VILI	A AT BRYN MAWR		AVENUE NO OLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 930	Continued From pa	ige 6	2 930			
	of the syringe, with down the tube into used another 30 cc and proceeded with physician orders. R70's 10/16, physic - Provide Isosource including at 10:00 a -100 milliliters (cc's feeding -Check placement food or medications -Do not cocktail me -Check residual eve Medication orders f -Amlodipine besyla (Norvasc) 1 tab via hypertension -Atenolol 25 mg tak morning for hyperte -Certavite-Antioxida morning for osteop -citalopram 20 mg depression -clonidine HCL 0.1 morning for hyperte -lisinopril 20 mg, 1 for hypertension -loratadine (Claritin daily for allergic rhi	) water flush before and after of tube prior to administering edications ery shift and enter amount for 10/16 included: te 10 milligram (mg) tab g-tube every morning for o, 1 tab via g-tube every ension ant 1 tab via g-tube every orosis tab, 1 tab every morning for mg tab 1 tab via g-tube every ension tab via g-tube every morning tab 1 tab via g-tube every ension				
	7/13/16, indicated I Nutritional Care Pla	r pain num Data Set (MDS) dated R70 had a feeding tube. A an indicated R70 had a and used had tube feeding via				

If continuation sheet 7 of 9

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00175			10/	10/05/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S <sup>-</sup> NAVENUE NO				
THE VIL	LA AT BRYN MAWR		POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 930	Continued From pa	age 7	2 930				
	dysphagia (swallow interventions direct medications as ord for side effects and and provide Isosou The care plan also medications. On 10/5/16, at 10:5 (DON) stated an or Medications" referr medication. The DO medication could h then flushed and ar one medication sho On 10/5/16, at 11:0 white binder book w stated he had crust certavite, citaloprar and gabapentin into	ational/fluid intake due to <i>v</i> ing disorder). Care Plan ed staff to administer ered and to monitor/document l effectiveness and to provide rce 1.5 and flush as ordered. directed staff to not cocktail 68 a.m. the director of nursing rder that read "Do Not Cocktail ed to both liquid and crushed DN explained that one ave been mixed with water, nother given, but no more than buld have been given at a time. 2 a.m. LPN-G referred to a with tube feeding orders and hed atenolol, Norvasc, n, clonidine, lisinopril, Claritin p one cup, added water and redicaiton to R70. When asked he "Do Not Cocktail					
	Medications" order, referred to liquid m On 10/5/16, at 11:1	, LPN-G stated the order					
	Medications" mean medications and gi confirmed that putti medications into or	t they were not to co-mingle ve them together. She ing multiple crushed ne medication cup, stirring, and ther was considered cocktailing					
	2011) policy directed than one medication	al Tube (Med-Pass, revised ed staff if administering more n, to flush with at least 15 ml unt) warm sterile water					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	(X3) DATE SURVEY COMPLETED	
		00175	B. WING			R 0 <b>5/2016</b>	
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE			
HE VILI	LA AT BRYN MAWR		NN AVENUE NO APOLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 930	Continued From pa	age 8	2 930				
	between medicatio	ns.					

### STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	SIT
	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		DAT	E I	ТЕМ		DATE	ITEM		DATE
Y4		Y5	5	Y4		Y5	Y4		Y5
ID Prefix	20302	Correc	tion ID Pr	efix 205	65	Correction	ID Prefix	21000	Correction
Reg. #	MN State Statu 144.6503	te Compl	eted Reg.	# Subp	Rule 4658.0405 p. 3	Completed	Reg. #	MN Rule 4658.061 Subp. 4	0 Completed
LSC		10/05/2	016 LSC			10/05/2016	LSC		10/05/2016
ID Prefix	21426	Correc	tion ID Pr	efix 214	35	Correction	ID Prefix	21475	Correction
Reg. #	MN St. Statute Subd. 3	Compl	eted Reg.	# MN Subp	Rule 4658.0900 p. 1	Completed	Reg. #	MN Rule 4658.100 Subp. 1	Completed
LSC		10/05/2	016 LSC			10/05/2016	LSC		10/05/2016
ID Prefix	21550	Correc	tion ID Pr	efix 215	65	Correction	ID Prefix		Correction
Reg. #	MN Rule 4658. <sup>-</sup> Subp. 1	Compl	eted Reg.	# MN	Rule 4658.1325 p. 4	Completed	Reg. #		Completed
LSC		10/05/2	016 LSC			10/05/2016	LSC		
ID Prefix		Correc	tion ID Pr	efix		Correction	ID Prefix		Correction
Reg. #		Compl	eted Reg.	#		Completed	Reg. #		Completed
LSC			LSC			_	LSC		
ID Prefix		Correc	tion ID Pr	efix		Correction	ID Prefix		Correction
Reg. #		Compl	eted Reg.	#		Completed	Reg. #		Completed
LSC			LSC			_	LSC		
REVIEWED BY STATE AGENCYREVIEWED BY (INITIALS) GL/mm			DATE SIGNATURE OF 10/19/2016		F SURVEYOR 33043			<b>DATE</b> 10/05/2016	
REVIEWED BY CMS RO			DATI		TITLE			1	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?					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

## **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					ND TRANSMITTAL E SURVEY AGENCY			9DEF cility ID: 00175
1. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245203           2.STATE VENDOR OR MEDICAID NO.         (L2)           1780028878	0.	3. NAME AND ADD (L3) THE VILLA (L4) 275 PENN AV (L5) MINNEAPOI	AT BRYN MAWR /ENUE NORTH		(L6) <b>55405</b>		<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 08/01/2013	VERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 C	LIA	<ol> <li>7. On-Site Visit</li> <li>8. Full Survey After Comp</li> </ol>	9. Other plaint
6. DATE OF SURVEY     08/05/       8. ACCREDITATION STATUS:     0 Unaccredited     1 TJC       2 AOA     3 Other	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING D	NATE: (L35)
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF         18/19 SNF         120         (L37)         (L38)	120 (L18) 120 (L17) 19 SNF (L39) S (IF APPLICABLE S	X B. Not in Comp Requirements a ICF (L42)	ace With quirements Based On: cceptable POC pliance with Program and/or Applied Waive IID (L43)	IS:	And/Or Approved Waiv 2. Technical Pe 3. 24 Hour RN 4. 7-Day RN (F _X_ 5. Life Safety C * Code: <b>B</b> , 5 15. FACILITY MEETS 1861 (e) (1) or 1861 (j)	rsonnel Rural SNF) Code	Collowing Requirements: 6. Scope of Service 7. Medical Director 8. Patient Room Siz 9. Beds/Room (L12) (L15)	es Limit r
See Attached Remarks		Date :					DOVAL	
17. SURVEYOR SIGNATURE						TNICK ADDI		
Sandra Tatro, HFE N	EII		09/06/2016	(J. 19)	18. STATE SURVEY AG		Enforcement Specialis	09/16/2016
		(		(L19) GIONAL		eath,	Enforcement Specialis	st
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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 9DEF Facility ID: 00175

	TAKE I - TO BE COMPLETED DI THE SIMIE SORVET AGENCI	Facility ID: 00
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.



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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:

The Villa At Bryn Mawr August 22, 2016 Page 3

• 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.

The Villa At Bryn Mawr August 22, 2016 Page 4

# 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

The Villa At Bryn Mawr August 22, 2016 Page 6

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

PRINTED: 08/22/2016 FORM APPROVED OMB NO 0938-0391 . ۹

(EACH DEFICIENCY REGULATORY OR LS IITIAL COMMENT the facility's plan of s your allegation of epartment's accept ottom of the first p e used as verificat pon receipt of an visit of your facilit	245203		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Please accept the following as the Facility's credible allegation compliance. Please note that this POC is submitted per State a Federal requirements only and should not be considered as th facility's admission of non-compliance with any State or Feder standard, requirements or regulations. F176: It is the policy of The Villa at Bry Mawr that our facility will permit reside to self-administer their medications unless such practice for the resident is	re DATE
AT BRYN MAWR SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS IITIAL COMMENT the facility's plan of s your allegation of epartment's acception of the first p e used as verification pon receipt of an	TMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TS of correction (POC) will serve of compliance upon the otance. Your signature at the bage of the CMS-2567 form will tion of compliance. acceptable POC an on-site	ID PREFIX TAG	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Please accept the following as the Facility's credible allegation compliance. Please note that this POC is submitted per State rederal requirements only and should not be considered as th facility's admission of non-compliance with any State or Feder standard, requirements or regulations. F176: It is the policy of The Villa at Bry Mawr that our facility will permit resid to self-administer their medications	re completion DATE
(EACH DEFICIENCY REGULATORY OR LS IITIAL COMMENT the facility's plan of s your allegation of epartment's accept ottom of the first p e used as verificat pon receipt of an visit of your facilit	TMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TS of correction (POC) will serve of compliance upon the otance. Your signature at the bage of the CMS-2567 form will tion of compliance. acceptable POC an on-site	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Please accept the following as the Facility's credible allegation compliance. Please note that this POC is submitted per State Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Feder standard, requirements or regulations. F176: It is the policy of The Villa at Bry Mawr that our facility will permit reside to self-administer their medications	re completion DATE
he facility's plan of your allegation of epartment's acception of the first p totom of the first p used as verification pon receipt of an visit of your facilit	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will tion of compliance. acceptable POC an on-site	F 000	compliance. Please note that this POC is submitted per State a Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Feder standard, requirements or regulations. F176: It is the policy of The Villa at Bry Mawr that our facility will permit reside to self-administer their medications	nnd Sinna na Sinna N Sinna N
epartment's acception of the first period as verificat pon receipt of an voisit of your facilit	otance. Your signature at the bage of the CMS-2567 form will tion of compliance. acceptable POC an on-site	-	Mawr that our facility will permit resid to self-administer their medications	1
visit of your facilit				
as been attained i erification.	npliance with the regulations		deemed unsafe. If the resident wishes self-medicate, the facility Interdisciplir Team will assess cognitive, physical an	to hary
omplaints were invubstantiated at F3	vestigated. H5203050 was 22; H5203051 was		responsibility.           Plan of correction for residents cited w	<u>vith</u>
nsubstantiated. 83.10(n) RESIDEI	NT SELF-ADMINISTER	F 176	Nursing staff completed self- administration evaluations on R47 and	
e interdisciplinary	team, as defined by	U xel x	effects as a result of the observations	
ractice is safe.		29/6/16	Plan to address/prevent this deficience other residents:	y for
y: Based on interviev acility failed to ens elf-administered n	v and document review, the sure residents who nedications had been		administration evaluations on all curre residents. Nursing staff have been educated on self-administration policy	
of 2 residents (R- dministration of m indings include: 147 was interviewe	47, R20) reviewed for self nedications. ed on 8/2/16, at 4:15 p.m. R47		appropriate to self-administer medications have been reviewed by ID Inter-Disciplinary Team) and have	DT (
	rification. addition to the re- mplaints were im- bstantiated at F3 bstantiated at F4 substantiated. 3.10(n) RESIDE RUGS IF DEEME n individual reside e interdisciplinary 83-20(d)(2)(II). In actice is safe. nis REQUIREME cased on interview cility failed to ens seff-administered r seessed and/or re- of 2 residents (R- dministration of m ndings include: 47 was interview ated he attended	rification. addition to the recertification survey, mplaints were investigated. H5203050 was bstantiated at F322; H5203051 was bstantiated at F425; H5203053 was substantiated. 3.10(n) RESIDENT SELF-ADMINISTER RUGS IF DEEMED SAFE n individual resident may self-administer drugs if e interdisciplinary team, as defined by 83.20(d)(2)(ii), has determined that this actice is safe. nis REQUIREMENT is not met as evidenced ased on interview and document review, the cility failed to ensure residents who elf-administered medications had been sessed and/or reassessed as safe to do so for of 2 residents (R47, R20) reviewed for self dministration of medications. ndings include: 47 was interviewed on 8/2/16, at 4:15 p.m. R47 ated he attended renal dialysis on Mondays,	rification. addition to the recertification survey, mplaints were investigated. H5203050 was bstantiated at F322; H5203051 was bstantiated at F425; H5203053 was substantiated. 3.10(n) RESIDENT SELF-ADMINISTER RUGS IF DEEMED SAFE n individual resident may self-administer drugs if e interdisciplinary team, as defined by 83:20(d)(2)(ii), has determined that this actice is safe. nis REQUIREMENT is not met as evidenced c. ased on interview and document review, the cility failed to ensure residents who elf-administered medications had been ssessed and/or reassessed as safe to do so for of 2 residents (R47, R20) reviewed for self dministration of medications. ndings include: 47 was interviewed on 8/2/16, at 4:15 p.m. R47	rification. rification. addition to the recertification survey, mplaints were investigated. H5203050 was bstantiated at F322; H5203051 was substantiated. 3.10(n) RESIDENT SELF-ADMINISTER RUGS IF DEEMED SAFE n individual resident may self-administer drugs if e interdisciplinary team, as defined by 183-20(d)(2)(ii), has determined that this actice is safe. nis REQUIREMENT is not met as evidenced r: ased on interview and document review, the cillity failed to ensure residents who effects and a 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 deficience other residents: Nursing staff has completed self- administration evaluations on all currer residents. Nursing staff has completed self- administration evaluations on all currer residents. Nursing staff has completed self- administration evaluations on all currer residents. Nursing staff has been seessed and/or reassessed as safe to do so for of 2 residents (R47, R20) reviewed for self dministration of medications. ndings include: 47 was interviewed on 8/2/16, at 4:15 p.m. R47 ated he attended renal dialysis on Mondays,

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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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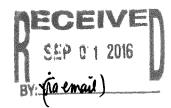
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		245203	B. WING			08/0	5/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR				75 PENN AVENUE NORTH 11NNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176	Wednesdays and f expressed concerr care by the facility here does nothing R47 explained that nurse was suppose medication Lidocai stated, "this never	Fridays. At that time, R47 is he had about his dialysis staff stating, "the nursing staff for my dialysis access site." one hour prior to dialysis the to apply a numbing ne, to his access site. He happens. I have to do it." R47	F 1	176	administer medications. All care p have been updated accordingly. So administration of medication eval will be completed upon admission quarterly, annually and PRN. If the resident is deemed safe to self-ad medications, nursing staff will req physician order to self-administer	elf- uations , then e minister uest a	
	room, and the nurs gauze to cover the why I have to do th this, but they don't.	s stored in a drawer in his be provided the resident with site. R47 stated, "I don't know is. Nursing should be doing It's been going on like this for			Education will be conducted on Au 31 <sup>st</sup> to nursing staff and will be pro at new employee orientation.	-	•
	nurse put a bandar completed, and he in the evening afte	47 explained that the dialysis ge on his arm after the run was removed the bandage himself r it stopped bleeding. When ad ever observed him apply the		• • • • •	Plan to monitor: A self-administration of medicatic and procedure along with a self- administration of medication eval		
	Lidocaine to detern medication he repl my top drawer in n R47 was outside o called for the surve bandaged. The res went to dialysis too	nine if he correctly used the ied, "No, I keep the cream in			has been implemented. To ensure compliance, the nursing managen staff or designee will conduct ran- audits of 10% of our census for th months. The results of the audit v presented to at the Quality Assur- Committee Meeting with audits	nent dom e next 3 vill be	
	R47 explained the cream, but the nur cream prior to his A Quarterly Review dated 6/16/2016 re Interview of Menta indicating a good r to communicate no care plan dated 6/	dialysis clinic ordered the se placed a bandage over the			continuing as warranted. The QA Committee will monitor complian review trends and make recommendations as necessary. <u>Responsible for maintaining comp</u> Director of Nursing <u>Completion date:</u> 9/7/16		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:9DEF11

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FORM APPROVED OMB NO. 0938-0391

245203     B. WING     08/05/2016       NAME OF PROVIDER OR SUPPLIER       THE VILLA AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZP CODE       THE VILLA AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZP CODE       THE VILLA AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZP CODE       THE VILLA AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZP CODE       THE VILLA AT BRYN MAWR       THE VILLA AT BRYN MAWR STATE, MERGEND WILLS AT THE MARGEND AD COLSPANE       THE VILLA AT BRYN MAWR       THE VILLA AT BRYN MAWR    <		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
THE VILLA AT BRYN MAWR     275 PERN AVENUE NORTH MINEAPOLIS, MN 55405       PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCIENCY MIST BE PRECEDED BY FULL (EACH CORRECTION COLOR DEFICIENCIES) (EACH CORRECTIVE ATION SHOULD BE DECOMPETING TO INSCRIPTING INFORMATION)     ID PREFIX TAG     PREFIX PREFIX     ID COMPETING TO CORRECTION (EACH CORRECTION COLOR TO CORRECTION (EACH CORRECTIVE ATION SHOULD BE DEFICIENCY)     COMPETING (EACH CORRECTION EACH CORRECTION DATE     COMPETING (EACH CORRECTION (EACH C			245203	B. WING _	· · · · · · · · · · · · · · · · · · ·	08/05/2016
PHEEX TAG       CEACH OPERCENCY MUST BE PRECEDED BY FULL REGULTIONY OR LSC IDENTIFYING INFORMATION       PREEX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY       COMMENTION DATE         F 176       Continued From page 2 Licensed practical nurse (LPN)-H who routinely worked with R47 was interviewed on 8/3/16, at 107 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 "Timself". 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."       F 176       COMPLIANCE MONTORING DIVISION         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 to nurse, and R47 had not been assessed to the surveyor that in 12/15, R47 was sent back an order from the dialysis clinic to apply Lidocaine 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 up neturining 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 appointment. RN-C stated, "I don't think the facility looks at the information sheets we send hoak with him after each dialysis nurse (harey on whave to call the facility directly." RN-C restated, "I really don't think the facility clocks at the sheets we send	-				275 PENN AVENUE NORTH	
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 1 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 for medication self-administration. RN-A reported to the access site on hour prior to his appointment. RN-A said sometimes the resident twing 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. 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. Later that day R47's dialysis nurse (RN-C) was Interviewed by telephone. She verified R47 obtained the order for Lidocaine reream from the dialysis. RN-C stated, "I don't think the facility looks at the information sheets we seme 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF	ULD BE COMPLETION
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	F 176	Licensed practical worked with R47 w 1:07 p.m. LPN-H v the Lidocaine creat explained that the resident with a tube and he performed- stated she used to dialysis appointme "now he goes befo Registered nurse ( was unaware R47 topical medication verified anyone tak should have been nurse, and R47 ha medication self-ad the surveyor that ir order from the dial the access site one RN-A said sometin the paperwork to the from dialysis. Later that day R47 interviewed by tele obtained the order dialysis center, wha access site one ho RN-C stated, "I do information sheets each dialysis run.	nurse (LPN)-H who routinely vas interviewed on 8/3/16, at erified R47 self-administered m prior to dialysis. She dialysis clinic had provided the e of the cream and a bandage, the-treatment "himself." LPN-H- help the resident when his nts were at 10:00 a.m. adding, re I start work." RN)-A stated at 1:10 p.m. she was applying prescribed to his dialysis access site. She sing or applying medications assessed as safe to do so by a d not been assessed for ministration. RN-A reported to n 12/15, R47 was sent back an ysis clinic to apply Lidocaine to e hour prior to his appointment. nes the resident did not give he facility nurse upon returning "s dialysis nurse (RN-C) was ephone. She verified R47 for Lidocaine cream from the ich was to be applied to the our prior to his appointments. n't think the facility looks at the s we send back with him after We [dialysis nurses] have-	F 1'	76 RECEIV SEP 0 \$ 20 COMPLIANCE MONITORI LICENSE AND CERTIF	16 NG DIVISION
		needs to be addre call the facility dire	ssed or changed. we have to ectly." RN-C restated, "I really			

Facility ID: 00175

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OMB NO.	0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245203	B. WING		08/0	05/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	- <b></b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176	On 8/4/16, at 10:38 been moved to a n asked if he had the "Yescome, I will s opened the drawer RN-D who worked could-not-locate th treatment cart. RN in the treatment car resided until last e LPN-H reported sh cream." Later, at 2:14 p.m.	B a.m. R47 stated he had just ew room last evening. When b Lidocaine cream he replied, show you." However, when R47 r he could no find the cream. on the resident's new unit e Lidocaine cream in the -D said it would have been left at on the unit where R47 vening. At 12:58 p.m. however, he was unable to find the the administrator and RN-E	F 176	3		
	verified R47 should self-administering	d have been assessed prior to medication.				
	on bed on right sid mask over face, w continuous observ observed with eye place, machine ru medication assista hall and looked in away. At 10:26 a.r the right side with	l on 8/3/16, at 10:01 a.m. lying le, eyes open, with nebulizer ith machine running. During ation at 10:07 a.m. R20 was s closed nebulizer mask still in nning. One minute later trained ant (TMA)-C walked down the R20's room and then walked n. R20 was observed lying on the nebulizer mask on face, with no steam going into the				
	indicated R20 had problems, had sev making skills, and fluctuated. R20's dated 4/06/16, trig Loss/Dementia an	nimum Data Set dated 7/29/16, short and long term memory verely impaired daily decision had delirium present, which Care Area Assessment (CAA) gered for Cognitive ind indicated R20 had, to make self understood or to s."			·	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ECONSTRUCTION		E SURVEY PLETED
		245203	B. WING			08/0	05/2016
	PROVIDER OR SUPPLIER	L		27	REET ADDRESS, CITY, STATE, ZIP CODE 75 PENN AVENUE NORTH INNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176		-	F	176			
	came down from s feedings and insuli trained to pass me	5 a.m. TMA-C stated the nurse tation 3 and did residents' tube ns. TMA-C stated she was dications and administer ts. At 10:26 a.m. TMA-C stated					
-	R20-got-up-for-brea	akfast, had his morning					
	R20 would put on t TMA-C stated she off of R20. TMA-C	ent back to bed. TMA-C stated the nebulizer mask himself. would go and take the mask stated she had not applied the					
	put it on himself. A	t for R20, that he must have At 10:33 a.m. TMA-C verified					
	the machine was r partially full with m going into the mas	was on R20's face and that unning, that the cylinder was edication and no steam was k. TMA-C stated she had not ulizer mask, nor had she filled			••••••		
	the cylinder with m written on the outs marker, "8/2/16, 2 not been aware the cylinder nor had sh nebulizer in place TMA-C stated R20 nebulizer treatmen	edication. TMA-C verified ide of the cylinder in black p.m." TMA-C stated she had ere was medication in the ne been aware that R20 had his with the machine running. only received prn (as needed) nts and that she would call nurse (LPN)-E to see if she had					
	given R20 his trea call LPN-E and wa R20's nebulizer trea machine must not his nebulizer treate half hour and was the cylinder was d cylinders were dat new one once a w been the one that when the cylinder	tment. TMA-C proceeded to as told LPN-E had not applied eatment. TMA-C stated R20's be working since R20 had had ment running for approximately still only half full. TMA-C stated ated 8/2/16, 2 p.m. since ed when changing out with a reek. TMA-C stated she had not had written the date and time was replaced. TMA-C stated it nurse yesterday who would					

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OMB NO. 0938-0	)391

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
	245203	B. WING		08	/05/2016
PROVIDER OR SUPPLIER	L		275 PENN AVENUE NORTH		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
have exchanged control know who gave R20 as it had not be TMA-C stated whete treatment, she wood cylinder and put the leave the room and treatment was finis come back in about did not take long to giving R20 a nebul on the front of the was a PRN treatm supposed to do his On 8/3/16, at 2:30 worked the previou R20's cylinder at 2 nebulizer treatmer R20 a nebulizer treat in R20's room durit take the mask off stated R20 had se	ylinders.TMA-C stated she did e the last nebulizer treatment to been initialed in the TAR. In she gave R20 a nebulizer uld put the medication in the e-mask on R20's face and d-come back when the shed. TMA-C stated she would ut 2-3 minutes as the treatment orun. TMA-C stated when lizer treatment she would initial TAR and write on the back as it ent. TMA-C stated R20 was not s own nebulizer treatment. p.m. LPN-I stated she had us evening, had not changed p.m. and had not given R20 a it. LPN-I stated when she gave eatment she would have to stay ng the treatment as R20 would and throw it on the floor. LPN-I vere chronic obstruction		6	·	
replaced R20's tub the new cylinder 8 date and time. LPI nebulizer treatmer and when he exer had checked R20' had been a little lo	bing and cylinder and labeled /2/16, 2 p.m. as that was the N-J stated she had given R20 a ht as R20 was kind of wheezing ted himself. LPN-J stated she s oxygen saturations and they we before applying the nebulizer				
	PROVIDER OR SUPPLIER LA AT BRYN MAWR SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pathave exchanged content of the sector o	OF CORRECTION       IDENTIFICATION NUMBER:         245203         PROVIDER OR SUPPLIER         LLA AT BRYN MAWR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245203       B. WING         PROVIDER OR SUPPLIER       LA AT BRYN MAWR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         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.       F 17         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 given 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	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245203       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP C         LA AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZIP C         REQUATORY OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES         (EACH OFFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         TAG       TAG         Continued From page 5       F 176         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.       F 176         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 n         giving R20 a nebulizer treatment.       On 8/3/16, at 2:30 p.m. LPN-I 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 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 an cylinder and labeled the new cylinder 8/2/16, 2 p.m. as that was the data and time.	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       00         245203       B. WING       STREET ADDRESS, CITY, STATE, ZIP CODE       275 PENN AVENUE NORTH         HA AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZIP CODE       275 PENN AVENUE NORTH       MINEAPOLIS, MIN 55405         SUMMARY STATEMENT OF DEFICIENCES       0       PROVIDER PLAIL OF CORRECTION       PROVIDERS PLAIL OF CORRECTION         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX       INNEAPOLIS, MIN 55405       PREFIX         Continued From page 5       F 176       PREFIX       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Continued From page 5       F 176       F 176       PREFIX         TMA-C stated when she gave R20 a nebulizer treatment to R20 as it had not been initialed in the TAR.       F 176       PREFIX         TMA-C stated when she gave R20 a nebulizer treatment to Gid not take long to run. TMA-C stated when ould come back in about 2-3 minutes as the treatment did not take long to run. TMA-C stated when she gave R20 a nebulizer treatment.       On 8/3/16, at 2:30 p.m. LPN-I stated she had worked the previous evening, had not changed R20 a nebulizer treatment as R20 would take the mask off and throw it on the floor. LPN-I stated she had worked the previous evening, had not changed R20 a nebulizer treatment as R20 would take the mask off and throw it on the floor. LPN-I stated she had repiaced R20's tubing and cylinder and labeled the new cylinder 812/16, 2 p.m. as that was the date and fluice. LPN-J stated she had repiaced R20's tubing and cylinder a

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		TE SURVEY MPLETED
		245203	B. WING		08/05/2016	
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COI 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 176	cylinder and she new working correctly. who to tell about the had told the oncom LPN-J stated she he treatment to R20 a verified she had no R20 will put his new when then, "asked shake his head an will keep his mask stated she thought treatment as she t assessment had b but had not seen the	bticed the machine was not She stated she had not known he machine not working and hing evening nurse about it. had not given a nebulizer t 2 p.m. but at 10:00 a.m. and bt documented it. LPN-J stated bulizer mask on himself and d if he wants a treatment will d say yes " LPN-J stated R20 on until she returns and LPN-J R20 could be alone with his hought a self-administration een completed on R20 in July. he assessment or any administration assessment in	F 170	6		
	not given R20 a ne TMA-C asked her normally left R20 a on as she believed completed at one	0 a.m. LPN-E stated she had abulizer the day before nor had to give one. LPN-E stated she alone in his room with the mask d R20 had an assessment time to self-administer but the record one had been				
	"Ipratropium-Albut Nebulize 1 vial by dated 7/16/16"-ar Before And After 1 Respirations Befo R20's August MAR TMA regarding an	5 physician orders included: erol 0.5-3 mg/3 Ampu-Neb mouth every 4 hours as needed d "Document Heart Rate reatment, Document re And After Treatment." R showed no initials by nurse or y nebulizer treatment given or ubulizer treatment respiratory				

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Facility ID: 00175

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# DEPARTMENT OF CENTERS FOR ME

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DEPARTMENT OF HEALTH AND HUMAN SERVICES						08/22/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245203	B. WING		08/0	05/2016
NAME OF F	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT BRYN MAWR			275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	Continued From pa	•	F 176	·		

(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 176	Continued From page 7	F 176	, ,	
	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		F248: It is the policy of The Villa at Bryn	
	review date, " dated initiated 4/28/14 and also		Mawr to provide ongoing program of	
	indicated, "Review medication self-administration			
	with resident [R20] /monthly and as needed to		activities designed to meet, in accordance	
	reassess abilities," Dated initiated 4/28/14.		with the comprehensive assessment, the	
	On 0/4/40 at 10:47 and ADON stated the facility	<u> </u>	interests and the physical, mental and	
	On 8/4/16, at 10:47 a.m. ADON stated the facility had been talking about the self-administration		psychosocial well-being of each resident.	
	assessments and would need to correct and		teren en e	
x	educate staff-regarding self-administration		Plan of correction for residents cited with	
	assessments. ADON stated there had to be an		this survey:	
	assessment completed to know the resident is		For R92, R52, and R26, a review of activity	
	safe to administer medication.		assessments and care plans to include	
F 248		F 248	interventions, such as interests of	
SS=D	INTERESTS/NEEDS OF EACH RES	ŝ	residents. We will audit the participation	
	The facility must provide for an ongoing program		of activities against the calendar.	
	of activities designed to meet, in accordance with		Education was provided on these three residents to activity staff to ensure we	
	the comprehensive assessment, the interests and		were holding activities to best meet their	
	the physical, mental, and psychosocial well-being-		interests. The residents identified had no	
	of each resident.		adverse effects noted as a result of the	
			observations noted by the state. The	
	This REQUIREMENT is not met as evidenced		attendance for these residents will be	
	by:		logged.	
	Based on observation, interview and document			
	review, the facility failed to provide activities to		Plan to address/prevent this deficiency for	
	meet the individual interests for 3 of 3 residents		other residents:	
	(R92, R52, R26) who were dependent on staff to		All residents in the facility will have a	
	provide activities, and were reviewed for activities.		review of their activity assessments and	
			care plans.	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		(X3) DATE	SURVEY PLETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
		245203			05/2016		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT BRYN MAWR				5 PENN AVENUE NORTH INNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 248	lying in bed sleepir R92 was awake ar in the dining area. the residents. On 8/3/16, at 2:46	age 8 oserved on 8/1/16, at 3:57 p.m. ng soundly. Later, at 7:29 p.m. nd was seated in a wheelchair No staff was interacting with p.m. R92 was lying in bed. ision was turned on, R92's bed	F	248	Measures put in place to prevent recurrence: The activity calendar will be reviewe monthly to ensure we have activitie best meet the needs of all of our residents. The attendance for all res will be logged. Education was provie activity staff to ensure we were hol activities to best meet their interest	es that sidents ded to ding	
	was positioned ad his head, where he 8/4/16, at 8:54 a.m and the surveyor v still." At 9:47 a.m. room by nursing a where the "1:1 with	acent to the television next to acent to the television next to a could not see the screen. On n. R92's room door was shut vas told, "He is in bed sleeping R92 was assisted back to his ssistant (NA)-A. When asked h Rec [recreation] staff" activity 30 to 11:30 a.m. was usually	: · · ·		Plan to monitor: A random 10% audit of resident car and activity participation will be conducted the next 3 months to en we are holding activities on the cal that best suit the needs of our resid The results of the audit will be pres	isure endar dents	
·	held, NA-A walked activities and state room." NA-A then for the activity he R92 to a place at other residents we being held at that signs of agitation	to the white board listing ed, "It's usually held in the dining asked R92 if he wished to stay replied, "Yes." NA-A wheeled the dining room where a few ere seated. No activity was time. R92 sat calmly with no such as yelling or increased wheelehair. Twelve other			to at the QA Meetings with audits continuing as warranted. The QA Committee will monitor complianc review trends and make recommendations as necessary.		
	residents were in and forth and the the dining room a a.m. a staff perso Yahtzee was bein staff person offere R92's 8/6/15, ann indicated the resid cognition. The foll somewhat import	the room as staff walked back nurse passed medications in nd no activity was held. At 10:20 n stated the board game g played on the third floor. No ed to take R92 to the activity. ual Minimum Data Set (MDS) dent had moderately impaired lowing activities were all ant to the resident: having music, pets, keeping up on			<u>Responsible for maintaining compl</u> Activity Director, Administrator <u>Correction Date</u> : 9/7/16	<u>iiance</u> :	

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CENTER	AS FOR MEDICARE	: & MEDICAID SERVICES					0930-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		245203	B. WING	۱ <u></u>		08/05/2016		
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 248	news, group activit religious activity. A dated 5/10/2016 in severely impaired skills and had som a decline in menta assessment indica including dementia He was dependent unit. He displayed	ies, pets, going outside, and subsequent quarterly MDS ndicated the resident had cognition for decision making e difficulty focusing, however, I status was not noted. The ted the resident had diagnoses a, depression and psychosis. t on staff for mobility on/off the verbal behaviors 1-3 days ment period, however, mood	F	248	3			
	was dependent on his emotional and directed staff to pr with television, pro-	ated 9/10/14, noted the resident staff and his wife for meeting social needs. Interventions ovide individual activities, assist ovide activity calendar, invite-to- es, and thank resident for						
	p.m. he reported h enjoyed watching difficulty speaking	w with R92 on 8/3/16, at 2:47 ne did not attend activities, but television in his room. R92 had and was short of breath, so vide details as to why he did not						
	worked with R92 v 2:48 p.m. LPN-Av activity preference the activity staff. R92 was brought loudly and want to asked whether sh	I nurse (LPN)-A who routinely was interviewed on 8/3/16, at was unable to state R92's es, and referred the surveyor to NA-A then explained that when to an activity he would yell o return to his room. When e had observed 1:1 ovided for R92 NA-A replied,					- · · · ·	

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STATEMENT	IS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED			
		245203	B. WING			08/	05/2016		
	ROVIDER OR SUPPLIER			27	REET ADDRESS, CITY, STATE, ZIP CODE 5 PENN AVENUE NORTH NNEAPOLIS, MN 55405				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 248	Assistant (RTA)-A her activities positi reported R92 enjou using the mind, su sayings and music previously attenda attended activities RTA-A verified she resident attended was provided, and	age 10 p.m. Recreational Therapy explained she had only been in on for a month. RTA-A yed activities that required ch as spelling bees, old . RTA-A explained that nce was taken when residents but that "fell to the wayside." e did not document when a an activity or when a 1:1 visit she was unable to produce an nt since R92's admission.	F 2	248					
	following: 1) 8/9/15, R92 atte in the past quarter 2)-11/19/15, R92 communion, and r 3) 3/3/16, R92 atte sayings and churc	attended Bible study, novie matinee; ended social ball toss, old h;							
	A review of the ac July and August 2 activities were pro	es were located in the record s R92 attended or declined. tivity calendar for the months of 016, revealed numerous vided for persons cognitively z challenge, hangman, spelling I horse racing.							
	directed staff, "Wi admission to the f will be conducted plan that reflects resident. The ass the activity depart employees input.	9, Activity Assessment policy thin 14 days of a resident's acility, an activity assessment to help develop an activities the choices and interests of the sessment will be conducted by ment staff and other staff The activity assessment will be nts' medical record and updated			•				

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PRINTED: 08/22/2016
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OMB NO. 0938-0391

UENTER	13 FUR MEDICARE	& MEDICAID SERVICES			<u> </u>		0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING COMF				3) DATE SURVEY COMPLETED	
		245203			3/05/2016			
	PROVIDER OR SUPPLIER	· ·		2	STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 248	Continued From pa as needed and anr		F	248			·	
	"I do not want to be waiting for someor where to go. Altho	terview on 8/1/16, at 3:23 p.m., e here." R52 said he was just te to tell him what to do and ugh a television was on in the stated he was not watching it.						
	room except for clo	items were observed in the othing. The curtains were ed he used to be a carpenter and fishing.						
	On 8/3/16, at 2:17	p.m. R52 was seated in the				-		
	dining room. He ag about living at the would like to do at hunting and fishing	yain reiterated his feelings facility. When asked what he the facility he said he liked g and wanted to go outside. He O minute conversation with the			· · · · · · ·		· · · ·	
	R52 was severely self-reported depre watching television socialize or partici	note dated 9/16/15, revealed cognitively impaired, had ession, spent some time n and lying in bed. R52 did not pate in activities; activity hunting and fishing.		•••••				
	resident had little related to disintered will express satisfi- level of activity invi- the review date." / resident's preferen movies. His preferen to country music a Staff was to ensur- opportunities for s	/5/16 goal date), indicated the or no activity involvement est. The goal was, "The resident action with type of activities and olvement when asked through Approaches included the nee for old westerns and rences were noted as listening and watching western shows. The he received daily ocial contact and eat all meals , attended daily activities of his						

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/22/2016
FORM APPROVED
OND NO COOR COOL

		& MEDICAID SERVICES					. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY APLETED	
		245203	B. WING			08	/05/2016	
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD			
THE VILI	LA AT BRYN MAWR				75 PENN AVENUE NORTH INNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 248	choice, and comm activities. Staff wer others with similar	age 12 unicated his feelings regarding e to introduce the resident to background, interests and e interaction and activity	F:	248				
	An activity assess	nent-dated-6/15/16, indicated						
	related to dementia	severe cognitive impairment a. Resident does not participate lary to lack of desire, only Ils."						
	DE010 6/02/16 opr	nual Minimum Data Set						
		s of dementia, anxiety, and						
	depression. Althor	ugh the assessment indicated						
		cognition. It was "somewhat						
		nings with groups of people and weather. The assessment						
		nt did not display mood or	-					
	behavioral indicato period, but a new experienced "little	problem was that the resident pleasure in doing things" every y day. R52's care plan,						
	however, did not in importance to the	resident or concerns with sure his needs were met.		14 .	Site av großen and site Site in State Site av Site Site Site Site Site Site Site Site			
	June 2016, reveal	5 a.m. R52's activity log for ed the resident attended movie /8/16 and Bingo on 6/27/16.						
	Assistant-A (RTA- reported R52 did in She described the activities" and inst family to visit mor- or activities, but d	w with the Recreational Therapy A) on 8/3/16, at 1:14 p.m. she not wish to attend activities. e resident as "disinterested in read, the resident wanted his e often. He watched television id not generally participate. He ograms such as birthday					-	

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# DEPARTMEN **CENTERS F**

		AND HUMAN SERVICES			FORM	08/22/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			<b>v</b> ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245203	B. WING		08/	05/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 248	from more interacti made attempts to c numbers were no l responsive to conv silent treatment." T the resident to mov had not been atten some magazines v room. RTA-A said occupation.	ed R52 would have benefited on with his family, and had call them, but the phone onger valid. R52 was not ersation and gave staff "the here were no current plans for ve to a different location. He ding his care conferences, but- vere provided for him in his she had no idea R52's previous	F 24			
	The social worker	(SW) was interviewed on				

made attempts to call them, but the numbers were no longer valid. R52 responsive to conversation and gave	was not ve staff "the					
silent treatment." There were no cu						
the resident to move to a different l						
had not been attending his care co						
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 intervi	ewed on					
8/4/16, at 11:58 a.m. and described						
"unhappy" at the facility, and had n						
was encouraged to attend activities						
allowed him space. The SW-said th						
attempted other approaches with F						
his stay at the facility more satisfac						
resident continued to say things we	ere					
unacceptable and the SW said, "W						
look at trying something new. He d						
this to be a prison." The SW report						
utilize the patio, and said, "We will						
outside to the care plan. There ma			1	i de la composición de		
opportunities that we need to cons				4		
resident." The SW explained they						
traditional dementia symptoms with						
what meal was being served. In a						
often did not provide a reason why						
wish to attend activities, just stated	i ne did not					
wish to attend.						
R26, who had diagnoses that inclu	Ided brain					
injury, cognitive (thinking) problem						
stroke with left-sided paralysis was	s observed on					
8/2/16, at 6:15 p.m. after being as	sisted out of					
bed for the evening meal. While tr						
FORM CMS-2567(02-99) Previous Versions Obsolete	Event ID:9DEF11	Facility ID: 00175		If continuation s	sheet Page 14	of 55

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DAT CON	e survey Ipleted
		245203	B. WING			08/	05/2016
	NAME OF PROVIDER OR SUPPLIER THE VILLA AT BRYN MAWR			275	REET ADDRESS, CITY, STATE, ZIP CODE PENN AVENUE NORTH NNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 248	conversation, R26 little response. The following morr was up in a wheeld facing the televisio	age 14 avoided eye contact and gave ning at 8:25 a.m. the resident chair in the bedroom. R26 was n, which was off at the time.	F 2	248			
	movements. R26 of by the surveyor. W okay, the response	id not respond to two greetings hen asked if things were going was "yah," and was barely m. the resident was being					
	assisted to eat bre 9:30 a.m., still in th	akfast in the dining room. At ne dining room, R26					
	between active loc residents in the ro	d at a morning television show oks around at the other om. At 10:24 a.m. the resident o bed, and again did not ing.					
	indicated R26's m up in a wheelchair breakfast. NA-C w was, "mostly in be	w on 8/2/16 at 4:13 p.m., NA-D orning routine was to be gotten , get washed up and then eat ras also present and added R26 d because of her bottom getting , but that is better now."	5				
		R26 does some activities, they articipate, moviesI'm not sure			<u> </u>		
	10:27 a.m.: "Her r cleaned up, then g stays up an hour a back to bed and c again before we g a lot because of [s come and go." Sh	during an interview on 8/3/16, at outine is that we get her get her up for breakfast - she approximately. Then we put her heck her [skin], then check her let her up at lunch. She's in bed skin issues] on her behindthat le doesn't do activities now, she she's left up longer her head					

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	OF DEFICIENCIES		(X2) MULT	IPLE CON	STRUCTION		(X3) DAT	E SURVEY	
	FCORRECTION	DENTIFICATION NUMBER:	A. BUILDIN	1G			CON	PLETED	
		245203	B. WING _				08/	05/2016	
NAME OF F	PROVIDER OR SUPPLIER	<b>.</b>	<u> </u>	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
THE VILI	_A AT BRYN MAWR				N AVENUE NORTH	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOUL O THE APPRO	D BE	(X5) COMPLETION DATE	
F 248	goes down, like thi During an interview registered nurse (F nurse had request buttocks due to he said they occasion activity, but she did what was going on RN-G stated, "I'm	-	F 24	48					
		/03/16 the Recreational							
	Therapy Assistant leading Bingo in th	(RTA-A) was observed just le dining room - R26 was not s previously observed.							
	resident had little of her limitations rela and a stroke. It was to use some sense vision. Intervention resident's preferre sensory, and a van She does not toler time. Resident wa Study, Birthday Pa	blan for R26 indicated the or no activity involvement due to ted to traumatic brain injury as noted the resident was able ory skills such as hearing and ns included a list of the ad activities: "Spiritual, cognitive, riety of programs on her floor. rate being up for long periods of tches TV in her room. Bible arty, Manicures, church." An nent for R26 was requested but							
	After she finished conducted with R services existed for prevented them a she answered she interventions. For television into the								

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CENTER	RS FOR MEDICARE	<u>&amp; MEDICAID SERVICES</u>					0930-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245203	B. WING			08/0	05/2016
	PROVIDER OR SUPPLIER	L		27	REET ADDRESS, CITY, STATE, ZIP CODE 5 PENN AVENUE NORTH INNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	visit. "And I like to g possible." As to Ri read to her, "have weather." She add everywhereI see She added, "I cove more than 1 day [to	get them outside when 26, RTA-A indicated she would conversations, tell her the ed, "I'm a little bit of everyone who needs a 1:1," er the whole facility so it takes o see every resident who		248			
F 250 ——SS=D	needs it]." She add Bingo."	led, "Last week R26 played the		250			
	services to attain o	rovide medically-related social or maintain the highest al, mental, and psychosocial resident.	· · · ·				
	by: Based on observa review, the facility medically-related maintain the highe psychosocial well-	social services to attain or est practicable mental and being for 1 of 1 resident (R52)			F250: It is the policy of the Villa at Mawr that residents receive all nec medically-related social services an social service care plans are update reviewed in a timely manner. It is a policy at the Villa at Bryn Mawr to r sure that residents and persons inv	essary d that d and lso the make olved	
	nursing home. Findings include: R52 stated in an i	atisfaction with his life at the nterview on 8/1/16, at 3:23 p.m.			in a resident's care are updated in a timely manner. <u>Plan of correction for residents cite</u> <u>this survey</u> :	<b>*</b> y	
	informed of cares was prescribed. V doing overall at th and indicated, "I c	ny say in and/or was not , treatments, or medications he Vhen asked about how he was le facility, he used an expletive to not want to be here." R52 vaiting for someone to tell him			R52 had the psychosocial well-bein plan updated to reflect the care an services provided to attain or main the highest level of adjustment and	d tain	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245203	B. WING		08/05/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	ION
F 250	what to do and whe A social services n R52 was severely self-reported depre watching television socialize or particin note dated 12/13/1 to attend his quarted declined stating, "" note indicated ass and the resident ha making skills, and guardianship for th (SW) documented member to assist R52 saw the in-ho and the-resident w roommate and wa SW noted she woo meet the resident" 12/17/15, the SW care conference.	ere to go. ote dated 9/16/15, revealed cognitively impaired, had ession, spent some time a and lying in bed. R52 did not bate in-activities. A subsequent 5, indicated R52 when asked erly care conference he I don't even know you." The essments had been completed ad severely impaired decision the physician recommended he resident. The social worker I difficulty finding a family with guardianship. It was noted use psychologist on 10/14/15, vas not getting along with his s rejecting leg treatments. The uld continue to be available to s psychosocial needs. On and nurse manager met for a The note did not indicate ent was invited or declined or	F 25	psychosocial well-being while resid the nursing home. R52's family me have been found and appointed as decision makers for this resident. T have been updated about resident and care plan. Social service will in care conference with family and R Notes from Associated Clinic of Psychology (ACP) will also be adde R52's chart. Social service remover of having resident improve curren of cognitive function. The interdise team will implement behavior trac identify the frequency that he void discontent with placement. Social and IDT will implement intervention help decrease resident's discontent worker will meet with the resident weekly basis and talk about areas interest. Resident has not demon- any adverse effects from the observed observed by MDH.	mbers legal 'hey 's cares itiate a 52. d into d goal t level ciplinary cking to ces service ons to nt. Social t on a of strated	· · ·
	behaviors of refus names, and had a rummaging throug wrote, "Resident is and desires to live doctor and IDT-[in community discha resident's cognitiv discussed with gu appointed."	6/14/16, indicated R52 had ing treatment and calling staff need for a private room due to gh others' belongings. The SW s dissatisfied with placement e in independent living, but iterdisciplinary team] agree that arge is not appropriate due to re status. Plan of care to be lardian when guardian is			plan t.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245203	B. WING			08/	05/2016
	PROVIDER OR SUPPLIER			275 PE	ADDRESS, CITY, STATE, ZIP CODE IN AVENUE NORTH APOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 250	when R52's medic although it was not 4/6/16. A medicatic antidepressant was	age 18 al record was reviewed, ed the resident was seen on decrease in the resident's s made and the note indicated again in six months.	F	cal ind or <u>M</u>	erdisciplinary team. The guide re plan attendance will be upo clude the identification of resid family attendance. easures put in place to preven currence:	lated to dent and	
	found in R52's recorreviewed on 8/3/16 was invited but did however, a reason note dated 3/16/16 invited but did not	onference summary form was ord when the record was 5. The summary indicated R52 not attend the conference, was not noted. A conference 5, indicated the resident was attend his conference, and the		ca Th pla	ne policy and procedure for re re plan has been reviewed and e staff will be educated the pr an implementations to best m sidents psychosocial needs.	d updated. oper-care	
	increase complian form dated 6/30 la indicate whether th	ed his bath to the morning to ce with bathing. A conference cked the year and did not ne resident was invited or			an to monitor: random 10% audit of resident	's care	
	conference forms R52's 6/23/16, and included diagnose depression. Altho severely impaired interviewed for the	ed his conference. No other were located in the record. nual Minimum Data Set s of dementia, anxiety, and ugh the assessment indicated cognition, he was able to be assessment. The only area		be mo of M	ans and care conference atten conducted monthly for the n onths to ensure compliance. T the audit will be reported on eeting with audits continuing arranted. QA Committee will e	ext 3 he results at the QA as	
	have his family inv care. The assessment p the assessment p that the resident e doing things," eve R52's care plan, h these areas of imp concerns with app were met. The 6 comprehensive C	ted as, "very important," was to volved in discussions about his nent showed the resident did or behavioral indicators during eriod, but a new problem was experienced, "little pleasure in ry day or nearly every day. however, did not incorporate portance to the resident or proaches to ensure his needs /15/16, social services are Area Assessment (CAA) for nual review indicated "Resident		on <u>Re</u> Di <u>Cc</u>	going compliance with F250 a going recommendations as ne sponsible for maintaining con rector of Social Services prrection Date: 7/16	eeded.	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				l			
		245203	B. WING		08/0	)5/2016	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH			
THE VIL	LA AT BRYN MAWR			MINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR( DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 250	states that he wo physician agree the appropriate." R52's care plan (ge resident is adjustin home placement. I and would like to n significant dement resident had impai or impaired though term memory loss/ agreed to be resid results of backgrou resident will improv function through the also noted the resi routine and nursin facility "jail" and wo	buld like to go home. IDT and at community placement is not oal date 9/5/16) indicated, "The g to a new routine and nursing Resident calls this place 'jail,' nove to community, but has ia." It also indicated the red cognitive function/dementia at processes related to short (dementia. "Daughter has ent's guardian, waiting on und check." The goal was, "The ve current level of cognitive he review date." The care plan ident was adjusting to a new g home placement, called the buld-like-to-live in the		)			
	community but had During an interview 7:58 a.m. she stat conferences were depend on the res the care plan was depending on the started at the first how it drove the ca primarily nursing a also a process cal before the assess staff gave input. During an intervier assistant A (RTA-/ described the resi activities" and inst more often. RTA-/	d significant dementia. w with RN-E on 8/4/2016 at ed that resident care sometimes a team, but it would ident. The adjustment part of a team effort and varied resident. Initial care plans were referral which then triggered are plan. Care conferences are and social services. There was lled Grand Rounds that occurs ment period where additional w with the recreational therapy A) on 8/3/16, at 1:14 p.m. she dent as "disinterested in tead, wanted his family to visit A said R52 would have pre interaction with his family,			· · · · · · · · · · · · · · · · · · ·		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATI	E SURVEY PLETED
		245203	B. WING		08/	05/2016
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH THE VILLA AT BRYN MAWR MINNEAPOLIS, MN 55405					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 250	and had made atte phone numbers we not responsive to c "the silent treatmen plans for the reside	age 20 mpts to call them, but the ere no longer valid. R52 was onversation and gave staff nt." There were no current ent to move to a different of been attending his care	F 250	0	,	
	and said she and t two staff who atten	viewed on 8/4/16, at 11:58 a.m. he nurse manager were the ded resident care conferences. etitian may attend, but the				
	daughter was appo SW described R52 and had not adjust tolerate a roomma toward them and t waiver for this reas family to reach him	t attend. She stated R52's binted his guardian in 5/16. The as "unhappy" at the facility, ed. The resident could not te, as he was "unfriendly" hey received a private room son. The staff had utilized the and ensure he could do the in the situation. The SW verified			· · · · · · · · · · · · · · · · · · ·	
,	the care plan rega home including the approaches, rema resident was admi The SW said they	rding adjusting to the nursing problem statement, goal, and ined the same as when the tted more than a year prior. could have attempted other 152 to make his stay at the				
	facility more satisfies the plan was work continued to expre- the facility, the SW at trying something be a prisonThere that we need to co SW explained the symptoms with RS being served. In a	actory. When asked if it was felt ing, since the resident iss dissatisfaction with life at replied, "We may need to look g new. He does consider this to e may be more opportunities insider for this resident." The y had noted traditional dementia 2, such as what meal was iddition, he did not provide a not wish to attend his care				

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245203	B. WING			05/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
THE VILI	LA AT BRYN MAWR			275 PENN AVENUE NORTH MINNEAPOLIS, MN 5540	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 282 SS=D	PERSONS/PER C/ The services provided b	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of	F 2	E282: It is the policy at	The Villa at Bryn ovided or arranged provided by cordance with each o of care.	
	by: Based on observa review, the facility care to adequately residents (R63) in non-pressure relate failed to ensure 1 of supervised during- to follow the care p receiving dialysis. Findings include: R63 did not receive assessment as dir The current plan o	NT is not met as evidenced tion, interview and document failed to follow the plan of monitor and assess 1 of 3 the sample, reviewed for ed skin conditions (bruising), of 1 residents (R20) was nebulizer treatment, and failed blan for 1 of 1 resident (47) e skin monitoring and ected in the plan of care. f care, target date 7/8/16,		R63 has been reasses been updated, and the implemented new into a new walker. Resider adverse effects identif SAM (Self Administrat Assessment) of nebul reassessed. R20 has h updated. Resident has effects identified as a observations by the su self-administration of evaluated. The plan o	erapy has erventions, including it has had no fied. R20 has had ion of Medication izer treatment ad plan of care s had no adverse result of the urvey. R47 has had Lidoderm gel re- f care has been	
	unsteady gait, and of deficits. The car document, and rep medical doctor for not identify bruises 7/22/16. R63 was observed bruise on her right forearm). The area were lighter purple	a fall risk related to actual falls, I failure to be cognoscente [sic] re plan directed staff to monitor, port as needed for 72 hours to r pain and bruises, however did s or abrasions obtained on d on 8/1/16 to have a purple t bicep area (inner, upper as to the edge of the bruise e and the center was a deeper ad a scrape noted on the		review, updated and n had no adverse effect result of the observat The facility has contac update the care plan appropriate dialysis in	s identified as a ions by the survey. cted dialysis to regarding	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245203	B. WING		08/05/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 282	middle knuckle of h a dry scab. When a fall while she was y shopping trip and o time. The medication ad and the treatment for 7/2016 and 8/2 monitoring of the b An Occurrence Re 8:56 p.m. noted the the Right Upper Ar looking bruise; Ski scrape on knuckle treatment and mea mentioned in the r A skin /wound note occurrence, indica night with extensiv complete skin ass	her left hand. It was covered by asked, R63 stated she had a with her "companion" on a obtained both injuries at that ministration records (MAR) administration records (TAR) 016 lacked identification or oruise or the scrape. port completed on 7/22/16, at <u>e following injuries: Bruise to</u> m, near chest, purple, new n Tear to right middle Finger 3, of right middle finger. A asurements were not eport. e on 7/23/16, the day after the ted R63 took a bed bath that re assistance of one staff and a essment was completed. The be dry, intact and no pressure	F 282	Plan to address/prevent this deficient other residents: A post-incident checklist and the sk conditions policy has been impleme at the facility. Nursing staff will com the post-incident checklist at the tim an incident. Nursing staff will then t the completed checklist into nursing management for review and further follow-up. The post-incident checklit be completed after each incident occurrence. All residents will be auc for skih impairment documentation Bruises to be identified on TAR ( Treatment Administration Record) a monitored until resolved. The policy procedures for skin impairment, dia treatments, self-administration of medication and nebulizers has been reviewed and updated.	in nted plete ne of urn st will lited 
	a tub bath with exit Her skin was dry a bruises were note During an intervier registered nurse ( were to be monito least daily, until re She verified that F	e on 7/31/16, indicated R63 took tensive assistance of one staff. and intact. No pressure areas or d. w on 8/3/16, at 1:31 p.m., a RN)-E stated all skin issues red and tracked on the TAR, at solved as the policy indicated. R63's TAR for 6/2016, 7/2016 d monitoring of non-pressure		_All residents will be assessment for self-administration of meds. Nursing will be educated on the self- administration of meds, nebulizer administration, pre and post assess and appropriate functionality of equipment. Staff educated on the r to monitor all areas of skin impairm All residents receiving dialysis will b	g staff ment leed ent.

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		245203	B. WING			08/05/2016		
	PROVIDER OR SUPPLIER			27	REET ADDRESS, CITY, STATE, ZIP CODE 5 PENN AVENUE NORTH INNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 282	A policy to care pla non-pressure skin not provided. On 8/4/16, at 8:19 did not have a syst and other non-pres During an interview director of nursing monitor bruising at	age 23 n for monitoring and assessing conditions was requested but a.m. RN-E stated the facility em in place to monitor bruising sure skin conditions. v on 8/4/16, at 8:48 a.m., the stated she expected staff to nd care plan for all skin		282	assessed and have care plans review ensure pre and post dialysis intentio being implemented. Nursing staff we educated on appropriate dialysis fol up. Nursing staff educate on the need ensure accurate assessments within required time frames, the need to complete comprehensive care plans the need to update NAR (Nursing Assistant Registered) care sheets. S educated on appropriate monitorin	ns are ere low ed to the and Staff		
	[R20] has a physic self-administration Nebs," date initiate for Goal, "The res medications safely review date," date indicated, "Review	plan Indicated, "The resident ian's order for supervised of the following medications: ed 4/28/14 and also indicated ident [R20] will take / and as prescribed through the d initiated 4/28/14 and also / medication self-administration ] /monthly and as needed to			coordination of care. <u>Plan to monitor</u> : To ensure compliance, the nursing management staff or designee will- conduct audits of all of our dialysis residents on a monthly basis. All residents will receiving nebulizer treatments will reviewed. All residents with impair will be reviewed. The results of the	be ed skin		
	reassess abilities. R20's quarterly M 7/29/16, indicated memory problems decision making s which fluctuated. (CAA) dated 4/06 Loss/Dementia an "Decreased ability understand other R20 was observe	linimum Data Set dated R20 had short and long term s, had severely impaired daily skills, and had delirium present, R20's Care Area Assessment /16, triggered for Cognitive nd indicated R20 had, / to make self understood or to			will be presented to at the QA Mee with audits continuing as warranter QA Committee will monitor compli review trends and make recommendations as necessary. <u>Responsible for maintaining compl</u> Director of Nursing <u>Correction Date</u> :	tings d. The ance,		

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FORM	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			08/05/2016		
	PROVIDER OR SUPPLIER	L		275	REET ADDRESS, CITY, STATE, ZIP CODE 5 PENN AVENUE NORTH NNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	mask over face, wi continuous observa observed with eyes place, machine run medication assista and looked in R20 At 10:26 a.m. R20	th machine running. During ation at 10:07 a.m. R20 was s closed, nebulizer mask still in nning. One minute later trained nt (TMA)-C walked down hall s room and then walked away. was observed lying on right	F	282			
		mask on face, machine eam going into the nebulizer					
٦.	would come down residents' tube fee	5 a.m. TMA-C stated the nurse from station 3 and complete edings and insulins. TMA-C ined to pass medications and					
	administer nebuliz At 10:26 a.m. TMA				··· ·· · · · · · · · · · · · · · · · ·		·
	back to bed. TMA- nebulizer mask hir go and take the m she had not applie R20,that he must I At 10:33 a.m. TMA was on R20 ' s fac running, that the c	C stated R20 would put on the nself. TMA-C stated she would ask off of R20. TMA-C stated of the nebulizer treatment for have put it on himself. A-C verified the nebulizer mask and that the machine was ylinder was half full with	-			· · · · · · · · · · · · · · · · · · ·	
	mask. TMA-C stat nebulizer mask, ne with medication. T the outside o fthe "8/2/16, 2 p.m." T aware there was r had she been awa place with the may R20 only received treatments and the practical nurse (LI	ed she had not given R20 his or had she filled the cylinder MA-C verified that written on cylinder in black marker was, MA-C stated she had not been nedication in the cylinder nor are that R20 had his nebulizer in chine running. TMA-C stated prn (as needed) nebulizer at she would call licensed PN)-E to see if she had given . TMA-C proceeded to call			illiy ID: 00175 If continua		Page 25 of 55

STATEMENT OF DEFICIENCIES         (X1)         PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245203	B, WING			08	/05/2016	
	PROVIDER OR SUPPLIER	· ·		2	TREET ADDRESS, CITY, STATE, ZIP CODE 75 PENN AVENUE NORTH /IINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
F 282	LPN-E and was tol nebulizer treatmen machine must not nebulizer treatmen hour and it was stil cylinder was dated were dated when co once a week. TMA one that had writte	age 25 d LPN-E had not applied R20's t. TMA-C stated R20 ' s be working since R20 had his t running for approximately half I half full. TMA-C stated the 8/2/16, 2 p.m. since cylinders hanging out with a new one -C stated she had not been the n the date and time when the ced. TMA-C stated it would be	F 2	282				
	the day nurse yest exchanged cylinde	erday who would have rs. TMA-C stated when R20						
	TMA-C verified the record (MAR) Indic assessment was to after the treatment the assessments b treatments. TMA - nebulizer treatmen nurse told her to d never been told to respiratory assess she did not know v treatment to R20 a TAR. TMA-C state nebulizer treatmen in the cylinder app room and come ba finished. TMA-C s about 2-3 minutes long to run. TMA-C nebulizer treatmen of the TAR and wr	n have a nebulizer treatment. medication administration eated a pre and post respiratory be completed before and but that she did not complete before applying nebulizer C stated she could give the t if R20 coughed a lot or if the o it. TMA-C stated she had complete the pre and post ments ordered. TMA-C stated who gave the last nebulizer as it had not been initialed in the d when she gave R20 a at she would put the medication ly on R20' s face and leave the ack when the treatment was tated she would come back in as the treatment did not take C stated when giving R20 a at she would initial on the front ite on the back as it was a PRN stated R20 is not supposed to						
	do his own nebuliz On 8/3/16, at 2:30							

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
	245203		B. WING		08/	05/2016
NAME OF PROVIDER OR SUPPLIER THE VILLA AT BRYN MAWR				STREET ADDRESS, CITY, STATE, 2 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	cylinder at 2 p.m. a treatment. LPN-I s treatment she wou and write on the ba when she gave R2 would have to stay treatment as R20 v	age 26 and not given R20 a nebulizer tated when she gave R20 a Id initial on the front of the TAR ack of the MAR. LPN-I stated 0 a nebulizer treatment she in R20's room during the would take the mask off and r. LPN-I stated R20 had severe		282		
	chronic obstruction	n pulmonary disease (COPD). ad not observed R20's the previous evening as R20			· · · ·	
	she had replaced new and labeled th	ning at 9:46 a.m. LPN-J stated R20's tubing and cylinder with ne cylinder 8/2/16, 2 p.m. as and time. LPN-J stated she had				
	given R20 a nebul of wheezing when verified she had no anywhere about th given to R20 nor a assessments. LPN there was still med and she noticed th	izer treatment as R20 was kind he exerted himself. LPN-J ot documented anything he PRN nebulizer treatment any of the pre or post respiratory V-J stated after 10 minutes dication left in R20 's cylinder he machine was not working not known who to tell-about the	,			
	machine not worki evening nurse abo his nebulizer masl asked if he wanted head and say, "ye keep his mask on she thought R20. treatment as she f assessment had k LPN-J stated R20 disease). LPN-J s	ing and had told the oncoming but it. LPN-J stated R20 will put < on himself and when then d a treatment would shake his s." LPN-J stated R20 would until she returned and stated could be alone with his thought a self-administration been completed on R20 in July. had asthma and COPD (lung tated by her not documenting acoming nurse would not know i		Facility ID: 00175	If continuation shee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING		08/(	05/2016			
		PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 75 PENN AVENUE NORTH /IINNEAPOLIS, MN 55405			
	(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE	
	F 282	treatment. LPN-J s that day as she ha between two floors	age 27 Id give R20 a PRN nebulizer stated she had been really busy d been going back and forth s and could forget things then he nebulizer treatment.	F 282				
		not given R20 a ne	0 a.m. LPN-E stated she had bulizer the day before nor had to give one. LPN-E stated she				· · · ·	
		normally left R20 a on as she believed	alone in his room with the mask d R20 had an assessment					
		could not verify in	time to self-administer but the record one had been					
		completed for R20	).					
		Ipratropium-Albut	6 physician orders included: erol 0.5-3 mg/3 Ampu-Neb					
		dated 7/16/16" an Before And After 7	mouth every 4 hours as needed nd " Document Heart Rate Freatment, Document re And After Treatment "					
		TMA regarding an	R showed no initials by nurse or by nebulizer treatment given or abulizer treatment respiratory apleted for R20.					
		had been talking a assessments and educate staff rega assessments. AD	47 a.m. ADON stated the facility about the self administration I would need to correct and arding self-administration OON stated there had to be an pleted to know the resident is r medication.					
		nebulizer treatme	dent was left alone with his ent at times, facility staff had andings as to his abilities to					

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CENTER	IS FOR MEDICARE	: & MEDICAID SERVICES			C		0930-0391
					(X3) DATE SURVEY COMPLETED		
		245203	B. WING			08/	05/2016
NAME OF F	PROVIDER OR SUPPLIER		L	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	75 PENN AVENUE NORTH		
THE VILL	A AT BRYN MAWR			N	INNEAPOLIS, MN 55405		
	SUMMARY ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTIO	)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
E 000	Operation and Expert ro	-	F 2	000			
F 202	Continued From pa	-	Г	.02			
	safely administer the	he nebulizer treatments when Ind there was no evidence he					
		ssessed for his self					
	adminsitration abili						
	auministration aoin						
	R47's quarterly Min	nimum Data Set (MDS) dated					
	6/25/16, indicated	R47 was cognitively intact,					
		viors of refusal of cares and					
		ervision at times or was					
		personal hygiene. R47 had entia, depression and					
	schizonbrenia B4	17's care plan dated 6/23/15,					
		uired dialysis related to renal					
	failure. Staff inter	ventions included to check and					
		laily, monitor signs and					
		tions at access site and					
	document on treat	tment sheets.					
	Duriture are testimates	$P_{\rm M}$ an $P_{\rm M}$					
	burning an interview	w on 8/2/16, at 4:15 p.m. R47 dialysis on Mondays,	1	:-			
	Wednesdays and	Fridays. R47 expressed					
		about the care he was receiving	· ·				
	at the facility. R47	7 stated, "the nursing staff here		- 1			
	does nothing for n	ny dialysis access site." R47					
		e I go to my dialysis					
	appointment the r	nurse is to put on a numbing					
		aine 2.5%) cream to my access					
	site 1 hour before	my appointment time. This have to do it." R47 stated, "I					
	have the numbing	cream in the drawer by my					
	hed I put the crea	am on my dialysis access site					
		ngs me a dressing to cover it. I					
	don't know why I	have to do this, nursing should	ал 1 - 1 - 1 - 1 - 1				
	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 pu	t				
	a bandage on his	arm and he removed it later in					

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FORM A	PPROVED
OMB NO (	1938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245203	B. WING		08/05/2016
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 282	the evening after it was asked if the fa safety or looking fo replied, "No, the st how or what to loo dressing on my arr any monitoring of r	stopped bleeding. When R47 cility ever educated him on or signs of infections, R47 aff here has never taught me k for, how to change my m they [nursing] never done	F 282	2	
	licensed practical r been R47's nurse and removed R47	for a long time and checked dressing from dialysis around t document that she had done			
	Review of R47's m (MAR) and treatm for the month of 7/ indication for nursi	nedication administration record ent administration record (TAR) 2016, revealed there was no ng to check and change R47's-	1	to the second	
	signs of infection. to the nurse mana intervention were 8/4/16. During an interview the administrator a both verified R47 changes and mon	r to monitor for bleeding and However, after it was brought ger's attention, these added to R47's 8/2016 MAR on w on 8/4/16, at 2:14 p.m. with and registered nurse (RN)-E, should have had dressing itoring for signs and symptoms MAR/TAR. RN-C stated that		F309: It is the policy of The Villa at E Mawr that residents are provided th necessary care and service to attain maintain the highest practicable we being. <u>Plan of correction for residents cite</u>	he nor ell-
F 309 SS=D	nursing should be resident's dressing A policy and proce provided. 483.25 PROVIDE HIGHEST WELL Each resident mu provide the neces or maintain the high	documenting when the g was last changed. edure was requested but not CARE/SERVICES FOR	F 30	this survey: R63 has been reassessed. Plan of ca been updated, and therapy has implemented new interventions, in a new walker. Resident has had no adverse effects identified. R20 has self-administer medications (SAM) nebulizer treatment reassessed. R2 had plan of care updated. Resident	cluding had of 0 has

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Event ID:9DEF11

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY PLETED
		245203	B. WING			08/	05/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILI	A AT BRYN MAWR				75 PENN AVENUE NORTH IINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF CI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	Continued From pa accordance with th and plan of care.	age 30 le comprehensive assessment	F	309	had no adverse effects identifier result of the observations by the R47 has had self-administration Lidoderm gel reevaluated. The p	e survey. of olan of	
	by:	NT is not met as evidenced	100 × 1	- ··	care has been review, updated revised. Resident has had no ad effects identified as a result of t observations by the survey. Th	verse he	
	review, the facility of 3 residents (R6 non-pressure relat and failed to ensu	ation, interview and document failed to monitor and assess 1 3) in the sample, reviewed for red skin conditions (bruising) re care was provided		. `	has contacted dialysis to update plan regarding appropriate dial interventions.	e the care	
	resident (R47)rece	services coordinated for 1 of 1 eiving dialysis.			<u>Plan to address/prevent this de</u> other residents:	ficiency for	
- · · · · · · · · · · · · · · · · · · ·		d on 8/1/16 to have a purple		· · · · · · · · · · · · · · · · · · ·	A post-incident checklist and th conditions policy has been imp	lemented	7
	forearm). The are were lighter purple purple. She also h middle knuckle of a dry scab. When fall while she was	bicep area (inner, upper as to the edge of the bruise and the center was a deeper ad a scrape noted on the her left hand. It was covered by asked, R63 stated she had a with her "companion" on a			at the facility. Nursing staff will the post-incident checklist at th an incident. Nursing staff will th the completed checklist into nu management for review and fu follow-up. The post-incident ch	ne time of hen turn ursing irther	
	time. A nurse's progres described a fall d while getting into check and noted and bruising pres chest that seeme The medication a and the treatmen 7/2016 and 8/201	obtained both injuries at that s note on 7/22/16, at 8:24 p.m. uring an outing. R62 tripped a car. The nurse did a body a "scrape right middle knuckle ent on the right arm near the d new." dministration records (MAR) t administration record (TAR) for 6 lacked identification or bruise or the scrape.			be completed after each incide occurrence. All residents will b for skin impairment document Bruises to be identified on TAR Treatment Administration Rec monitored until resolved. The procedures for skin impairmer treatments, self-administratio medication and nebulizers has reviewed and updated.	ent e audited ation. ( ord) and policy and nt, dialysis n of	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245203	B. WING			08/0	05/2016
	PROVIDER OR SUPPLIER			27	TREET ADDRESS, CITY, STATE, ZIP CODE 75 PENN AVENUE NORTH IINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	resident's injury, st tonight with extens a complete skin as	age 31 e on 7/23/16, the day after the ated R63 took a bed bath ive assistance of one staff and sessment was done. The skin y, intact and no pressure areas	F	309	Measures put in place to prevent recurrence: All residents will be assessment for self-administration of meds. Nursin will be educated on the self- administration of meds, nebulizer administration, pre and post assess	g staff	
	tub bath with exter	on 7/31/16 stated R63 took a nsive assistance of one staff. and intact. No pressure areas or d.		-	administration, pre and post assess and appropriate functionality of equipment. Staff educated on the to monitor all areas of skin impairm All residents receiving dialysis will b	need nent <del>.</del>	
	registered nurse ( were to be monito least daily, until re She verified that F	w on 8/3/16, at 1:31 p.m., a RN)-E stated all skin issues red and tracked on the TAR, at solved as the policy indicates. 363's TAR for 6/2016, 7/2016			assessed and have care plans revie ensure pre and post dialysis intenti being implemented. Nursing staff y educated on appropriate dialysis fo	ions are were ollow	
	skin conditions An Occurrence Re 8:56 p.m. noted th the Right Upper A looking bruise; Sk scrape on knuckle	I monitoring of non-pressure eport completed on 7/22/16, at le following injuries: Bruise to rm, near chest, purple, new in Tear to right middle Finger 3, e of right middle finger. A asurements-were-not			up. Nursing staff educate on the ne ensure accurate assessments within required time frames, the need to complete comprehensive care plan the need to update NAR care shee educated on appropriate monitorin coordination of care.	in the ns and its. Staff	
	A list of current or and treat current The current plan identified R62 as "Unsteady gait, P cognoscente [sic] directed staff to n	ders lacked direction to monitor non-pressure skin conditions. of care, target date 7/8/16, a fall risk related to actual falls, oor Balance, and failure to be of deficits." The care plan nonitor, document, and report hours to medical doctor for			<u>Plan to monitor</u> : To ensure compli the nursing management staff or o will conduct audits of all of our dia residents on a monthly basis. All r	designee alysis	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245203	B. WING		08/	05/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	pain and bruises. A policy to monitor conditions was req regarding Suspect Protocol Injury, Fra of unknown origin, provided. The polic or assessing non-p On 8/4/16, at 8:19 did not have a syst and other non-pres	and assess non-pressure skin juested however a policy ed Abuse and Neglect -Clinical actures, Bruises and Skin Tears revised June 2014) was cy did not address monitoring pressure skin conditions. <u>a.m. RN-E stated the facility</u> tem in place to monitor bruising ssure skin conditions. She	F	receiving nebulizer treatmen reviewed. All residents with i will be reviewed. The results will be presented to at the Q with audits continuing as wa QA Committee will monitor review trends and make recommendations as necess <u>Responsible for maintaining</u> Director of Nursing	impaired skin of the audit A meetings rranted. The compliance, sary.	
	non-pressure alter Abuse/Neglect pol verified the policy	only policy to monitor these ations in skin integrity was the icy that was provided. She and procedure did not direct		Correction Date: 9/7/16	1	nga sanjaran na mana na Na sana na mana
	monitoring of thes explained she did measurement of a monitor for change	nplete_and_standardized e skin conditions. RN-E not expect staff to take an initial bruise or an abrasion or to es in size or color and / body audits as an effective 1.		· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	
	director of nursing monitor bruising a She stated the me or wound nurse sl size, color or pain an initial measure information such a pain should be ob she did not consid adequate system	w on 8/4/16, at 8:48 a.m., the stated she expects staff to t least daily, if not every shift. edical doctor, nurse practitioner hould be notified if increase in was noted. She further stated ment and other identifying as color, area and presence of tained. The DON further stated der weekly body audits as an to monitor bruises, abrasions essure related skin conditions.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245203	B. WING_		08	/05/2016
	PROVIDER OR SUPPLIER	J *****		STREET ADDRESS, CITY, STATE, ZIP CO 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	R47 was interview stated he attended Wednesdays and expressed concern care by the facility here does nothing R47 explained tha nurse was suppos medication, Lidoca stated, "this never stated, "I don't known Nursing should be been going on like explained that the on his arm after the removed the bance it stopped bleeding	ed on 8/2/16, at 4:15 p.m. R47 I renal dialysis on Mondays, Fridays. At that time, R47 ns he had about his dialysis staff stating, "the nursing staff for my dialysis access site." t one hour prior to dialysis the ed to apply a numbing aine, to his access site. He happens. I have to do it." R47 ow why I have to do this. doing this, but they don't. It's this for some time now." R47 dialysis nurse put a bandage he run was completed, and he lage himself in the evening after g. The resident also indicated g staff did not monitor his	F 3	09	•	
	On 8/3/16, at 1:02 run went well toda any paperwork tha didn't get any pap might get paperwo A Quarterly Revie dated 6/16/2016 r Interview of Menta indicating a good the resident was The resident was The resident was The resident's cu indicated facility s access site care/a Licensed practica worked with R47 1:07 p.m. LPN-H	p.m. R47 stated his dialysis y. When R47 was asked about at was given to him, he replied "I erwork back from dialysis I ork once a month." w Minimum Data Set (MDS) evealed the resident had a Brief al Status (BIMS) score of 15 memory. The MDS indicated receiving dialysis treatments. able to communicate needs. rrrent care plan dated 6/25/2015 taff were to complete dialysis assessment daily. I nurse (LPN)-H who routinely was interviewed on 8/3/16, at verified R47 self-administered am prior to dialysis. She				

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FORM	APPR	OVED
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CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			0	MR NO.	0938-0391
	IDENTIFIC ATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	r.	245203	B. WING	B. WING			05/2016
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	275 PENN AVENUE NORTH		
THE VILL	A AT BRYN MAWR			1	MINNEAPOLIS, MN 55405		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLÉTION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	ż	DEFICIENCY)		
			<u> </u>				
E 200	Continued From pa	200.34	E .	309			
1 309		-	1	000			
		e of the cream, the facility					
		age, and he performed the					
		" LPN-H stated she used to hen his dialysis appointments					
	melp the resident w	adding the resident's					
	appointment time	was now earlier and she was					
	appointment time to	by to help him. LPN-H					ļ
	avalated when B	47 leaves for his appointment					
	wo fourses send r	paperwork with him, but when					
	he comes back he	does not give it to us."					
		(RN)-A stated at 1:10 p.m. on					
		naware R47 was applying					
	prescribed topical	medication to his dialysis					
	access site RN-A	said sometimes the resident					
		paperwork to the facility nurse					
<b>1</b> . alis 10.000	upon returning fro	m dialysis. RN-A stated when	· · · · · ·		and a second		· · · · · · · · · · · · · · · · · · ·
		en a prescription in the past he					
	has kept or has lo	st them, "so we have asked the					
		any prescriptions be called					
		rmacy." RN-A stated she was					
	unsure why R47 d	id not have a physician order in		·			
		for the Lidocaine, "I will have to	a de la composición de la comp				
		nic for the order." At 1:25 p.m.					
		had spoken to the dialysis nurse					
		her the clinic had contacted the					
		5, to notify them R47 had been					
		ine-cream which had been filled	-				_
		ic, with directions to apply 1					
	hour prior to his a						
		oximately 3 p.m., R47's dialysis					
	nurse (RN-C) was	interviewed by telephone. She					
		eceived an order for Lidocaine					
	cream from the di	alysis center, which was to be					
	applied to the acc	ess site one hour prior to his					
	appointments. RN	I-C stated, "I don't think the					
		e information sheets we send					
		er each dialysis run. We [dialysis					
		nd that if we have something that	u				
	really needs to be	addressed or changed, we					1

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Facility ID: 00175

If continuation sheet Page 35 of 55

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245203	B. WING		- 08/	/05/2016
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STAT 275 PENN AVENUE NORTH MINNEAPOLIS, MN 5540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 309	have to call the fac On 8/4/16, at 10:3 been moved to a r When asked if he replied, "Yes, I will R47 opened the di cream. RN-D, a nu	sility directly." B a.m. R47 stated he had just new room the previous evening. had the Lidocaine cream he show you." However, when rawer he could not find the urse on the resident's current	F 3	09		
	the Lidocaine creater been left in the tre living unit. At 12:50 found the lidocain					
	on 8/4/16. On top dialysis center tha team, we put this communication ar	of the book was reviewed of the book was a note to the t included: "Dear dialysis care book together to improve the ad should travel to/from with				· · · · · · · · · · · · · · · · · · ·
	add data to assist only contained a f very little other inf medical record re communication be the facility. There found in the residu dialysis treatment	review, suggest changes and our team." However, the book ace sheet dated 7/25/16 ,and ormation. A review of R47's vealed a lack of documented etween the dialysis clinic and was no documentation at all ent's records related to the runs.				
	On-8/4/16, at 1:31 R47's dialysis run the documents ha had the dialysis c confirmed there h notes in R47's ch During an intervie administrator and have had dressin signs and sympto MAR/TAR. RN-0 documenting whe	<u>p.m. RN-E-provided pages of</u> results. When asked where ad come from, RN-E said she'd linic fax them over. RN-E ad been no other dialysis run			· · · · · · · · · · · · · · · · · · ·	-

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:9DEF11

Facility ID: 00175

If continuation sheet Page 36 of 55

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES 20000

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	LA AT BRYN MAWR			2	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ц IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309 F 322 <del>SS=D</del>	acknowledged that back his paperwork staff should be call asking for a faxed A policy and procee provided.	t if R47 does not take or bring k from dialysis, the nursing ling the dialysis clinic and copy of the run for the day. edure was requested but not REATMENT/SERVICES -		309 322			
	Based on the compresident, the facility (1) A resident who alone or with assistube unless the res	prehensive assessment of a ty must ensure that has been able to eat enough stance is not fed by naso gastric isident ' s clinical condition t use of a naso gastric tube was			F322: It is the policy of The Villa at I Mawr to provide guidelines for the administration of medications throu enteral tube.	safe Igh an	
	gastrostomy tube treatment and sen pneumonia, diarrh metabolic abnorm	b is fed by a naso-gastric or receives the appropriate vices to prevent aspiration hea, vomiting, dehydration, halities, and nasal-pharyngeal ore, if possible, normal eating	× ••••	• • •	Plan of correction for residents cite this survey: Nursing staff completed hydration assessments on R149. R149 incurre adverse effects as a result of observ Dietician has evaluated the resident	risk d no ation.	•
	by: Based on observa review, the facility and monitoring wa (R149) reviewed f	ENT is not met as evidenced vation, interview and document v failed to ensure proper care as provided for 1 of 1 resident for use of a tube feeding, to ent received adequate nutritional			ensure appropriate nutritional interventions are implemented. A ca conference was held with resident a IDT to ensure her care concerns wer being met. Resident has now been receiving bolus tube feeding with increased compliance. Resident voic satisfaction with the changes to her plans.	ind e	

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Facility ID: 00175

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391

AS FOR MEDICARE	: & MEDICAID SERVICES			V	IVID NO.	0938-0391
IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245203	B. WING			08/	05/2016
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LA AT BRYN MAWR						
SUMMABY ST	ATEMENT OF DEFICIENCIES		L		N	(X5) COMPLETION
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI				COMPLETION DATE
Continued From br	07	E (	იიი	Plan to address/prevent this deficie	ncy for	
	age 37		322	other residents:		
				The facility has implemented a polic	wand	
Findings include:					y anu	
					sk	
				-	51	
					N. If a	
					u	
					and	
per registered diet	d 8/3/16 confirmed the orders					
				hydration interventions. Nursing sta	ff has	
nutritional needs w	vere 1000-1400 kilocalorie,					
40-60 grams prote	in and 1000-1400 ml fluids.	·				
	lated 7/25/16. indicated R149			gastrostomy tube care.		
had a nutritional p	roblem with a weight loss of					
				recurrence:		
				Nursing staff has completed hydrat	ion	
				· · ·		
On 8/3/16, at 7:37	a.m. the surveyor observed					
					- 1	
supplement was h	anging on an IV pole with				th the	
G-Tube ( a tube s	urgically placed into the					
stomach to provid	e nutritional support) was			· ·		
tube during the ni	explained H149 will shut off her aht when she goes to the					
	Continued From particles (EACH DEFICIENCIES REGULATORY OR L Continued From particles intake. Findings include: R149's physician's indicated R149 wa liquid high-calorie in milliliters per hour- (midnight) to 9:00 a flushes at 12am, 3 per registered dietti progress note date on 8/2/16, with the nutritional needs w 40-60 grams prote R149's care plan of had a nutritional protes R149's care plan of had a nutritional plan of had	OF DEFICIENCIES FE CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245203         PROVIDER OR SUPPLIER         LA AT BRYN MAWR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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 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 </td <td>OF DEFICIENCIES FORMECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203       (X2) MUL A. BUILD         245203       B. WING         22014       B. WING         22015       B. G. G.</td> <td>OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPL         IDENTIFICATION NUMBER:       245203       B. WING         PROVIDER OR SUPPLIER       245203       B. WING         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFICIENCIES         IEAAT BRYN MAWR       ID       PREFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX         IEAAT BRYN MAWR       ID       PREFIX         Continued From page 37       F 322         intake.       Findings include:       F 322         R149's physician's order sheet on 8/2/16,       indicated R149 was to receive petamen 1.5 (a       Iiquid high-calorie nutritional supplement) at 105         millillers per hour (ml/hr) from 12:00 a.m.       mm.       (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 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       estimated 19% loss in 180 days and was on tube         feedings to provide adequate calories and fluids.       Staff interventions were to provide tube feeding</td> <td>OP DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION         A BUILDING       245203       B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE       STREET ADDRESS, CITY, STATE, ZIP CODE         AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       ID         ILA AT BRYN MAWR       SUMMARY STATEMENT OF DEFICIENCIES         SUMMARY STATEMENT OF DEFICIENCIES       ID         ILEACH CONCENTRY MAY STATEMENT OF DEFICIENCIES       ID         ILEACH CONCENTRY MAY STATEMENT OF DEFICIENCIES       ID         ILEACH CONCENTRY STATEMENT OF DEFICIENCIES       ID         Intake.       ID       ID         FINDINGS INCLUE       ID       ID         Intake.       F 322       Plan to address/prevent this deficie         FINDINGS INCLUE       ID       ID       ID         Indicated R149 was to receive peptamen 1.5 (a       ILEACH CONCENTRY         ILIGUED</td> <td>OP DEFICIENCIES FORMECTION       (X) PROVIDERSUPPLIENCIAL IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILONG       (X3) DATL A BUILONG         PROVIDER OR SUPPLIER       245203       B. WING       08/         LA T BRYN MAWR       STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405       08/         Isource of the operation of the providence of the operation of the operatio</td>	OF DEFICIENCIES FORMECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203       (X2) MUL A. BUILD         245203       B. WING         22014       B. WING         22015       B. G.	OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPL         IDENTIFICATION NUMBER:       245203       B. WING         PROVIDER OR SUPPLIER       245203       B. WING         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFICIENCIES         IEAAT BRYN MAWR       ID       PREFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX         IEAAT BRYN MAWR       ID       PREFIX         Continued From page 37       F 322         intake.       Findings include:       F 322         R149's physician's order sheet on 8/2/16,       indicated R149 was to receive petamen 1.5 (a       Iiquid high-calorie nutritional supplement) at 105         millillers per hour (ml/hr) from 12:00 a.m.       mm.       (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 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       estimated 19% loss in 180 days and was on tube         feedings to provide adequate calories and fluids.       Staff interventions were to provide tube feeding	OP DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION         A BUILDING       245203       B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE       STREET ADDRESS, CITY, STATE, ZIP CODE         AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       ID         ILA AT BRYN MAWR       SUMMARY STATEMENT OF DEFICIENCIES         SUMMARY STATEMENT OF DEFICIENCIES       ID         ILEACH CONCENTRY MAY STATEMENT OF DEFICIENCIES       ID         ILEACH CONCENTRY MAY STATEMENT OF DEFICIENCIES       ID         ILEACH CONCENTRY STATEMENT OF DEFICIENCIES       ID         Intake.       ID       ID         FINDINGS INCLUE       ID       ID         Intake.       F 322       Plan to address/prevent this deficie         FINDINGS INCLUE       ID       ID       ID         Indicated R149 was to receive peptamen 1.5 (a       ILEACH CONCENTRY         ILIGUED	OP DEFICIENCIES FORMECTION       (X) PROVIDERSUPPLIENCIAL IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILONG       (X3) DATL A BUILONG         PROVIDER OR SUPPLIER       245203       B. WING       08/         LA T BRYN MAWR       STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405       08/         Isource of the operation of the providence of the operation of the operatio

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Facility ID: 00175

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PRINTED:	08/22/2016
FORM A	<b>APPROVED</b>
OMB NO.	0938-0391

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED		
		245203	B. WING		08/0	)5/2016	
	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 322	bathroom and not LPN-D stated "I we and it was off [the R149 gets all her r and receives 30 m medication given to	tell anyone she has done this. ent into her room at 7:45 a.m. G-tube pump]. LPN-D stated nutritional needs via the G-tube I flushed before and after any o her. LPN-D verified R149	F 32	DON or designee will conduct audit residents monthly with naso-gastric gastrostomy tubes for the next 90 of The results of the audits will be pre	c or daγs. sented		
	day.	xtra flushes throughout the v the same day at 2:57 p.m.		at the QA Meetings with audits cor as warranted. QA Committee will e ongoing compliance with F322 and	nsure make		
	R149 explained sh previous day beca She said the G-tut	ne was in the hospital the use her G-tube was clogged. De was now unclogged but her		ngoing recommendations as need Responsible for maintaining compl	led.		
×	does take out her smoke or to the ba and let staff know	clogged. R149 explained she tubing when she goes to athroom but will put her light on when she is back in her room. my nutrition from this [pointing]	· · · · · · · · · · · · · · · · · · ·	Director of Nursing and Director of Dietary Services	f	, ,	
-	to her nutritional s hanging on the IV keeps clogging du awhile to come in, the nutrition I need supplement left in indicated she had clogged tube. On	upplement fluid in the bag pole] however my G-tube ring the night and it takes staff each time it stops I don't get all d, "look there is still nutritional my bag." The resident been in the hospital for a 8/4/16 at 4:20 p.m., R149		<u>Correction Date</u> : 9/7/16	*		
	G-tube on her own to this facility. "I h about this G-tube	has been managing the n for a long time before coming have asked staff to teach me because it's different than the ne, but they have never done ne."					
	(LPN)-C verified h been working with LPN-C explained room and not let s	w on 8/4/16, at 6:48 a.m. he works the night shift and has h R149 the last two nights. R149 would come out of her staff know when she G-tube so LPN-C kept peeking					

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PRINTED:	08/22/2016
FORM	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 08/05/2016	
	<b>245203</b> B. V		B. WING _			
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 322	in on her often to s was still running. L whole bag of nutriti talking with LPN-C a.m. R149 came o disconnected and to smoke. The sur smoking courtyard when I unplug my come back to hool previous night the G-tube, but he war nutritional supplem the room all day." fresh nutrition that day and it will mak	ee if her nutritional supplement PN-C stated R149 gets a ional supplement. While at the nursing station, at 6:48 ut of her room with the G-tube told LPN-C she was going out veyor interviewed R149 in the R149 said, "I do tell staff G-tube, but they [staff] don't k it up. R149 explained that the nurse came in to hook up her need to put on the same nent that had been hanging in I told him that I should get stuff has been sitting there all e me sick." He put a new bag stated, "I am very worried about				
· ·	A review of R149's record (MAR) for t R149 was to receir peptamen 1.5 at 8 was changed on 8 (midnight) to 9 am documention the r nutritional_support initial the MAR as document on the k not given for two ti indicated one note resident, "refused allowed staff to ho documentaion was nutritional supplem	s medication administration he month of 8/2016, revealed ve nutritional support of 0 ml/hr from 8pm to 8am then /2/16, to 105 ml/hr from 12am . The MAR indicated no esident received any of her on 8/2 or 8/3. Staff did not being given nor did staff back of the MAR reasons why imes. Review of nursing notes that on 8/2/16, at 21:40 the her tube feeding at 8PM but ook it up at 9:30 pm." No s noted as to how much nent she received daily.				

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PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPP THE VILLA AT BRYN MAV		B. WING STREET ADDRESS, CITY, STATE, 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN O PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
The facility mu (1) Procure for considered sat authorities; and	D PROCURE, ARE/SERVE - SANITARY st - od from sources approved or isfactory by Federal, State or local d are, distribute and serve food	F 371F371: It is the policy of Mawr to store, prepare service food under saniPlan of correction for re this survey: No residents were harm practice.Plan to address/preven other residents:	e, distribute and itary conditions. <u>esidents cited with</u> ned by this
by: Based on obs review, the fac dietary sanitati to affect all 110 from the kitche Findings includ An initial tour of the certified di 12:36 p.m. The Cook-A was pi The gloves he exposed his fil cheese, and to available glove had not been p the gloves coor resulting in ho	de: of the kitchen was conducted with etary manager (CDM) on 8/1/16, at e following concerns were noted: repping food for the noon meal. was wearing had large holes that ngers as he touched lettuce ortillas. Cook-A explained the es were too small and larger gloves provided. The CDM then confirmed ok-A was wearing were too small,	eliminates the tray carts. New serving from st each station w of the locked u which will cont line service. 3. Staff will be ed cereal storage 4. Chipped/crack be repaired or 5. Compressor of cooler will be o painted surfac or replaced wi surface. 6. All equipment	hing ure. vice provided that need for so many w service involves team tables on vith the exception unit of station 3, tinue getting tray ducated on proper procedures. ked floor tiles will replaced. f the reach-in white cleaned. The we will be removed

PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391

	15 FUR MEDIUARE	& MEDICAID SERVICES				. 0930-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		245203	B, WING		08/	/05/2016
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COD 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE
F 371	explained the stack prepared for reside lunch menu. They disposed of not se The dish room are trays being readied	age 41 ked cereal bowls had been ents as an alternative to the would either get put away or be rved at the noon meal. a was crowded. Carts with t to deliver to dining rooms also e. Staff were required to cross	F3	<ul> <li>7. Painted prep surfaces, c and sliding door tracks of removed or replaced with cleanable surfaces.</li> <li>8. Staff will be re-educated dishwashing procedures general kitchen sanitati guidelines including not between dirty and clean</li> </ul>	vill be th d on s and on c crossing	
	over between the o tray set up to reach stated dirty dishes right, were sent the	e. Stair were required to cross carts and clean dishes used for h the dirty dish area. The CDM came into the dish room to the rough the dish machine, and clean dish area on the back		and prevention of overs from the dish room into clean area. 9. Ice chests will have removable/cleanable li	pray the	
	with trays at every Floor tiles in the pr were chipped and	reparation and serving area cracked and parts of tile were		ice scoop holders instal 10. Staff educated on the p delivery of cold items o bath and the proper dis	led. roper n an ice posal of	
	cracks and missin There was a heav compressor of the surface of the coo the surface was un surrounded the ec	s a heavy black build-up in the g tile areas. y layer of dust/dirt on the reach-in white cooler. The ler had been painted white and neven. Dark finger prints lges of refrigerators. A freezer s and finger prints, as well as		items not kept to adeq temperature. 11. Staff will be re-educate proper cleaning policy, for the can opener. 12. Janitor closet door will cleaned and/or repaire	ed on the /procedure be	
	white substance s The three-door re- was cracked and closed tightly). The sides of the c been painted blue were not cleanabl black build-up alo Chips and cracks interior of three dr	hrome preparation counter had and corroded, blackened areas e. The sliding door tracks had a ng the doors and drawers. were noted in the painted rawers where scoops and other ed. The outside edges of the		Measures put in place to prever recurrence: 1. Ensure all necessary g are in stock for emplo 2. Cleaning schedules are monthly with the expe that staff are cleaning assigned areas daily.	ove sizes yee use. e posted ectation	**** • * * * * * *

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Facility ID: 00175

If continuation sheet Page 42 of 55

PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391 •;;\*

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IN FUT OF A DEPARTMENT IN FUT ON AN INFORM				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245203	B. WING	i		08/0	05/2016
	PROVIDER OR SUPPLIER	L	1	2	TREET ADDRESS, CITY, STATE, ZIP CODE 75 PENN AVENUE NORTH IINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	peeling paint, and w More than half of th was splattered with Splatters were also Food tray preparat 11:12 a.m. While th a staff person was the dish machine w person was prepar trays, silverware an tray cart faced the	age 42 track marks, chipped and were soiled at the handles. The door to the janitor closet a brown unknown substance. In noted on cork bulletin board. The trays were being prepared, pre-spraying dishes prior to vash cycle. A second staff ing the clean tray carts with and other items. The door on the back wall toward the dish mately three to four feet from		371	<ol> <li>Commercial can opener cle will be done each shift with complete disassembly of th blade each time.</li> <li>Ice bins will have covered s separated from the ice and kitchen staff will run scoop holders through dish mach daily. DDS will check the ic on a weekly basis to ensur- adherence to guidelines.</li> <li>Staff will be re-educated o maintaining a separation c and clean items in the dish Staff will be educated on</li> </ol>	n the ne scoops I the ine e bins e n of dirty n room.	
	the dish sprayer. N	Aist from the spray reached the an tray set-up process.			appropriate kitchen sanita avoid the prevention of fo	tion to	
	dining areas were registered dietitian were responsible f residents as they r dining areas conta in a chest cooler.	on 8/3/16, at 7:05 a.m. the toured with the CDM and . The CDM explained nurses or delivering ice water to requested. Carts in four of five lined ice stored in a plastic bag An ice machine was also t floor. All ice chests were kept			borne illness. 6. DDS ( Director of Dietary Services) will do weekly r checking kitchen cleanline sanitation. <u>Plan to monitor:</u>	ounds	
	contained ice scool ice that was restin water. The CDM the facility used for night nursing staff the ice in the cool during the tour the melted, and scoop in the ice. When a considered accep not. We are taking	be coolers and the ice machine- ops or a plastic cup to remove g on the ice itself or in melted stated on 8/4/16 at 2:39 p.m. ur ice coolers on the units. The were responsible for replacing ers. The CDM-verified that- e ice was observed to have os and cups were being stored asked if the practice was table she replied, "Definitely g it over from nursing." Going was for dietary staff to take			DDS will do weekly rounds and will the cleaning schedules, ice bins, st adherence, maintenance of items above, and forward the audits to Committee. QA Committee will er ongoing compliance with F371 an ongoing recommendations as nee	taff listed the QA nsure d make	

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OMB NO 0938-0391	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE SURVEY COMPLETED
		245203	B. WING		08/05/2016
NAME OF F	ROVIDER OR SUPPLIER	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
			27	75 PENN AVENUE NORTH	
THE VILL	A AT BRYN MAWR		м	INNEAPOLIS, MN 55405	
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 371	Continued From pa	43	F 371	2.4.20068 <b>8</b> .042 - 1.1.2	
1 0/1		-	1 3/1		
		suring ice was changed in the		Responsible for maintain complia	ince:
		was unsure whether the facility		Director of Dietary Services	
	had a related polic	y.		Director of Dietary Services	r T
	On 8/2/16 at 7:30	a.m. a cart containing coffee			
		alf gallon plastic bottles of milk		Correction Date:	
	was at the unit 2 n	ursing station. The milk was	1	9/7/16	
	not stored on ice a	nd it was unclear when it had		- X	· · · · · · · · · · · · · · · · · · ·
		8:13 a.m. a dietary assistant			
		the unit two dining room. The			
		out cooling or refrigeration for			
17 Y.Y. BUTCHER BALLET 111 11		t 8:42 a.m. milk was poured for			
		ibuted to residents. A dietary			
		tated she brought the milk to			
		:15 and 7:30 a.m. that morning.		,	
		at the nurses were supposed to			nemer - autor an an an anna an anna an an an an an an
		ilk in the refrigerator but, "that—			
		lay." DA-C said any remaining	-		
		he meal would be discarded, "it			
		y serve and do not do the milk,			
		now." At 8:49 a.m. LPN-B			
		supposed to come up from the			
	kitchen on ice and	then be placed into the			
		B stated, "There was not ice			
		ub of ice was delivered and the			
		n the ice. DA-B stated at 8:57 prought_milk_to_the_units_from			
	the kitchen and it	should have been placed in a			
		/16, at 1:55 p.m. The CDM			
		ded to leave the kitchen on ice,			
		hen been refrigerated or			
		ol. Milk was sent to the units at			
		ter the meal unused portions			** * * * * * ** ** **
		The CDM did not know why			
		ivered the previous morning			
	without ice, but sh	e instructed staff to provide a			
		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	)		
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		: & MEDICAID SERVICES				. 0936-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT CON	E SURVEY MPLETED	
		B. WING		08	/05/2016	
		L		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH		
THE VIL	LA AT BRYN MAWR		1	MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	the kitchen and wa kept in a bin. If not Sanitation concern during observation sides of the chrom	age 44 Is still cold, it was marked and , it was disposed of. Is were noted in the kitchen s on 8/4/16, at 9:15 a.m. The e preparation counter had The paint was chipped and	F 37	1		
	bubbling and had to have had to have here and have here and here a	plack corroded areas that were sliding door tracks had a black doors and drawers.				
	exterior and interio	were noted on the painted or of three drawers that store				
110000 - 11000 A - 110	cart was not clean	soiled at the handles. The plate and had food spills on the				
	had blackened wh	y cart was also not clean and eels.				
	near the blade of t reported the blade the opener was clu- noticed the metal "The blade was ju cleaning schedule schedule included was-due that-day. and instructed DA the dish machine. showed the surve metal shavings ar the blade. DA-A th scrape the blade the sides, and put second time. DA-	d black build-up was observed the can opener. Cook-A was changed "last week" and eaned weekly. Cook-A had not shavings. DA-A then explained, st changed and is part of my ." DA-A said the cleaning cleaning the can opener and Cook-A took it to the dish room -A to rinse it and put it through Following this process, DA-A yor, who pointed out that the d black build up remained near nen used a butter knife to as well as a scrubber to wash it through the dish washer a A then rinsed it with the sprayer of the dish room to remove the lue" and returned it to the	•			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED		
		245203	B. WING			08/05/2016	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILI	A AT BRYN MAWR				275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371	DA-A then proceed pans on the right si clean dishes came reached for the spr sprayed off the disi clean dishes. DA-/ stainless steel, clean and explained she	age 45 ed to rinse dirty dishes and de of the dish machine. As the out of the machine, she ayer with her right hand and nfectant residue from the A pointed out residue on the an side of dish room counter would not want that on her performing hand washing, she	F	37	1		· · · · · · · · · · · · · · · · · · ·
	rinsed her hands u moved to the clear	sing the dirty sprayer, and then side of the dish room. DA-A					
	process. She proce	s or wash her hands during the beded to the rack where					
		ored, obtained a blue cloth and					
		trays. The cloth was then					
		over the clean dishes. She ays back to the dirty side of					
		then moved two clean, but still					
		nveyor line in the kitchen. DA-A					
		arts with a cloth. When asked					
		g DA-A responded, "Yes, we					
	wash our hands be	etween clean and dirty. We are	i.				
		ing our hands. It is required." It					
		n DA-A first approached a sink					
		ids, but did not wash using		,			
	soap. DA-A then to	or the first time, applied gloves ty side of the dish machine.					
		ed on the dirty side of the sink					
		ks which were moved through					
		fter the rinse cycle, racks were					
	pulled using her le	ft hand and without touching					
		oves were removed at 10:00					
		sprayer, DA-A again sprayed			·····		
		counter. She proceeded to					
	move clean plates	and plate covers to the racks.					
		cloth and began to wipe the					
		en finished wiping the dishes, ands on the towel and placed it					
		above the clean dishes. DA-A					
L			1				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245203	B. WING _		08/	05/2016
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CC 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	dishes. She then ri washing sink, but a stacked clean plate prior to stacking. D rack, retrieved an the chemical rack handled the dirty p	s and returned to washing dirty insed her hands at the hand again did not use soap. She es and bowls, shaking them DA-A placed two trays in the tray orange towel from the bin on and wiped the trays dry. DA-A lots and pans:on:numerous	F 37	71		
	then rinsed them c	m through the dishwasher, and ff with the dirty sprayer.				
	p.m. hand washing CDM reported she and hand provided confirmed staff we clean dishes/ proc She did not consic sprayer on the dirt with hand washing sanitizer is meant rinsed off." Dishwa not have occurred the CDM. The CDM also ver	an interview on 8/4/16, at 1:55 g was "an expectation." The had made similar observations d education for DA-A. She ire not to go between dirty and esses without washing hands. Her rinsing hands with the y side of the sink consistent g. The CDM explained, "The to sit on the dishes and not be ashing and tray set up should at the same time, according to rified there were surfaces that eanable in the kitchen and				
	preparation area. was bubbled and pattempted to clear door, but it would were supposed to after each use in or removed. There so of any food debris opener. The CDM blade last week. T	She verified some of the paint peeled. The CDM said she had in the splatters off the janitor not come clean. Can openers be run through the dishwasher order for food residue to be should have been no evidence or metal shavings on the l verified she had changed the The CDM confirmed they ut the compressor vent on the		Facility ID: 00175	continuation shee	

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FORM	APPROVED
OMB NO.	0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245203	B. WING		08/05/2016
	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	2	REET ADDRESS, CITY, STATE, ZIP CODE 5 PENN AVENUE NORTH INNEAPOLIS, MN 55405	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETION
F 371	Continued From pa	age 47	F 371		
	staff as follows: "A and equipment sha good repair and sh	ed Sanitization policy directed Il utensils, counters, shelves all be kept clean, maintained in all be free from breaks, eams, cracks and chipped			
1.10	areas that may affe	ect their use or proper cleaning. fasteners will be kept in good			
	surfaces and utens or completely loos	y, "All equipment, food contact sils shall be washed to remove en soils by using the manual or			
	hot water and/or c	s necessary and sanitized using hemical sanitizing solutions d ice storage containers will be			
	drained, cleaned a				
	directed staff to, "\	ted Dishwashing Machine Use Wash hands before and after ng machine, and frequently			
F 425 SS=D	483.60(a),(b) PHA	RMACEUTICAL SVC -	F 425		
	drugs and biologic	provide routine and emergency cals to its residents, or obtain reement described in		F 425: It is the policy of The Villa a Mawr to provide routine drugs an	
	§483.75(h) of this unlicensed persor	part. The facility may permit nnel to administer drugs if State nly under the general	• .	biologicals to its residents.	
	(including procedul acquiring, receivir	vide pharmaceutical services ures that assure the accurate ng, dispensing, and II drugs and biologicals) to meet n resident.			

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TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COMF	PLETED
		245203	B. WING			08/0	5/2016
	ROVIDER OR SUPPLIER			27	TREET ADDRESS, CITY, STATE, ZIP CODE 75 PENN AVENUE NORTH		
				N	INNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROT DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	a licensed pharmad	nploy or obtain the services of cist who provides consultation e provision of pharmacy	F	425	Plan of correction for residents cite this survey: R2 has now received Depakote and Clozapine. Resident has had behavi assessed and no adverse effects ide as a result of the survey. R120 has received Oxycodone. Resident has pain assessment reviewed and upd	ors entified had	
	by: Based on observa review, the facility services were sect medications and b residents (R2, R12 for missed medica not being available Findings include: During an observa administration, on medication aid (TM Depakote (a medic activity but has als and behavior) for f schizophrenia and advised a licensed was also unable to nursing medication	NT is not met as evidenced tion, interview and document failed to ensure pharmaceutical ured, including routine iologicals as ordered for 4 of 8 20, R145 and R149), reviewed tion doses due to medications of or administration. ation of medication 8/1/16, at 7:07 p.m. a trained MA)-B was unable to locate cation used to decrease seizure to been used to stabilize mood R2. R2's diagnoses included I major depression. TMA-B d practical nurse (LPN)-G who to locate the medication in the n cart and the medication room.			No adverse effects have been ident a result of the observation by the s R145 has been discharged from the facility. Prior to discharge, she did Trazadone Requip. No adverse effect have been identified as a result of observation by the survey. R149 has received her Ferrous Sulfate and Gabapentin. The resident has had adverse effects identified as a result the observation by the survey. Consultation with staff and has had adverse effects identified as a result the observation by the survey. Consultation with pharmacist rega policy and procedure with medicat administration. <u>Plan to address/prevent this defici- other residents:</u> Nursing is reviewing all of the MAR (Medication Administration Record	tified as urvey. receive ects the as a care no It of rding tion ency for	
	p.m., explained th medications to en label on the medic approximately 7 p	y. ctor of nursing (ADON), at 7:15 e process for reordering sure availability was to pull the cation card when there were ills left and fax it to the aid it was important to allot					

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RS FOR MEDICARE	& NEDICAID SERVICES					1
T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
	245203	B. WING _		08/	05/2016	
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
I A AT BRYN MAWR			275 PENN AVENUE NORTH			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE	
adequate time in c able to be reordererere reasons. She explained if it would be ordered ' on the next run fro would pick up the ereasons. It was th	ase the medication was not ed due to insurance or other was a necessary medication, it 'stat" and would be expected m the pharmacy. The facility expense for any or these e responsibility of the nurses or	F 42	to the physician's orders. Nursi being educated on proper med administration, reordering and on missing meds. <u>Measures put in place to preve</u> <u>recurrence</u> : Facility will complete a MAR to	ng staff is ication follow up <u>nt</u> cart		
ensure it had been the residents.	reordered and available for		Facility will do random audits of staff_with_medication_administ	of nursing ration, 10		
(MAR) revealed th initialed and circled explanation was d	e medication Depakote was d on 8/1/16, at 8:00 p.m. No ocumented on either side of the	,	consultant will do audits of nu	sing		
the initials were cir written on 1/26/16 Depakote ER (ext (mg) by mouth (pc plan, target date 1 mood and behavio delusions, active h and the potential f schizophrenia. Th	cled A physician's order, directed staff to administer ended release) 2000 milligrams every bedtime. R2's care 0/17/16, identified R2 as having or problems, grandiose nallucinations and depression or self-harm related paranoid e care plan directed staff to		Committee. QA Committee wi ongoing compliance with F425 ongoing recommendations as <u>Responsible for maintain com</u>	II ensure and make needed. pliance:		
staff to administer A Heath Status No did not have any a Clozapine, used to suicidal behavior, unavailable and w	Clozapine 400 mg at bedtime ote written 7/23/16 indicated R2 antipsychotic medication, b treat schizophrenia and lower stating at present time it was vas being processed by the VA		<u>Correction Date:</u> 9/7/16			
	PROVIDER OR SUPPLIER LA AT BRYN MAWR SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From para adequate time in c able to be reorderer reasons. She explained if it would be ordered ' on the next run fro would pick up the a reasons. It was th TMAs that were ac ensure it had been the residents. A review of the me (MAR) revealed th initialed and circler explanation was de MAR or in the nurs the initials were cir written on 1/26/16 Depakote ER (extu (mg) by mouth (por plan, target date 1 mood and behavior delusions, active h and the potential f schizophrenia. The administer medica A physician's order staff to administer A Heath Status No did not have any a Clozapine, used to suicidal behavior, unavailable and w	DF CORRECTION       IDENTIFICATION NUMBER:         10ENTIFICATION NUMBER:         245203         PROVIDER OR SUPPLIER         LA AT BRYN MAWR         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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	ICOP DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULT         DECORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULT         LA AT BRYN MAWR       245203       B. WING_         PROVIDER OR SUPPLIER         LA AT BRYN MAWR         SUMMARY STATEMENT OF DEFICIENCIES       ID         REGULATORY OR LSC IDENTIFYING INFORMATION)       F 42         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 Molace data the administer Clozapine 400 mg at bedtime         A Heath Status Note written 7/23/16 indicated R2 did not	TOP DEFICIENCIES OF CORRECTION       (X1) PROVIDERSUPPLIENCEA IDENTIFICATION NUMBER:       (X2) MULTIFIE CONSTRUCTION A. BUILDING         245203       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       ID PROVIDERS PLAN OF CORRE (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)         Continued From page 49 adequate time in case the medication was not able to be reordered due to insurance or other reasons.       F 425 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	OP DEFICIENCIES       (X1) PROVIDERSUPPLICENCLAN       (X2) MUTIFILE CONSTRUCTION       (X3) DATI A BUILDING         OPCOMPACTION       245203       B. WING       (Q2) MUTIFILE CONSTRUCTION       (Q2) MUTIFILE CONSTRUCTION         A T BRYN MAWR       275 PENN AVENUE NORTH       (Q2) MUTIFILE CONSTRUCTION       (Q2) MUTIFILE CONSTRUCTION       (Q2) MUTIFILE CONSTRUCTION         A T BRYN MAWR       275 PENN AVENUE NORTH       (Q2) MUTIFILE CONSTRUCTION       (Q3) MUTIFILE CONSTRUCTION         SumMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER ALL CONTROLLS, MN 55405         Continued From page 49       EACH DEFICIENCY OR LSC IDENTIFING INFORMATION)       F 425         all of the residents and comparing them adequate time in case the medication was not able to be reordered 'stat' and would be expected on the next run from the pharmacy. The facility       F 425         would pick up the expense for any or these       Feacility Will complete a MAR to cart         reasonst.was the responsibility of the nurses or TMAS that were administering the medications to the residents.       Facility Will complete a MAR to cart         A review of the medication administration records       consultant-Will do audits of nursing staff with and citation fursing medication distribution practices and technique.         A review of the medication administration records       consultant-Will do audits of nursing medication distribution practices and technique.         A review of the medication administration re	CORDINCIES       [X1] PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER:       (20) DATE SURVEY COMPLETED         242203       a. WING       08/05/2016         PROVIDER ON SUPPLIER       245203       s. WING       08/05/2016         LA AT BRYN MAWR       STREET ADDRESS, CITY, STATE, ZP CODE Z75 PENN AVENUE NORTH MINNEAPOLIS, MN 55405       08/05/2016         Continued From page 49 adequate time in case the medication was not able to be reordered due to insurance or other reasons.       ID She explained if it was a necessary medication, it would be ordered "stat" and would be expected on the next unif rom the pharmacy. The facility would pick up the expense for any or these reasons.       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.       comparing them to the physician"s orders. Nursing staff is being educated in proper medication administration, reordering and follow up on mussing meds.       comparing them to the physician"s orders. Nursing staff is being educated on proper medication administration, reordering and follow up on mussing meds.       comparing them to the physician"s orders. Nursing staff is being educated on proper medication administration, reordering and follow up on mussing meds.       comparing them to the physician"s order.       comparing them to the physician"s order.         A review of the medication administration records       comparing them to the physician"s order.       comparing them to the physician"s order.       comparing them to the physician"s order.         A review of the medic

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245203	B. WING		08/05/2016
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 175 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 425	not receive Clozap 7/23/16 and 7/24/1	ine 400 mg at bedtime on	F 425		
	a.m., R120 stated left shoulder and h manage it. He exp	he frequently had pain in his ad an order for Oxycodone to lained, however, the facility medication and he had to			
	take Tylenol as an getting medication	alternate, "They are so slow s here. They are always se they don't order in time."			
	p.m., R120 stated on 8/1/16 and 8/2/	versation on 8/4/16, at 2:40 he did not receive Oxycodone 16 because there was no stock			
· · · · · · · ·	received Tylenol, i level of the Oxyco	cility. He explained, although he t did not manage his pain to the done. He again stated this to often," and, "they just don't	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	
	reorder the medic Diagnoses for R12 pain that occurs to	ations when they should." 20 included Cervicalgia (neck oward the rear or the side of the ) and low back pain. A			
	physician's order to administer Oxy hours prn (as nee MAR revealed R1	written on 7/21/16 directed staff codone HCL 5 mg every 6 ded) for pain. A review of the 20 was administered 2 tablets			
	and did not receiv 4:45 p.m. The inc 77, showed that a given at 8:00 a.m	L 5 mg on 8/1/16, at 8:00 a.m. e another dose until 8/2/16, at dividual narcotic record, page after the 8/1/16 dose that was the Oxycodone HCL 5 mg			
	actual and potent pain and to monit	as depleted. Ted 6/27/16, Identified R120 with ial leg pain and chronic low back or and document side effects, ew onset of signs and	ו k		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/22/2016 FORM APPROVED

	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU		ECONSTRUCTION	0	(X3) DATE	<u>J938-0391</u> SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245203	B. WING	B. WING			08/05/2016	
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
THE VILL	A AT BRYN MAWR				75 PENN AVENUE NORTH IINNEAPOLIS, MN 5540	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	-IX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULI	D BE	(X5) COMPLETION DATE
F 425	symptoms of pain physician if interve a significant chang On 8/4/16, at 3:00 nurses' station loca She asked the stat	or behavior, and to update the ntions were not successful or i ge in status was observed. p.m. R145 approached the ated on unit 1 in the facility. ff, "Can someone please make	f	425				
	medication also us	e (an anti-depressant sed to treat insomnia) is had it in 2 nights and I didn't yht."						
		interview the next day at 7:53						
	trazadone again o the third night in a my bipolar and my	she had not received her n 8/4/16. She explained it was row and it was, "messing with remotions are unstable." She						
	she didn't get any restless and got u and when she was	hard to manage stress when sleep. She stated she was p several times during the nigh s given Trazadone she, "slept continued, "If I have to go	it		· · · · · · · · · · · · · · · · · · ·	· · · · · · ·		
	through another n don't want to end I am on the edge. time and I don't ne	ight like this, it won't be good. up like a basket case. I feel lik I have been stable for a long eed this, I really don't." She the d not received her Requip (a	ie n					
	medication used t for several days.	o treat restless leg syndrome)						
	found in the cart of verified the last do given on 8/1/16, a	tated R2's Trazadone was not or the medication room. She ose of Trazadone 200mg was at 8:00 p.m. The TMA further equip was not given from 8/1/10	6		· · · · · · · · · · · · · · · · · · ·			
	At 8:17 a.m. LPN Requip and Traza	-G reported that he located R2 adone in the bottom drawer of	's					
ORM CMS-	2567(02-99) Previous Versio	ons Obsolete Event ID:9DI	EF11	F	acility ID: 00175	If continu	ation sheet	Page 52 of 55

FORM CMS-2567(02-99) Previous Versions Obsolete

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	08/22/2016
FORM A	<b>\PPROVED</b>

• . 1

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391						<u>. 0938-0391</u>
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		245203	B. WING			08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR				275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	the medication cart filled by Omni phar been dispensed to Diagnoses for R14	t. The medications had been macy on 8/2/16 but had not yet R145. 5 included Bipolar disorder,	F 4	42	5		
	orders directed sta	and insomnia. The physician ff to administer Trazadone,					
	HCL 3 mg every be	time for insomnia and Requip edtime. A review of the MARs ne 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 7/1/1	6, indicated R145 was to use cation to treat insomnia and					
	depression and dir	ected staff to administer					
	psychotropic medi	cation, including Trazadone, as					
-		ysician-and-to-monitor-for-side-					
	effects including in suicidal ideation.	somnia, depression and			· · · · · · · · · · · · · · · · · · ·		· · · · · · · ·
	administration, on practical nurse (LF ferrous sulfate (a r deficiency anemia medication) for R1 acute kidney injury LPN-D stated "the	tion of medication 8/3/16, at 8:44 a.m. a licensed PN)-D was unable to locate medication used to treat iron ) and gabapentin gel (a pain 49. R149's diagnoses included 4 and altered mental status. medications are not in the cart e to give them, I will have to ne pharmacy."	k				
	8/2/16, indicated F sulfate 220 milligr three times a day every 8 hours. R <sup>+</sup> record (MAR) for ferrous sulfate wa	s physicians orders dated R149 was to receive ferrous ams per 5 milligrams (mg/ml) and gabapentin 8% gel topically 49 medication administration 8/2016 indicated the medication s not initialed as being e on 8/3/16, and her gabapentin					•••• • • • • • • • • • • • •

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00175

If continuation sheet Page 53 of 55

PRINTED: 08/22/2016 FORM APPROVED OMB NO: 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED	
		245203	B. WING			08/0	05/2016	
	ROVIDER OR SUPPLIER	I		27	REET ADDRESS, CITY, STATE, ZIP CODE 15 PENN AVENUE NORTH INNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 425	was not administer explanations were	red once the same day. No documented on either side of nursing progress notes as to	F	425				
	assistant director of	v on 8/5/16, at 9:57 a.m. the of nursing (ADON) verified ved her 8am or noon		na <b>10.000</b>				
	medication of ferro	ous sulfate and her 8am apentin gel on 8/3/16. On h. the ADON and surveyor	1					
	reviewed R149 M/ medications was i	AR and noted both of her nitialed as being given by						
	LPN-D, however v medication cart sh the medications. ADON verified tha	when the ADON looked into the le could not find either one of The same day at 10:50 a.m. the t both medication are still not ION explained R149 received	1					
	the medication fer instead of liquid an facility needs to of	rous sulfate in a pill form nd for R149 gabapentin the ptains a new prescription for the he pharmacy will refill it.			· · · · · · · · · · · · · · · · · · ·			
	9:34 a.m. the Om he would expect a filled and delivere	ne conversation on 8/5/16, at ni Pharmacy consultant stated a new medication order to be d the same dayIf a refill, it						
	expect the facility days of medicatio That would ensur medication. He fu	days so therefore he would staff to reorder when 3 to 5 n were left for the resident. e ample time availability of the urther stated it was, "concerning	J.,					
	He further explain for a reason. If the	e or other antipsychotic not given for 3 or more days. ned, "Medications are ordered ney are ordered, they should be ey are ordered because they are	9					
L							t Dogo E4 of 55	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9DEF11

Facility ID: 00175

If continuation sheet Page 54 of 55

PRIN	TED:	08/22/2016
FC	DRM.	APPROVED
OMB	NO.	0938-0391

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245203	B. WING			08/	05/2016
	PROVIDER OR SUPPLIER	1		275	EET ADDRESS, CITY, STATE, ZIP CO PENN AVENUE NORTH INEAPOLIS, MN 55405	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	The Omnicare of M Schedule, revised pharmacy and faci determine delivery possible after the e Services Agreeme Agreement. The p	age 54 Ainnesota Pharmacy Ordering 1/1/13, indicated the lity should coordinate to days and times as soon as execution of the Pharmacy nt or Pharmacy Consultant policy did not address the e-ordering medications.	F	425		24	
	During an interview director of nursing staff to reorder res	w on 8/5/16, at 10:25 a.m. the (DON) stated she expected idents' medications when a					
	4-day supply was pharmacy if the m find out the reasor	left and to contact the edication was not delivered to n.					
_							
							t Dago 55 of 55

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:9DEF11

Facility ID: 00175

If continuation sheet Page 55 of 55

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - MAIN BUILDING 01		SURVEY
		245203	B. WING		08/0	2/2016
	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO		
	A AT BRYN MAWR		27	5 PENN AVENUE NORTH		
			M	INNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) GOMPLETIC DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY		API	PROVED This &	Sull.	
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.	By T	om Linhoff at 3:49 pr	n, Sep Off, 2	2016
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Divisio time of this survey, found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safi edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),		RECEI SEP - 1		
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 5510	R THE FIRE SAFETY ): pections Division Suite 145		MN DEPT. OF PUBL STATE FIRE MARSH	IC SAFETY	

any concreticity statement ending with an asterisk (\*) denotes a deticiency which the institution may be excused from correcting providing it is determined that enter 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
		245203	B. WING	+		08/0	02/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	A AT BRYN MAWR			_	75 PENN AVENUE NORTH		
				N	INNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or pr 3. The name and/or responsible for cor prevent a reoccurr The Villa at Bryn M partial basement. 2 different times. T constructed in 196 Type II(222) constr addition was const determined to be of Because the origin are of the same ty was surveyed as of This building is full has a fire alarm sy the corridors and s that is monitored f notification. The fa	state.mn.us and n@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. fawr is a 3-story building with a The building was constructed at The original 3 story building was 7 and was determined to be of ruction. In 1969, a 3 story tructed to the West that was of Type II(222) construction. hal building and the 1 addition pe of construction, the facility		000			
FORM CMS-2	The requirement a NOT MET as evid		21	F	acility ID: 00175 If cont	inuation she	eet Page 2 of

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	08/22/2016 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION 01 - Main Building 01	(X3) DATE	1
.(*	12	245203	B, WING	i		08/0	2/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT BRYN MAWR				75 PENN AVENUE NORTH IINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 067 SS=F	Heating, ventilating with the provisions in accordance with specifications. 19 19.5.2.2 This STANDARD is Based on observat could not be verified ventilating and air of installed in accorda 19.5.2.1 and NFPA noncompliant HVA0 residents. Findings include: On a facility tour be and 01:00 PM on A revealed that the ve corridor as an air pl This deficient pract Administrator at the	9.5.2.1, 9.2, NFPA 90A, s not met as evidenced by: ion and staff interviews, it d that the facility's general conditioning system (HVAC) is nce with the LSC, Section 90A, Section 2-3.11. A C system could affect all 268 etween the hours of 09:00 AM ugust 08, 2016, observation entilation system for the o be utilizing the egress lenum for the resident rooms. ice was verified by the e time of the inspection.		067	K-067 Please see attached wa		
FORM CMS-28	567(02-99) Previous Versions	Obsolete Event ID: 9DEF2	21	Fa	cility ID: 00175 If contin	uation she	et Page 3 of 3

### Whitney, Marian (DPS)

From:	Linhoff, Tom (DPS)
Sent:	Thursday, September 01, 2016 4:00 PM
То:	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



Enhancing the Future of Public Safety in Minnesota through Exceptional Customer Service Today



2000 CODE

09-01-2016

Page 20

### Name of Facility The Villa at Bryn Mawr 275 Penn Avenue North, Minneapolis MN 55405

The Villa at Bryn Mawr	275 Penn Ave	anue Month, Manneapon	S MIT OF 100	PROVISIONS
			NIVER OF SPECIFIC LIFE SAFETY CODE	
	number and st applied, would provisions will	ate the reason for the conc	ommended for waiver, list the survey report lusion that: (a) the specific provisions of the dship on the facility, and (b) the waiver of s alth and safety of the patients. It additional	such unmet
PROVISION NUMBER(S)			JUSTIFICATION	
K84 K67 The building heating and ventilation and Alr Conditioning (HVAC) equipment does not comply with the Llfe Safety Code (00), Section 9.2, and NFPA 90A, 1999 Edition, because the corridors are being used as a plenum.	A. Compliand because: 1. The most upgrade of the \$17,800 for a 2. Installing period of insi- would be affe 3. Under curr facility has he 4. Given the However, a he 5. The build	recent cost estimate for the following systems; p structural engineering a a complying HVAC syst tallation in specific roor ected by this project. rent CMS reimburseme ad operating losses du facility's financial cond bank loan at 5.5% over ing is 48 years old and	If cause an unreasonable hardship r complying HVAC dated 7/14/14, is lease the attached quote from Gilbe and installing sheet rocks enclosures tem will force disruption to the facilit ins and add to noise and dust levels ant rates, it is estimated to take 10 o ring each of the last 3 years. ition, it would be difficult to acquire a 20 years would add \$142,450.00 in is not slated for replacement.	of for the resident rooms. y residents by displacing during the for an extended period. 38 rooms r more years to recoup the cost. This a loan in the amount of the estimate. interest to the cost of the project.
	1. 1.	The building Type II (2	(ZZZ) CONSEDCION WITH BE CROTTON	
	2. Th	te walls floors, ceiling a	ind vertical resist the passage of sm	ioke.
	3. Th sprint		eatures are installed; notified frie ala automatic dialer to fire department	arms through, reliable and Tyco bran monitor by Transalarm, UL300 rated
Surveyor (Signaturo)		Title	Office	Date
	A_A	Tille	Office	Date

Office

STATE FIRE MARSHAL

HOMAS LINHOPF 12424 FIRE SAFETY SOPV FORT CMS-2786R (03/04) Previous Versions Obsolete

Fire Authority Of

Tile

2000 CODE

Name of Facility 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). JUSTIFICATION PROVISION NUMBER(S) An annual/continuing waiver is being requested for K-67. Our fire safety plan addresses: fire containment, fire extinguish, evacuation, fire compartments, K84 location of ambulatory and non-ambulation residents, notification of fire department, 4 ... K67 The building heating We have a fire watch program. We have two secured smoking rooms which are secured or have and ventilation and Alr 5... camera's for observation. Conditioning (HVAC) equipment does not Current facility staff to resident ratio is 3.65. 6. There is a total of 13 smoke compartments per floor in the facility. Basement: 1 compartment, lower comply with the Llfe Safety Code (00). level: 2 compartments, first floor 5 compartments, second floor, 5 compartments, 7. Section 9.2, and NFPA 90A, 1999 Location of all residents: 8.. Edition, because the Basement: zero corridors are being a used as a plenum. Lower level: 8 residents b. First floor: two units: 50 residents C. Second floor: two unit: 62 residents d. We do not have a TCU unit. WE are 120 bed SNF facility which admits medical/mental e health residents. Closest fire department is: 1600 Glenwood Ave. 0.4 miles. 9.. Ŧ Date Office Title Surveyor (Signature) Date Office 19-01-2016 Fire Authority Official STATE FRE MANSHAL FIRE SAFETY SUPU Page 25 LINHOPP

Form CMS-2786R (03/04) Previous Versions Obsolete



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

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

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?)



#### 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 <u>only a suggestion</u> 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

The Villa At Bryn Mawr August 22, 2016 Page 2

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

Minneso	ta Department of He	alth			FORMAPPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00175	B. WING		08/05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	
	_A AT BRYN MAWR		AVENUE NO		
		MINNEAP	OLIS, MN 5	5405	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
2 000	Initial Comments		2 000	100 AV	
		NTION*****		RECEIVE	ED
		CORRECTION ORDER			
				SEP 0 1 2016	
	144A.10, this corre	Minnesota Statute, section ction order has been issued		SEP 0 <b>1</b> 2016 (via emaile)	
		y. If, upon reinspection, it is iency or deficiencies cited		COMPLIANCE MONITORING LICENSE AND CERTIFICA	
	herein are not corre not corrected shall	ected, a fine for each violation be assessed in accordance fines promulgated by rule of		LICENSE AND CERTIFICA	
	-corrected requires- requirements of the number and MN Ru When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with-all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was			
	that may result fror orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			· · · · · · · · · · · · · · · · · · ·
	Department's staff, the following corrections are corrections are corrections are corrections are corrections are correction at a copy of the original to the Minn	TS: 8/5/16, surveyors of this visited the above provider and ction orders are issued. When npleted, please sign and date, se orders and return the esota Department of Health, ification Program; P.O. Box		Minnesota Department of Healt documenting the State Licensir Correction Orders using federa Tag numbers have been assigr Minnesota state statutes/rules f Homes.	ng al software. ned to

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LABORATORY DECTOR'S OP PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE

FORM

.

Administrator (X6) DATE 114 9

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If continuation sheet 1 of 58

	ta Department of He	aith (X1) provider/supplier/clia	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		00175	B. WING		08/05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
THE VILI	LA AT BRYN MAWR		AVENUE NOLIS, MN 5	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
2 000	Initial Comments		2 000		
	****ATTEI	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.			
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.			
	Department's staff, the following correct corrections are com make a copy of the original to the Minne	TS: 3/5/16, surveyors of this visited the above provider and tion orders are issued. When npleted, please sign and date, se orders and return the esota Department of Health, fication Program; P.O. Box		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned t Minnesota state statutes/rules for N Homes.	0

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPL	
		00175	B. WING		08/0	5/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HE VILI	A AT BRYN MAWR	-	IN AVENUE N POLIS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	complaints were inv substantiated at Sta	ecertification survey, vestigated. H5203050 was ate Order 0930; H5203051 at State Order 1550;		The assigned tag number a far left column entitled "ID f The state statute/rule numb corresponding text of the sta out of compliance is listed ir "Summary Statement of De column and replaces the "To portion of the correction ord column also includes the fi are in violation of the state s statement, "This Rule is not evidenced by." Following th findings are the Suggested Correction and the Time Pe Correction. PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL CORRECTION." THIS APP FEDERAL DEFICIENCIES of WILL APPEAR ON EACH F THERE IS NO REQUIREM! SUBMIT A PLAN OF CORF VIOLATIONS OF MINNESO STATUTES/RULES.	Prefix Tag." er and the ate statute/rule in the ficiencies" o Comply" er. This indings which statute after the met as he surveyors Method of riod For E HEADING OF HICH AN OF LIES TO ONLY. THIS PAGE. ENT TO RECTION FOR	
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related of	lity serves persons with disorders, whether in a eral unit, the facility's direct				

STATE FORM

9DEF11

If continuation sheet 2 of 58

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	LA AT BRYN MAWR	275 PENN	AVENUE NO	ORTH		
		MINNEAP	OLIS, MN 55	6405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	age 2	2 302			
	care staff and their supervisors must be trained in dementia care.					
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequen topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	by: Based on interview facility failed to ens information regardi related disorders as	ent is not met as evidenced and document review, the ure consumers were provided ng Alzheimer's disease or s required. This had the Il residents in the facility.				
	training program, e consumers had bee electronic format, a training program, th trained, the frequer topics covered as r survey, the facility h	the facility's Alzheimer's vidence was lacking to show en provided in written or description of an Alzheimer's ne categories of employees ncy of training and the basic equired. At the time of the nad residents with diagnoses ase or other dementia.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE VILI	LA AT BRYN MAWR		OLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	ge 3	2 302			
	administrator stated consumers was una not provide to the p related to Alzheime training in any form She further indicate	on 8/5/16, at 11:15 a.m., the d information provided to available,stating the facility did ublic any detailed information r's disease or related disorder including written or electronic. ed the facility did not have a juired dementia training.				
	SUGGESTED MET	HOD OF CORRECTION:				
	regarding staff train	ee could add information ing to the resident admission rs were aware of the				
	TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility fa to adequately monit (R63) reviewed for conditions (bruising residents observed	ent is not met as evidenced on, interview and document ailed to follow the plan of care for and assess 1 of 3 residents non-pressure related skin ) and failed to ensure 1 of 2 for self administrating careplan was followed during				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
THE VILI	A AT BRYN MAWR	-	N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	nebulizer treatment and failed to provide access site care for 1 of 1 resident (47) who was receiving dialysis treatments.					
	Findings included:					
	identified R62 as a unsteady gait, and deficits and directs and report as need doctor for pain and	care, target date 7/8/16, fall risk related to actual falls, failure to be cognoscente of staff to monitor, document, ded for 72 hours to medical bruises, hoever did not abrasions obtained from a				
	bruise on her right forearm). The area were lighter purple colored purple. She the middle knuckle covered by a dry so she had a fall while	on 8/1/16 to have a purple bicep area (inner, upper s to the edge of the bruise and the center was a deeper e also had a scrape noted on of her left hand. It was cab. When asked, R63 stated e she was with her "companion and obtained both injuries at	η			
	and the treatment a	ministration records (MAR) administration record (TAR) for lacked identification or ruise or the scrape.				
	bed bath tonight wi staff and a complet	on 7/23/16 stated R63 took a th extensive assistance of one e skin assessment was done. d to be dry, intact and no pruises noted.				
		on 7/31/16 stated R63 took a sive assistance of one staff.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE VILI	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 5	2 565			
	Her skin was dry and intact. No pressure areas or bruises were noted.					
	registered nurse (F were to be monitor least daily, until res She verified that R	v on 8/3/16, at 1:31 p.m., a RN)-E stated all skin issues ed and tracked on the TAR, at solved as the policy indicates. 63's TAR for 6/2016, 7/2016 monitoring of non-pressure				
	8:56 p.m. noted the the Right Upper Art looking bruise; Skir scrape on knuckle	port completed on 7/22/16, at e following injuries: Bruise to m, near chest, purple, new n Tear to right middle Finger 3, of right middle finger. A usurements were not eport.				
		n for monitoring and assessing conditions was requested but				
	did not have a syst	a.m. RN-E stated the facility em in place to monitor bruising sure skin conditions.				
	director of nursing	on 8/4/16, at 8:48 a.m., the (DON) stated she expected ising and care plan for all skin				
	[R20] has a physici self-administration Nebs" date initiated for Goal "The resid	plan indicated "The resident ian's order for supervised of the following medications: d 4/28/1,4 and also indicated ent [R20] will take medications cribed through the review date"				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		N AVENUE NC POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	dated initiated 4/28 "Review medication resident [R20] /mon reassess abilities." R20's quarterly Mir indicated 20 had sh problems, had seve making skills, and I fluctuated. R20's Care Area As 4/06/16, triggered f and indicated R20 make self understo R20 was observed on bed on right side mask over face, wi continuous observa observed with eyes place, machine run medication assistal and looked in R20's At 10:26 a.m. R20 side with nebulizer	age 6 /14, and also indicated n self-administration with nthly and as needed to Dated initiated 4/28/14. nimum Data Set dated 7/29/16, nort and long term memory erely impaired daily decision nad delirium present, which seessment (CAA) dated or Cognitive Loss/Dementia had "Decreased ability to nod or to understand others." on 8/3/16, at 10:01 a.m. lying e, eyes open, with nebulizer th machine running. During ation at 10:07 a.m. R20 was a closed nebulizer mask still in ning. One minute later trained nt (TMA)-C walked down hall s room and then walked away. was observed lying on right mask on face, machine am coming into mask.	2 565			
	On 8/3/16, at 10:05 comes down from s tube feedings and i was trained to pass treatments. At 10:26 a.m. TMA breakfast, had his n back to bed. TMA-0 nebulizer mask him go and take the ma	5 a.m. TMA-C stated the nurse station 3 and does residents ' nsulins. TMA-C stated she medications and nebulizer -C stated R20 got up for morning medications and went C stated R20 would put on the nself. TMA-C stated she would ask off of R20. TMA-C stated d the nebulizer treatment for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			
		00175	B. WING		08/	05/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HE VIL	A AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 565	Continued From pa	age 7	2 565			
	was on R20 's face running, that the cy medication and no mask. TMA-C state nebulizer mask, no with medication. TM written on the outsi " 8/2/16, 2 p.m. " T been aware there w nor had she been a nebulizer in place w TMA-C stated R20 treatments and tha practical nurse (LP R20 his treatment. LPN-E and was told s nebulizer treatment machine must not th his nebulizer treatment half hour and was s the cylinder was date cylinders were date new one once a we been the one that h when the cylinder w would be the day n have exchanged cy R20 coughs a lot h treatment. TMA-C administration reco post respiratory as before and after the complete the asses nebulizer treatment give the nebulizer t or if the nurse told had never been tole	-C verified the nebulizer mask e and that the machine was dinder was ½ full with steam was going into the ed she had not given R20 his r had she filled the cylinder MA-C verified the cylinder had de of cylinder in black marker MA-C stated she had not vas medication in the cylinder aware that R20 had his with the machine running. only prn (as needed) nebulized t she would call licensed N)-E to see if she had given TMA-C proceeded to call d LPN-E had not applied R20 ' so working since R20 had had nent running for approximately still only half full. TMA-C stated ted 8/2/16, 2 p.m. since ed when changing out with a sek. TMA-C stated she had not had written the date and time vas replaced. TMA-C stated it urse yesterday who would dinders. TMA-C stated when e can have a nebulizer verified the medication rd (MAR) indicated a pre and sessment was to be completed to complete the pre and post ments ordered. TMA-C stated she d to complete the pre and post ments ordered. TMA-C stated she d to complete the pre and post ments ordered. TMA-C stated she d to complete the pre and post ments ordered. TMA-C stated she d to complete the pre and post ments ordered. TMA-C stated she				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
		275 PENI	AVENUE NO	RTH		
	LA AT BRYN MAWR	MINNEAF	POLIS, MN 554	105		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ge 8	2 565			
	TAR and written on TMA-C stated when treatment she would cylinder apply on R2 and come back when TMA-C stated she w minutes as the treat TMA-C stated when treatment she would and write on the bac TMA-C stated R20 nebulizer treatment On 8/3/16, at 2:30 p worked last evening cylinder at 2 p.m. an treatment. LPN-I stat in July and when sh would initial on the fit the back of the MAR nebulizer treatment stated R20 would p she would ask him treatment and " he LPN- stated when s treatment she would during the treatment off and throw on the severe chronic obst (COPD). LPN-I state 2 p.m. and had not had given R20 a ne LPN-I stated normal	s it had not been initialed in the the back as instructed to do. In she gave R20 a nebulizer d put the medication in the 20's face and leave the room en the treatment was finished. would come back in about 2-3 tment did not take long to run. In giving R20 a nebulizer d initial on the front of the TAR ck as it was a PRN treatment. is not supposed to do his own				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
			-			
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IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
HE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 565	Continued From pa	ige 9	2 565			
	she had replaced F new and labeled th that was the date a given R20 a nebulit of wheezing and th himself. LPN-J stat oxygen saturations before applying the verified she had no anywhere about the given to R20 nor ar assessments. LPN there was still medi and noticed the ma correctly and stated tell about the mach the oncoming even stated she had not R20 at 2 p.m. but a had not documente his nebulizer mask asked if he wants a and say yes. " LPN mask on until she r stated she thought treatment as she th assessment had be but had not seen th indication of one in Nursing (ADON) st should have called the faulty nebulizer would check the su machine for R20. L really busy that day treatment. LPN-J s	ing at 9:46 a.m. LPN-J stated R20 's tubing and cylinder with e cylinder 8/2/16, 2 p.m. as nd time. LPN-J stated she had zer treatment as R20 was kind at when R20 he exerts ed she had checked R20 's and they had been a little low nebulizer treatment. LPN-J t documented anything e PRN nebulizer treatment ny of the pre or post respiratory -J stated after 10 minutes faction left in R20 's cylinder chine was not working d she had not known who to ine not working and had told ing nurse about it. LPN-J given a nebulizer treatment to t 10:00 a.m. and verified she ed it. LPN-J stated R20 will put on himself and when then " a treatment will shake his head J-J stated R20 will keep his eturns to R20 and LPN-J R20 could be alone with his nought a self-administration een completed on R20 in July the chart. Assistant Director of anding nearby stated LPN-J the supervisor to inform about machine and stated she pply room for another PN-J stated R20 a nebulizer tated R20 had asthma and te). LPN-J stated by her not	f			

	ta Department of He					
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	• • • • •	
	A AT BRYN MAWR		NAVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>Y</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 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.					
	not given R20 a ne TMA-C asked to gi normally left R20 a on as she believed completed at one t	a.m. LPN-E stated she had bulizer the day before nor had ve one. LPN-E stated she lone in his room with the mask R20 had had an assessment ime to self-administer but he record one had been				
	10:08 p.m. by LPN [R20] prn sats [sate evening, he appea breathing and vitals (Room Air). A duor he [R20] was put o Within fifteen minu	gress note dated 8/3/16, at -I indicated "Resident's urations] were 89%. During the red to have more difficulty s were done 73% R.A. neb was immediately done and n 2.5 L (liters) O2 (oxygen). tes, sats were up to 94% on are very diminished. "				
	Ipratropium-Albute Nebulize 1 vial by r dated 7/16/16 " an Before And After Tr	6 physician orders included: " rol 0.5-3 mg/3 Ampu-Neb mouth every 4 hours as needed id "Document Hart Rate reatment, Document e And After Treatment "				
	or TMA regarding a	R showed no initials by nurse any nebulizer treatment given nebulizer treatment respiratory pleted for R20.				
	Nursing (ADON) st	7 a.m. Assistant Director of ated the facility had been				
nesota De	epartment of Health M		<sup>6899</sup> 90	DEF11	lf continuati	on sheet 11 o

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00175	B. WING		08/05/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
тне VII I	LA AT BRYN MAWR	275 PENN	AVENUE NO	ORTH			
		MINNEAP	OLIS, MN 55	6405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>\</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	ige 11	2 565				
	to correct and educ self-administration there had to be an	assessments and would need cate staff regarding assessments. ADON stated assessment completed to s safe to administer					
	6/25/16, indicated F displayed no behav required staff super independent with p diagnoses of deme schizophrenia. R47 indicated R47 requires failure. Staff intervi- change dressing da symptoms of infect document on treatment						
	stated he went to d Wednesdays and F concerns he had at at the facility. R47 does nothing for my explained, "Before appointment the nu medication (lidocain site 1 hour before m never happens. I ha	rrse is to put on a numbing ne 2.5%) cream to my access ny appointment time. This ave to do it." R47 stated, "I					
	have the numbing of bed. I put the crean and the nurse bring don't know why I ha be doing this, but th like this for some tin he was done with d	cream in the drawer by my n on my dialysis access site gs me a dressing to cover it. I ave to do this, nursing should hey don't, it's been going on me now." R47 stated when lialysis the nurse at dialysis put rm and he removed it later in					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00175	B. WING	B. WING		08/05/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE					
THE VIL	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 55					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 565	Continued From pa	lge 12	2 565					
	was asked if the fact safety or looking for replied, "No, the stat how or what to look dressing on my arm any monitoring of m During an interview licensed practical m been R47's nurse fit and removed R47 of 2-3 p.m. but did not this. Review of R47's me (MAR) and treatme for the month of 7/2 indication for nursin dialysis dressing or signs of infection. If to the nurse manage intervention were a 8/4/16. During an interview the administrator and both verified R47 sl changes and monit of infection on his M nursing should be of resident's dressing A policy and proceed provided. SUGGESTED MET director of nursing the assessments within ensure complete an update the nursing then could educate	y on 8/3/16, at 7:15 a.m. iurse (LPN)-H stated she had or a long time and checked dressing from dialysis around t document that she had done edication administration record edication administration record administration record (TAR) 2016, revealed there was no ng to check and change R47's to monitor for bleeding and However, after it was brought ger's attention, these dded to R47's 8/2016 MAR on a on 8/4/16, at 2:14 p.m. with nd registered nurse (RN)-E, hould have had dressing oring for signs and symptoms MAR/TAR. RN-C stated that documenting when the						

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		00175	B. WING		08/	05/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 13	2 565				
		nursing assistant care sheets es of information are aplete.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830				
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident n bed.	d t				
	by: Based on observat review, the facility f of 3 residents (R63 non-pressure relate and failed to ensure	ent is not met as evidenced ion, interview and document ailed to monitor and assess 1 ) in the sample, reviewed for ed skin conditions (bruising) e care was provided services coordinated for 1 of 1 iving dialysis.					
	Findings included:						
		on 8/1/16 to have a purple bicep area (inner, upper					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00175	B. WING	B. WING		08/05/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
THE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 830	forearm). The areas were lighter purple colored purple. She the middle knuckle covered by a dry so she had a fall while on a shopping trip a that time. A nurse's progress described a fall dur while getting into a check and noted a and bruising preser chest that seemed The medication adr and the treatment a 7/2016 and 8/2016 monitoring of the br A skin /wound note bed bath tonight wit staff and a complet The skin was found pressure areas or b A skin/wound note of tub bath with extens Her skin was dry ar bruises were noted During an interview registered nurse (R were to be monitore least daily, until res She verified that Re	s to the edge of the bruise and the center was a deeper e also had a scrape noted on of her left hand. It was tab. When asked, R63 stated she was with her "companion" and obtained both injuries at note on 7/22/16, at 8:24 p.m. ing an outing. R62 tripped car. The nurse did a body "scrape right middle knuckle at on the right arm near the new." ninistration records (MAR) administration record (TAR) for lacked identification or uise or the scrape. on 7/23/16 stated R63 took a th extensive assistance of one e skin assessment was done. I to be dry, intact and no or uises noted. on 7/31/16 stated R63 took a sive assistance of one staff. nd intact. No pressure areas or					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00175	B. WING		08/	08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
THE VIL	LA AT BRYN MAWR		OLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 15	2 830				
	An Occurrence Rep 8:56 p.m. noted the the Right Upper Arr looking bruise; Skir scrape on knuckle treatment and mea mentioned in the re A list of current ord and treat current no The current plan of identified R62 as a unsteady gait, and deficits and directs	port completed on 7/22/16, at e following injuries: Bruise to m, near chest, purple, new n Tear to right middle Finger 3, of right middle finger. A usurements were not eport. ers lacks direction to monitor on-pressure skin conditions. f care, target date 7/8/16, fall risk related to actual falls, failure to be cognoscente of staff to monitor, document, ded for 72 hours to medical					
	conditions was req regarding Suspecte Protocol Injury, Fra of unknown origin, provided. The polic	and assess non-pressure skin uested however a policy ed Abuse and Neglect -Clinical actures, Bruises and Skin Tears revised June 2014) was by did not address monitoring pressure skin conditions.					
	did not have a syst and other non-press stated the facility's non-pressure altera Abuse/Neglect poli verified the policy a staff to ensure com monitoring of these explained she did r measurement of a	a.m. RN-E stated the facility em in place to monitor bruising sure skin conditions. She only policy to monitor these ations in skin integrity was the cy that was provided. She and procedure did not direct plete and standardized e skin conditions. RN-E not expect staff to take an initial bruise or an abrasion or to s in size or color and					
magata D		body audits as an effective					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00175	B. WING		08/	08/05/2016	
NAME OF	F PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
THE VIL	LA AT BRYN MAWR		AVENUE NO OLIS, MN 55				
(X4) ID	SUMMABY STA			PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	ge 16	2 830				
	director of nursing s monitor bruising at She stated the mec or wound nurse sho size, color or pain w an initial measurem information such as pain should be obta she did not conside adequate system to	r on 8/4/16, at 8:48 a.m., the stated she expects staff to least daily, if not every shift. dical doctor, nurse practitioner buld be notified if increase in vas noted. She further stated nent and other identifying s color, area and presence of ained. The DON further stated er weekly body audits as an o monitor bruises, abrasions sure related skin conditions.					
	stated he attended Wednesdays and F expressed concern care by the facility s here does nothing f R47 explained that nurse was suppose medication, Lidocai stated, "this never h stated, "I don't know Nursing should be been going on like explained that the c on his arm after the removed the banda it stopped bleeding.	ed on 8/2/16, at 4:15 p.m. R47 renal dialysis on Mondays, Fridays. At that time, R47 s he had about his dialysis staff stating, "the nursing staff for my dialysis access site." one hour prior to dialysis the ed to apply a numbing ine, to his access site. He nappens. I have to do it." R47 w why I have to do this. doing this, but they don't. It's this for some time now." R47 dialysis nurse put a bandage e run was completed, and he age himself in the evening after . The resident also indicated staff did not monitor his					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		E SURVEY PLETED	
001		00175	B. WING		08/	08/05/2016	
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
HE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLE DATE	
2 830	Continued From pa	age 17	2 830				
	run went well today any paperwork that didn't get any pape might get paperwork A Quarterly Review dated 6/16/2016 re Interview of Mental indicating a good m the resident was re The resident was re The resident was re The resident was re The resident was a The resident was a Che resident was re the Lidocaine create explained that the o resident with a tube provides the banda treatment "himself. help the resident w were at 10:00 a.m. appointment time w not yet in the facility explained when R4 we [nurses] send p he comes back he Registered nurse (1 8/3/16, she was un prescribed topical r access site. RN-A s does not give his p upon returning fron R47 has been give has kept or has los dialysis clinic that a	Minimum Data Set (MDS) vealed the resident had a Brief Status (BIMS) score of 15 nemory. The MDS indicated ceiving dialysis treatments. ble to communicate needs. ent care plan dated 6/25/2015 aff were to complete dialysis					

STATE FORM

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 18	2 830			
	call the dialysis clin RN-A stated she ha who had informed h facility on 12/20/15, prescribed Lidocair by the dialysis clinic hour prior to his app On 8/3/16 at approx nurse (RN-C) was i verified R47 had re cream from the dial applied to the acces appointments. RN-0 facility looks at the back with him after nurses] have found really needs to be a have to call the faci On 8/4/16, at 10:38 been moved to a ne When asked if he h replied, "Yes, I will s R47 opened the dra cream. RN-D, a nur unit, was notified ar the Lidocaine crear been left in the trea living unit. At 12:58 found the lidocaine R47's dialysis common on 8/4/16. On top of dialysis center that team, we put this be communication and him. Feel free to re add data to assist of only contained a fact	kimately 3 p.m., R47's dialysis nterviewed by telephone. She ceived an order for Lidocaine lysis center, which was to be ss site one hour prior to his C stated, "I don't think the information sheets we send each dialysis run. We [dialysis that if we have something that addressed or changed, we lity directly." a.m. R47 stated he had just ew room the previous evening. ad the Lidocaine cream he show you." However, when awer he could not find the rse on the resident's current nd was also unable to locate n. RN-D said it could have tment cart on R47's previous p.m. LPN-H reported they'd				

	IT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00175	B. WING		08/05/2016		
AME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
HE VIL	LA AT BRYN MAWR		AVENUE NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 19	2 830				
	the facility. There w found in the resided dialysis treatment r On 8/4/16, at 1:31 R47's dialysis run r the documents had had the dialysis clir confirmed there ha notes in R47's char During an interview administrator and F have had dressing signs and symptom MAR/TAR. RN-C s documenting when last changed. In ad acknowledged that back his paperwork staff should be call asking for a faxed of A policy and proceed provided. SUGGESTED MET director of nursing develop systems to adequate monitorin The DON or designee of systems to ensure present those findin committee	p.m. RN-E provided pages of results. When asked where d come from, RN-E said she'd hic fax them over. RN-E d been no other dialysis run rt. on 8/4/16, at 2:14 p.m. the RN-E both verified R47 should changes and monitoring for ns of infection included on his stated nursing staff should be the resident's dressing was					

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		00175	B. WING		08/	08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	LA AT BRYN MAWR	-	NAVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 930	Continued From pa	age 20	2 930				
2 930	MN Rule 4658.052 Nasogastric, Gastr	5 Subp. 7 B. Rehab - ostomy tubes	2 930				
	and feeding syringes. Based o assessment, a nurs B. a resident v gastrostomy tube o appropriate treatme aspiration pneumon dehydration, metab	tric tubes, gastrostomy tubes, on the comprehensive resident sing home must ensure that: who is fed by a nasogastric or or feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, polic abnormalities, and lcers and to restore, if eding function.					
	by: Based on observat review, the facility f and monitoring was (R149) reviewed fo	ent is not met as evidenced ion, interview and document ailed to ensure proper care s provided for 1 of 1 resident r use of a tube feeding, to t received adequate nutritional					
	indicated R149 was liquid high-calorie r milliliters per hour ( (midnight) to 9:00 a flushes at 12am, 3a per registered dietii progress note date on 8/2/16, with the	order sheet on 8/2/16, s to receive peptamen 1.5 (a nutritional supplement) at 105 ml/hr) from 12:00 a.m. a.m. with 120 ml free water am, 6am, 9am, 3pm and 8pm tian. A nutrition/dietary d 8/3/16, confirmed the orders addition that R149's calculated ere 1000-1400 kilocalorie,					

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 930		-	2 930			
	R149's care plan d had a nutritional pre- estimated 19% loss feedings to provide Staff interventions as ordered and ma On 8/3/16, at 7:37 a R149 asleep in her by the nursing stati supplement was ha approximately 250- supplement left in t supplement tubing attached to R149 w During an interview licensed practical n returned from the h G-Tube ( a tube su stomach to provide clogged. LPN-D ex tube during the nigl bathroom and not t LPN-D stated "I we and it was off [the C	n and 1000-1400 ml fluids. ated 7/25/16, indicated R149 oblem with a weight loss of s in 180 days and was on tube a dequate calories and fluids. were to provide tube feedings intain hydration status. a.m. the surveyor observed room which is the first room on. R149's nutritional anging on an IV pole with 400 ml of nutritional he bag, the end of nutritional was hanging down not <i>v</i> hile she slept. on 8/3/16, at 8:45 a.m. nurse (LPN)-D stated R149 hospital yesterday due to her rgically placed into the nutritional support) was cplained R149 will shut off her ht when she goes to the ell anyone she has done this. nt into her room at 7:45 a.m. G-tube pump]. LPN-D stated utritional needs via the G-tube				
	medication given to does not get any ex day. During an interview R149 explained sho previous day becau The G-tube was no was stilled clogged	flushed before and after any o her. LPN-D verified R149 ktra flushes throughout the the same day at 2:57 p.m. e was in the hospital the use her G-tube was clogged. w unclogged but her J-tube . R149 explained she does when she goes to smoke or to				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00175	B. WING	B. WING		08/05/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
			N AVENUE NO				
	LA AT BRYN MAWR		POLIS, MN 55				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		COMPLET DATE	
TAG			TAG	DEFICIENC			
2 930	Continued From no		2 930				
2 930	Continued From pa	ige 22	2 930				
		ill put her light on and let staff					
		back in her room. "I am aware					
		om this [pointing to her					
		ent fluid in the bag hanging on					
		er my G-tube keep clogging					
		d it takes staff awhile to come					
		I don't get all the nutrition I					
		still nutritional supplement left					
		sident indicated she had been					
		clogged tube. On 8/4/16 at					
		plained that she has been					
		on her own for a long time					
		is facility. "I have asked staff					
		his G-tube because it's					
		ne I have at home, but they					
	have never done ar	ny training with me."					
	During an interview	on 8/4/16, at 6:48 a.m.					
		works the night shift and has					
		R149 the last two nights.					
	0	149 would come out of her					
	room and not let sta						
		a-tube so LPN-C kept peeking					
		ee if her nutritional supplement					
		PN-C stated R149 gets a					
		onal supplement. While					
		at the nursing station, at 6:48					
	a.m. R149 came ou	ut of her room with the G-tube					
	disconnected and t	old LPN-C she was going out					
	to smoke. The sur	veyor interviewed R149 in the					
		R149 said, "I do tell staff					
		G-tube, but they[staff] don't					
		it up. R149 explained that the					
		nurse came in to hook up her					
		ted to put on the same					
		ent that had been hanging in					
		told him that I should get					
		stuff has been sitting there all					
		e me sick." He put a new bag					
	on The resident st	ated, "I am very worried about				1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING		08/	08/05/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HE VILL	A AT BRYN MAWR	-	N AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 930	Continued From pa	age 23	2 930				
	the cares I'm gettin	g here.					
	record (MAR) for th R149 was to receiv peptamen 1.5 at 80 was changed on 8/ (midnight) to 9 am. documention the re- nutritional support of initial the MAR as b document on the b- not given for two tir indicated one note resident, "refused h allowed staff to hoo documentaion was	medication administration he month of 8/2016, revealed re nutritional support of 0 ml/hr from 8pm to 8am then 2/16, to 105 ml/hr from 12am The MAR indicated no esident received any of her on 8/2 or 8/3. Staff did not being given nor did staff ack of the MAR reasons why mes. Review of nursing notes that on 8/2/16, at 21:40 the her tube feeding at 8PM but ok it up at 9:30 pm." No noted as to how much ent she received daily.					
	A policy and proced care but was not pr	dure was requested for G-Tube ovided.					
	DON or designee of	THOD OF CORRECTION: The could train and educate staff is to ensure monitoring and					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21000	MN Rule 4658.061 Requirements-Hyg	0 Subp. 4 Dietary Staff iene.	21000				
	wash their hands a	Dietary staff must thoroughly nd the exposed portions of p and warm water in a hand					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
		00175	B. WING			08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
THE VILI	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21000	Continued From pa	age 24	21000				
	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.						
	by: Based on observat review, the facility f dietary sanitation p	ent is not met as evidenced ion, interview, and document failed to maintain proper ractices. This had the potential idents who were served food					
	Findings include:						
	the certified dietary	e kitchen was conducted with v manager (CDM) on 8/1/16, at owing concerns were noted:					
	The gloves he was exposed his fingers cheese, and tortilla available gloves we had not been provi	ing food for the noon meal. wearing had large holes that s as he touched lettuce is. Cook-A explained the ere too small and larger gloves ded. The CDM then confirmed was wearing were too small, rom use.					
	three-high on the c explained the stack prepared for reside lunch menu. They	with dry cereal were stacked ounter. The cook also ked cereal bowls had been ents as an alternative to the would either get put away or be rved at the noon meal.	3				
		a was crowded. Carts with I to deliver to dining rooms also					

STATEME	Dta Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
THE VIL	LA AT BRYN MAWR	-	N AVENUE NC POLIS, MN 55			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21000	Continued From pa	ge 25	21000			
	over between the c tray set up to reach stated dirty dishes of right, were sent thro then stored in the c wall. The CDM exp with trays at every r DA-A then proceed pans on the right si clean dishes came reached for the spr sprayed off the disin clean dishes. DA-A stainless steel, clea and explained she dishes. Instead of p rinsed her hands us moved to the clean did not wear gloves process. She proce chemicals were sto used it to wipe two placed on a shelf or moved two clean tra the dish room. She wet pans to the cor then wiped down ca about hand washin wash our hands be very good at washin was 9:50 a.m. when and rinsed her hand soap. DA-A then for and went to the dirt Dishes were spraye and then set in rack	<ul> <li>e. Staff were required to cross arts and clean dishes used for the dirty dish area. The CDM came into the dish room to the ough the dish machine, and lean dish area on the back lained that five carts went out meal.</li> <li>ed to rinse dirty dishes and de of the dish machine. As the out of the machine, she ayer with her right hand and nfectant residue from the A pointed out residue on the an side of dish room counter would not want that on her berforming hand washing, she sing the dirty sprayer, and ther side of the dish room. DA-A c or wash her hands during the eeded to the rack where red, obtained a blue cloth and trays. The cloth was then ver the clean dishes. She ays back to the dirty side of then moved two clean, but stil nveyor line in the kitchen. DA-A arts with a cloth. When asked g DA-A responded, "Yes, we tween clean and dirty. We are ng our hands. It is required." It n DA-A first approached a sink ds, but did not wash using r the first time, applied gloves y side of the dish machine. ed on the dirty side of the sink ks which were moved through ter the rinse cycle, racks were</li> </ul>				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
and Plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00175	B. WING		08/05/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
THE VILL	A AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21000	Continued From page 26		21000			
	a.m. and using the her hands and the move clean plates She took the blue of clean dishes. When DA-A wiped her ha back on the shelf a then applied gloves dishes. She then ri washing sink, but a stacked clean plate prior to stacking. D rack, retrieved an of the chemical rack a handled the dirty pro occasions, ran ther	oves were removed at 10:00 sprayer, DA-A again sprayed counter. She proceeded to and plate covers to the racks. cloth and began to wipe the n finished wiping the dishes, nds on the towel and placed it bove the clean dishes. DA-A s and returned to washing dirty nsed her hands at the hand again did not use soap. She es and bowls, shaking them A-A placed two trays in the tray orange towel from the bin on and wiped the trays dry. DA-A ots and pans on numerous m through the dishwasher, and ff with the dirty sprayer.				
	p.m. hand washing CDM reported she and hand provided confirmed staff we clean dishes/ proce She did not conside sprayer on the dirty with hand washing sanitizer is meant t rinsed off." Dishwa	an interview on 8/4/16, at 1:55 was "an expectation." The had made similar observations education for DA-A. She re not to go between dirty and esses without washing hands. er rinsing hands with the v side of the sink consistent . The CDM explained, "The o sit on the dishes and not be shing and tray set up should at the same time, according to				
	directed staff to, "W	ed Dishwashing Machine Use Vash hands before and after ng machine, and frequently ."				
	The director of nurs	THOD OF CORRECTION: sing (DON) and/or designee				
ATE FORM	epartment of Health 1		<sup>6899</sup> 90	DEF11	If continuati	on sheet 27 (

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/05/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
	_A AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21000	Continued From pa	age 27	21000			
	provide education i sanitation in the kit food borne illness. Assurance (QAA) o audits to ensure co	ew or revise policies, and for staff regarding appropriate chen to ensure prevention of The Quality Assessment and committee could do random ompliance R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis	21426			
	maintain a compre- infection control pre- current tuberculosi- issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision mus he nursing home.	t			
	by:	ent is not met as evidenced and document review, the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
THE VILI	LA AT BRYN MAWR	-	N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 28	21426			
	residents (R19, R7 and failed to docur step Mantoux (TST for 4 of 5 residents addition the facility TST for 1 of 5 newl	een 3 of 5 newly admitted 9, R124) for tuberculosis (TB) ment the results of the 2nd 7, tuberculin skin test) results (R19, R76, R79, R124). In failed to provide the 2nd step ly hired employees (E-1). This affect all 110 residents ity.				
	Findings include:					
	medical record revelopment been completed at medication administ month of 3/2016, in and second step TS TST was identified induration, there has to whether the TST addition, there was of induration for the	to the facility on 3/4/16. R19's ealed a TB screening had not the time of admission. R19's stration record (MAR) for the indicated R19 had received first STs. Although the first step as 0 millimeters (mm) ad been no documentation as was positive or negative. In no documented measurement e second step, nor whether the test was positive or	t			
	R76's MAR for the R76 received the fi where staff recorde second step TST a induration, howeve	to the facility on 2/10/16. month of 2/2016, indicated rst and second step TST, ed on the MAR the first and s having zero mm for r R76's MAR lacked any t his first or second step TST pative.				
	R79's medical reco had not been comp admission. R79's I	to the facility on 2/19/16. ord revealed the TB screening pleted on the date of MAR for the month of 2/2016, ived his first TST, however				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING	B. WING		08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
THE VILI	LA AT BRYN MAWR	-	N AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	age 29	21426				
	there was no docur R79 ever received	mentation to indicate whether the second step.					
	record revealed the completed on the d MAR for the month step TST was given induration noted.	to the 3/1/16. R124 medical TB screening had not been late of admission. R124's of 6/2016, indicated R124 firs n and recorded as negative no R124 MAR lacked any t she was given the second					
	was reviewed on 8/	l on 5/23/16. E1's health file /5/16, and indicated E1 had no step TST as required.	t				
	11:00 a.m. registered she is in charge of training and docum verified R19, R79, I screen done for TB R79, R124 did not the first and second second step TST d only been with the first when she started s resident were not u documention on TS screens for TB. RN several months she	on 8/5/16, at approximately ed nurse (RN)-E. RN-E stated doing the infection control tentation for the facility. RN-E R124 did not have symptom at time of hire, R19, R76, have correct documentaion for d step TST, not did E1 have a one. RN-E verified she has facility for a short time and he became aware of staff and ip-to-date with current ST results and symptoms N-E explained over the last e and the medical director are am to get all employees and TB documentation.	r				
	"Tuberculosis Infect date 7/11/16, indica Nurse/Infection Con for developing, imp	and procedure titled tions Control Plan" revised ated "The infections Control ntrol Designee is responsible lementing, and monitoring the n in collaboration with the					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21426	Administrator, Medi Nursing and Assista The facility indicate health care facility. all healthcare works step TST and be as of active TB upon h SUGGESTED MET The DON or design procedures to ensu tuberculosis screen guidelines including correctly. The DON resident screening monitoring to ensur communicable dise could randomly aud ensure adequate do	ge 30 ical Director, Director of ant Director(s) of Nursing." d they are a medium risk The facility will implement that ers and residents received two sessed for current symptoms ire and/or admission. THOD OF CORRECTION: thee could develop policies and re residents are receiving ing according to the CDC g reading mantoux results or designee could conduct audits, interventions and te residents are free from ase. The DON or designee lit resident's documents to pocumentation for induration. R CORRECTION: Twenty-one				
21435	Recreation Program Subpart 1. Genera home must provide recreation program based on each indiv strengths, and need meet the physical, r well-being of each r comprehensive res comprehensive plat 4658.0400 and 468 provided opportunit	D Subp. 1 Activity and n; General al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and	21435			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00175	B. WING	B. WING		08/05/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
HE VILI	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
21435	Continued From pa	age 31	21435				
	recreation program	1.					
	This MN Requirem	ent is not met as evidenced					
	by:						
		ion, interview and document failed to provide activities to					
	meet the individual	interests for 3 of 3 residents					
		ho were dependent on staff to and were reviewed for					
	activities.	and were reviewed for					
	Findings include:						
		pserved on 8/1/16, at 3:57 p.m.					
		ng soundly. At 7:29 p.m. R92					
		is seated in a wheelchair in the iff was interacting with the					
	residents.	in was interacting with the					
		p.m. R92 was lying in bed.					
		sion was turned on, R92's bed					
		acent to the television next to					
		e could not see the screen. On . R92's room door was shut					
	-	as told, "He is in bed sleeping					
		R92 was assisted back to his					
		ssistant (NA)-A. When asked					
		Rec [recreation] staff" activity					
		30 to 11:30 a.m. was usually					
		to the white board listing d, "It's usually held in the dining	n l				
		asked R92 if he wished to stay	9				
		eplied, "Yes." NA-A wheeled					
		he dining room where a few					
		re seated. No activity was					
		ime. R92 sat calmly with no uch as yelling or increased					
		heelchair. Twelve other					
		he room as staff walked back					
		urse passed medications in					
		d no activity was held. At 10:20	)				
	a.m. a statt person	stated the board game					

	ota Department of He	(X1) Provider/Supplier/Clia		CONSTRUCTION		ESURVEY
	I OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00175	B. WING		08/05/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
			N AVENUE NO			
THE VIL	LA AT BRYN MAWR	MINNEAI	POLIS, MN 55	i405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21435	Continued From pa	ge 32	21435		,	
	staff person offered R92's 8/6/15, annua indicated the reside cognition. The follow somewhat importar reading material, m news, group activiti religious activity. A dated 5/10/2016 in severely impaired of skills and had some a decline in mental assessment indicat including dementia, He was dependent unit. He displayed w during the assessm indicators were not R92's care plan dat was dependent on his emotional and s directed staff to pro- with television, pro- scheduled activities attending. During an interview p.m. he reported he enjoyed watching te difficulty speaking a was unable to pro- attend activities. Licensed practical r worked with R92 wa 2:48 p.m. LPN-A wa activity preferences the activity staff. N R92 was brought to	ted 9/10/14, noted the resident staff and his wife for meeting social needs. Interventions wide individual activities, assist vide activity calendar, invite to s, and thank resident for with R92 on 8/3/16, at 2:47 e did not attend activities, but elevision in his room. R92 had and was short of breath, so ide details as to why he did not hurse (LPN)-A who routinely as unable to state R92's s, and referred the surveyor to A-A then explained that when o an activity he would yell return to his room. When				

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00175	B. WING			
		00175			08/	05/2016
IAME OF H	PROVIDER OR SUPPLIER		DDRESS, CITY, S I <b>N AVENUE NC</b>			
HE VILI	A AT BRYN MAWR	-	POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21435	Continued From pa	ige 33	21435			
	visits/activities prov "No."	ided for R92 NA-A replied,				
		o.m. Recreational Therapy				
		explained she had only been in	1			
		on for a month. RTA-A education and the second s				
		ch as spelling bees, old				
	sayings and music.	RTA-A explained that				
		ice was taken when residents				
		but that "fell to the wayside." did not document when a				
		in activity or when a 1:1 visit				
		she was unable to produce an				
	activity assessmen	t since R92's admission.				
		ticipation notes revealed the				
	following:	nded four structured programs				
	in the past quarter;					
		ttended Bible study,				
	communion, and m					
		nded social ball toss, old				
	sayings and church	i; s were located in the record				
		R92 attended or declined.				
		vity calendar for the months of	-			
		16, revealed numerous				
		ided for persons cognitively				
		challenge, hangman, spelling				
	bee, jeopardy and l	Activity Assessment policy				
		nin 14 days of a resident's				
		cility, an activity assessment				
	will be conducted to	b help develop an activities				
		e choices and interests of the				
		ssment will be conducted by				
		ient staff and other staff The activity assessment will be				
		s' medical record and updated				
	as needed and ann					
		terview on 8/1/16, at 3:23 p.m.				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING	B. WING		08/05/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			03/2010	
	FROVIDER ON SUFFLIER		N AVENUE NC				
THE VIL	LA AT BRYN MAWR		POLIS, MN 55				
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLET	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	THE APPROPRIATE	DATE	
				DEFICIENC	(Y)		
21435	Continued From pa	ige 34	21435				
	"I do not want to be	here." R52 said he was just					
	waiting for someone to tell him what to do and						
		ugh a television was on in the					
		stated he was not watching it.					
	No other personal i	tems were observed in the					
		thing. The curtains were					
		ed he used to be a carpenter					
	and enjoyed huntin	g and fishing.					
	$O_{22} = 0/0/10^{-1}$ at 0.17.	- m DEO was asstad in the					
		o.m. R52 was seated in the					
		ain reiterated his feelings acility. When asked what he					
		the facility he said he liked					
		and wanted to go outside. He					
		0 minute conversation with the					
	surveyor about fish						
		0					
		ote dated 9/16/15, revealed					
		cognitively impaired, had					
		ssion, spent some time					
		and lying in bed. R52 did not					
		ate in activities; activity					
	preferences were h						
		5/16 goal date), indicated the r no activity involvement					
		st. The goal was, "The residen	•				
		ction with type of activities and					
		lvement when asked through					
		pproaches included the					
		ce for old westerns and					
		ences were noted as listening					
	to country music ar	nd watching western shows.					
	Staff was to ensure	he received daily					
		cial contact and eat all meals					
		attended daily activities of his					
		unicated his feelings regarding					
		e to introduce the resident to					
		background, interests and					
		e interaction and activity					
	attendance.					1	

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				/ · · · · · · · · · · · · · · · · · · ·			
		00175	B. WING		08/	05/2016	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
THE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
21435	Continued From pa	ige 35	21435				
	the resident had, ". related to dementia in activities second comes out for mea R52's 6/23/16, ann included diagnoses depression. Althou severely impaired of important" he do th go outside in nice w showed the resider behavioral indicato period, but a new p experienced "little p day or nearly every however, did not in importance to the r approaches to ensi On 8/4/16, at 11:55 June 2016, reveale and popcorn on 6/8 During an interview Assistant-A (RTA-A reported R52 did no She described the activities" and inste family to visit more or activities, but did did attend food pro parties. RTA-A stat from more interacti made attempts to c numbers were no lo responsive to conv silent treatment." T the resident to mov	ual Minimum Data Set of dementia, anxiety, and ugh the assessment indicated cognition. It was "somewhat ings with groups of people and veather. The assessment at did not display mood or rs during the assessment roblem was that the resident bleasure in doing things" every day. R52's care plan, corporate these areas of esident or concerns with ure his needs were met. a.m. R52's activity log for d the resident attended movie 0/16 and Bingo on 6/27/16. with the Recreational Therapy a) on 8/3/16, at 1:14 p.m. she of wish to attend activities. resident as "disinterested in ead, the resident wanted his often. He watched television I not generally participate. He grams such as birthday ed R52 would have benefited on with his family, and had call them, but the phone onger valid. R52 was not ersation and gave staff "the here were no current plans for re to a different location. He ding his care conferences, but					

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 36	21435			
	room. RTA-A said she had no idea R52's previous occupation.		;			
	8/4/16, at 11:58 a.m "unhappy" at the fa was encouraged to allowed him space. attempted other ap his stay at the facili resident continued unacceptable and t look at trying some this to be a prison." utilize the patio, and outside to the care opportunities that w resident." The SW traditional dementia what meal was bein often did not provid wish to attend activ wish to attend.	the SW said, "We may need to thing new. He does consider ' The SW reported he could d said, "We will need to add plan. There may be more we need to consider for this explained they had noted a symptoms with R52, such as ng served. In addition, he le a reason why he did not rities, just stated he did not				
	injury, cognitive (thi stroke with left-side 8/2/16, at 6:15 p.m bed for the evening	noses that included brain inking) problems, depression, ed paralysis was observed on . after being assisted out of g meal. While trying to start a avoided eye contact and gave				
	was up in a wheelc facing the television The resident made movements. R26 d by the surveyor. W	ing at 8:25 a.m. the resident hair in the bedroom. R26 was n, which was off at the time. repetitive, nervous hand id not respond to two greetings hen asked if things were going was "yah," and was barely				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00175	B. WING		08/05/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	assisted to eat brea 9:30 a.m., still in the sporadically looked between active look residents in the roo was lying awake in respond to a greetin During an interview indicated R26's mo up in a wheelchair, breakfast. NA-C wa was, "mostly in bed red in a short time, NA-D continued, "R try to get her to part of any others." NA-E elaborated du 10:27 a.m.: "Her roo cleaned up, then ge stays up an hour ap back to bed and che again before we ge a lot because of [sk come and go." She doesn't follow - if sh goes down, like this During an interview registered nurse (R nurse had requeste buttocks due to her said they occasiona activity, but she did what was going on RN-G stated, "I'm n	akfast in the dining room. At e dining room, R26 at a morning television show ks around at the other m. At 10:24 a.m. the resident bed, and again did not ng. on 8/2/16 at 4:13 p.m., NA-D rning routine was to be gotten get washed up and then eat is also present and added R26 because of her bottom getting but that is better now." a26 does some activities, they ticipate, moviesI'm not sure uring an interview on 8/3/16, at utine is that we get her et her up for breakfast - she oproximately. Then we put her eck her [skin], then check her t her up at lunch. She's in bed in issues] on her behindthat doesn't do activities now, she he's left up longer her head				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING		08/	08/05/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
HE VILL	A AT BRYN MAWR		N AVENUE NC POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21435	Continued From pa	ige 38	21435				
	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 everywhereI 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."						
			,				
		HOD OF CORRECTION: designee could train and					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE VILI	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	ge 39	21435			
		ding residents activities' and ensure monitoring and				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21475	MN Rule 4658.1008 General Requireme	5 Subp. 1 Social Services: ents	21475			
	home must have ar department or prog related social servic nursing home must collaborate with out who is in need of ac	I requirements. A nursing norganized social services ram to provide medically ces to each resident. A make referrals to or side resources for a resident dditional mental health, or financial services.				
	by: Based on observati review, the facility fa medically-related so maintain the highes psychosocial well-b	ent is not met as evidenced on, interview and document ailed to provide ocial services to attain or st practicable mental and eing for 1 of 1 resident (R52) tisfaction with his life at the				
	Findings include:					
	he did not have any informed of cares, t was prescribed. Wh doing overall at the and indicated, "I do	erview on 8/1/16, at 3:23 p.m. y say in and/or was not reatments, or medications he nen asked about how he was facility, he used an expletive not want to be here." R52 iting for someone to tell him				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/05/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			03/2010
	LA AT BRYN MAWR	275 PEN	N AVENUE NO	RTH		
			POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21475	Continued From pa	age 40	21475			
	what to do and whe	ere to go.				
	R52 was severely of self-reported depre- watching television socialize or particip note dated 12/13/1 to attend his quarted declined stating, "I note indicated asse and the resident has making skills, and guardianship for th (SW) documented member to assist w R52 saw the in-hou and the resident was SW noted she wou meet the resident's 12/17/15, the SW a care conference. T	ote dated 9/16/15, revealed cognitively impaired, had ession, spent some time a and lying in bed. R52 did not bate in activities. A subsequent 5, indicated R52 when asked erly care conference he don't even know you." The essments had been completed ad severely impaired decision the physician recommended e resident. The social worker difficulty finding a family with guardianship. It was noted use psychologist on 10/14/15, as not getting along with his s rejecting leg treatments. The ild continue to be available to s psychosocial needs. On and nurse manager met for a 'he note did not indicate nt was invited or declined or rence.				
	behaviors of refusin names, and had a rummaging through wrote, "Resident is and desires to live doctor and IDT [inter- community dischar resident's cognitive discussed with gua appointed." Notes from the psy located when R52's	5/14/16, indicated R52 had ng treatment and calling staff need for a private room due to h others' belongings. The SW dissatisfied with placement in independent living, but erdisciplinary team] agree that 'ge is not appropriate due to e status. Plan of care to be ardian when guardian is ychology clinic were not s medical record was i it was noted the resident was				

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING		08/	08/05/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
THE VILI	LA AT BRYN MAWR		N AVENUE NC POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21475	Continued From pa	ige 41	21475				
	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.						
	found in R52's reco reviewed on 8/3/16 was invited but did however, a reason note dated 3/16/16 invited but did not a facility had changed increase compliand form dated 6/30 lad indicate whether th attended or decline	onference summary form was ord when the record was . The summary indicated R52 not attend the conference, was not noted. A conference , indicated the resident was attend his conference, and the d his bath to the morning to be with bathing. A conference cked the year and did not e resident was invited or d his conference. No other were located in the record.					
	included diagnoses depression. Althou severely impaired of interviewed for the the resident reported have his family invo- care. The assessmen not display mood of the assessment pet that the resident ex doing things," every R52's care plan, how these areas of impo- concerns with appri- were met. The 6/1 comprehensive Car mood/behavior and states that he wo	ual Minimum Data Set of dementia, anxiety, and ugh the assessment indicated cognition, he was able to be assessment. The only area ed as, "very important," was to olved in discussions about his ent showed the resident did r behavioral indicators during riod, but a new problem was perienced, "little pleasure in y day or nearly every day. wever, did not incorporate ortance to the resident or oaches to ensure his needs 15/16, social services re Area Assessment (CAA) for ual review indicated "Resident uld like to go home. IDT and at community placement is not					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00175	B. WING	B. WING		05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		275 PEN	N AVENUE NO	RTH		
THE VIL	LA AT BRYN MAWR	MINNEAI	POLIS, MN 55	405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21475	Continued From pa	ge 42	21475			
	home placement. F and would like to m significant dementia resident had impair or impaired thought term memory loss/c agreed to be reside results of backgrou resident will improv function through the also noted the resid routine and nursing facility "jail" and wo community but had During an interview 7:58 a.m. she state conferences were se depend on the resid the care plan was a depending on the resid the care plan was a depending on the resid started at the first re how it drove the car primarily nursing ar also a process calle before the assessm staff gave input. During an interview assistant A (RTA-A) described the resid activities" and inste more often. RTA-A benefited from mor and had made atter phone numbers we not responsive to co	g to a new routine and nursing Resident calls this place 'jail,' ove to community, but has a." It also indicated the ed cognitive function/dementia t processes related to short dementia. "Daughter has ent's guardian, waiting on nd check." The goal was, "The e current level of cognitive e review date." The care plan dent was adjusting to a new home placement, called the uld like to live in the significant dementia. with RN-E on 8/4/2016 at d that resident care sometimes a team, but it would dent. The adjustment part of a team effort and varied esident. Initial care plans were eferral which then triggered re plan. Care conferences are nd social services. There was ed Grand Rounds that occurs nent period where additional with the recreational therapy o on 8/3/16, at 1:14 p.m. she ent as "disinterested in ad, wanted his family to visit said R52 would have e interaction with his family, mpts to call them, but the re no longer valid. R52 was onversation and gave staff t." There were no current				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING		08/	08/05/2016	
IAME OF F	PROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE				
HE VILL	A AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21475	Continued From pa	age 43	21475				
	conferences.						
	and said she and the two staff who atten Sometimes, the dia activity staff did not daughter was apport SW described R52 and had not adjust tolerate a roommat toward them and the waiver for this reass family to reach him best he could given the care plan regar home including the approaches, remai resident was admit The SW said they approaches with R facility more satisfat the plan was workit continued to expre- the facility, the SW at trying something be a prisonThere that we need to con SW explained they symptoms with R52 being served. In an	viewed on 8/4/16, at 11:58 a.m. he nurse manager were the ded resident care conferences etitian may attend, but the t attend. She stated R52's binted his guardian in 5/16. The e as "unhappy" at the facility, ed. The resident could not te, as he was "unfriendly" hey received a private room con. The staff had utilized the and ensure he could do the n the situation. The SW verified rding adjusting to the nursing problem statement, goal, and ned the same as when the ted more than a year prior. could have attempted other 52 to make his stay at the actory. When asked if it was fel ng, since the resident ss dissatisfaction with life at replied, "We may need to look new. He does consider this to may be more opportunities nsider for this resident." The had noted traditional dementia 2, such as what meal was ddition, he did not provide a not wish to attend his care					
	administrator or de implement policies	THOD OF CORRECTION: The signee could develop and and procedures related to deducate all staff. Then					

Minneso	ta Department of He	alth			FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE VILI	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21475	Continued From pa	ge 44	21475			
		systems to ensure ongoing oort the findings to the Quality tee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21550	MN Rule 4658.1325 Medications; Pharm	5 Subp. 1 Adminiatration of nacy Serv.	21550			
		cy services. A nursing home e provision of pharmacy				
	by: Based on observati review, the facility fa services were secu medications and bio residents (R2, R120	ent is not met as evidenced on, interview and document ailed to ensure pharmaceutical red, including routine blogicals as ordered for 4 of 8 D, R145 and R149), reviewed ion doses due to medications for administration.				
	Findings include:					
	medication aid (TM Depakote (a medica activity but has also and behavior) for R schizophrenia and r advised a licensed was also unable to	tion of medication 3/1/16, at 7:07 p.m. a trained A)-B was unable to locate ation used to decrease seizure been used to stabilize mood 2. R2's diagnoses included major depression. TMA-B practical nurse (LPN)-G who locate the medication in the cart and the medication room.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING	B. WING		08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
	LA AT BRYN MAWR		N AVENUE NC POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21550	Continued From pa	lge 45	21550				
	LPN-G then stated he would order the medication from the pharmacy.						
	medications to ens label on the medica approximately 7 pill pharmacy. She sa adequate time in ca able to be reordere reasons. She explained if it w would be ordered " on the next run fror would pick up the e reasons. It was the TMAs that were ad	process for reordering ure availability was to pull the ation card when there were Is left and fax it to the id it was important to allot ase the medication was not d due to insurance or other was a necessary medication, it stat" and would be expected in the pharmacy. The facility expense for any or these e responsibility of the nurses or ministering the medications to reordered and available for					
	(MAR) revealed the initialed and circled explanation was do MAR or in the nurs the initials were circ written on 1/26/16, Depakote ER (exte (mg) by mouth (po) plan, target date 10 mood and behavior delusions, active ha and the potential fo	dication administration records e medication Depakote was on 8/1/16, at 8:00 p.m. No ocumented on either side of the ing progress notes as to why cled A physician's order, directed staff to administer nded release) 2000 milligrams o every bedtime. R2's care 0/17/16, identified R2 as having problems, grandiose allucinations and depression r self-harm related paranoid care plan directed staff to ions as ordered.					
		written on 1/26/16 directed Clozapine 400 mg at bedtime					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/05/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
THE VILI	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21550	Continued From pa	ge 46	21550			
	did not have any ar Clozapine, used to suicidal behavior, s unavailable and wa (veterans' administr A review of the July not receive Clozapi 7/23/16 and 7/24/16 During an initial inte a.m., R120 stated h left shoulder and ha manage it. He expla often ran out of the take Tylenol as an a getting medications running out becaus In a follow-up conve p.m., R120 stated h on 8/1/16 and 8/2/1 available in the faci received Tylenol, it level of the Oxycod happened, "way too reorder the medica Diagnoses for R120 pain that occurs tow cervical vertebrae) physician's order w to administer Oxyco	2016, MAR revealed R2 did ne 400 mg at bedtime on 5. erview on 8/2/16, at 10:51 he frequently had pain in his ad an order for Oxycodone to ained, however, the facility medication and he had to alternate, "They are so slow 6 here. They are always e they don't order in time." ersation on 8/4/16, at 2:40 he did not receive Oxycodone 6 because there was no stock lity. He explained, although he did not manage his pain to the one. He again stated this o often," and, "they just don't tions when they should." D included Cervicalgia (neck ward the rear or the side of the and low back pain. A ritten on 7/21/16 directed staff odone HCL 5 mg every 6 ed) for pain. A review of the				
	of Oxycodone HCL and did not receive 4:45 p.m. The indiv	0 was administered 2 tablets 5 mg on 8/1/16, at 8:00 a.m. another dose until 8/2/16, at <i>v</i> idual narcotic record, page er the 8/1/16 dose that was				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		00/05/0010	
		00175			08/	05/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
THE VILI	A AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21550	Continued From pa	age 47	21550			
	given at 8:00 a.m., the Oxycodone HCL 5 mg supply for R120 was depleted.					
	actual and potentia pain and to monitor increased pain, new symptoms of pain of physician if interver a significant chang On 8/4/16, at 3:00 nurses' station loca She asked the staf sure my Trazadone medication also us	d 6/27/16, Identified R120 with I leg pain and chronic low back r and document side effects, w onset of signs and or behavior, and to update the ntions were not successful or if e in status was observed. p.m. R145 approached the ated on unit 1 in the facility. f, "Can someone please make e (an anti-depressant ed to treat insomnia) is had it in 2 nights and I didn't ht."				
	a.m. R145 stated s trazadone again or the third night in a r my bipolar and my stated that it was h she didn't get any s restless and got up and when she was like a rock." She c through another nig don't want to end u I am on the edge. time and I don't new explained she had	interview the next day at 7:53 she had not received her n 8/4/16. She explained it was row and it was, "messing with emotions are unstable." She ard to manage stress when sleep. She stated she was o several times during the night given Trazadone she, "slept ontinued, "If I have to go ght like this, it won't be good. I up like a basket case. I feel like I have been stable for a long ed this, I really don't." She then not received her Requip (a treat restless leg syndrome)				
	found in the cart or verified the last dos	ated R2's Trazadone was not the medication room. She se of Trazadone 200mg was				
inesota D	epartment of Health M					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
HE VILI	LA AT BRYN MAWR		N AVENUE NC POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21550	Continued From pa	age 48	21550			
		8:00 p.m. The TMA further uip was not given from 8/1/16				
	Requip and Trazad the medication car	G reported that he located R2's lone in the bottom drawer of t. The medications had been macy on 8/2/16 but had not ye R145.				
	major depression a orders directed sta 200 mg prn at bedt HCL 3 mg every be revealed! Trazador or 8/4/16 and Requ five days between plan, initiated 7/1/1 psychotropic medic depression and dire psychotropic medic ordered by the phy	5 included Bipolar disorder, and insomnia. The physician ff to administer Trazadone, time for insomnia and Requip edtime. A review of the MARs he was not given 8/2/16, 8/3/16 uip was not administered for 7/31/16 and 8/4/16. The care 6, indicated R145 was to use cation to treat insomnia and ected staff to administer cation, including Trazadone, as ysician and to monitor for side somnia, depression and				
	practical nurse (LP ferrous sulfate (a n deficiency anemia) medication) for R14 acute kidney injury LPN-D stated "the	8/3/16, at 8:44 a.m. a licensed N)-D was unable to locate nedication used to treat iron and gabapentin gel (a pain 49. R149's diagnoses included and altered mental status. medications are not in the cart a to give them, I will have to				
	8/2/16, indicated R	physicians orders dated 149 was to receive ferrous ms per 5 milligrams (mg/ml)				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE, ZIP CODE			
			N AVENUE NO			
THE VIL	LA AT BRYN MAWR		POLIS, MN 55			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		COMPLET DATE
ma		,	1/10	DEFICIENC		
21550	Continued From pa	ae 49	21550			
	•	-				
		nd gabapentin 8% gel topically	r l			
		19 medication administration				
		2016 indicated the medication				
		not initialed as being				
		on 8/3/16, and her gabapentin				
		ed once the same day. No				
		documented on either side of				
		ursing progress notes as to				
	why the initials were	e circled.				
	During on interview	$a = \frac{9}{5}$				
		on 8/5/16, at 9:57 a.m. the				
		f nursing (ADON) verified ved her 8am or noon				
		us sulfate and her 8am				
		pentin gel on 8/3/16. On				
		the ADON and surveyor				
		R and noted both of her				
		itialed as being given by				
		hen the ADON looked into the				
		e could not find either one of				
		he same day at 10:50 a.m. the				
		both medication are still not				
		DN explained R149 received				
		ous sulfate in a pill form				
		d for R149 gabapentin the				
		ains a new prescription for the				
		e pharmacy will refill it.				
	[···] ·································					
	During a telephone	e conversation on 8/5/16, at				
		Pharmacy consultant stated				
		new medication order to be				
		the same day. If a refill, it				
	might take 2 or 3 da	ays so therefore he would				
	expect the facility s	taff to reorder when 3 to 5				
	days of medication	were left for the resident.				
	That would ensure	ample time availability of the				
		ther stated it was, "concerning,				
		or other antipsychotic				
	medications were n	not given for 3 or more days.				
	He further evolution	d, "Medications are ordered				1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00175	B. WING		08/05/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	T ADDRESS, CITY, STATE, ZIP CODE				
THE VILI	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21550	Continued From pa	ige 50	21550				
		y are ordered, they should be are ordered because they are					
	Schedule, revised pharmacy and facil determine delivery possible after the e Services Agreemer Agreement. The po procedure when re During an interview director of nursing	linnesota Pharmacy Ordering 1/1/13, indicated the ity should coordinate to days and times as soon as xecution of the Pharmacy nt or Pharmacy Consultant olicy did not address the -ordering medications.					
	4-day supply was le	dents' medications when a eft and to contact the dication was not delivered to					
	The director of nurs educate all staff res administration to er medication as orde	THOD OF CORRECTION: sing and/or pharmacist could sponsible for medicaiton nsure residents received their red by the physician The could complete audits to and compliance.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21565	MN Rule 4658.132 Medications Self Ad	5 Subp. 4 Administration of dmin	21565				
	self-administer med resident assessme	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and					

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00175	B. WING		08/05/2016	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LA AT BRYN MAWR					
SUMMARY STATEMENT OF DEFICIENCIES		ID		CORRECTION	(X5)
		PREFIX TAG	CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLET DATE
Continued From pa	ige 51	21565			
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.					
R47 was interviewed stated he attended Wednesdays and F expressed concern care by the facility s here does nothing f R47 explained that	renal dialysis on Mondays, ridays. At that time, R47 s he had about his dialysis staff stating, "the nursing staff for my dialysis access site." one hour prior to dialysis the				
medication Lidocain stated, "this never l said the cream was room, and the nurs gauze to cover the	ne, to his access site. He happens. I have to do it." R47 s stored in a drawer in his e provided the resident with site. R47 stated, "I don't know				
this, but they don't. some time now." R nurse put a bandag completed, and he in the evening after	It's been going on like this for 47 explained that the dialysis ge on his arm after the run was removed the bandage himself it stopped bleeding. When				
Lidocaine to detern medication he repli my top drawer in m	nine if he correctly used the ed, "No, I keep the cream in y room."				
called for the surve bandaged. The res	yor. His access site was ident informed the surveyor, "I				
	OF CORRECTION PROVIDER OR SUPPLIER <b>AAT BRYN MAWR</b> SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par 4658.0405 indicate is a written order from This MN Requirem by: Based on interview facility failed to ens self-administered no assessed and/or rec 2 of 2 residents (Ra- administration of m Findings include: R47 was interviewe stated he attended Wednesdays and F expressed concernon care by the facility so here does nothing fact R47 explained that nurse was supposed medication Lidocain stated, "this never fact stated, "this never fact state fact state fact state fact state fact state fact state fact state fact sta	OF CORRECTION         IDENTIFICATION NUMBER:           00175         00175           PROVIDER OR SUPPLIER         STREET AI           A AT BRYN MAWR         275 PEN MINNEA           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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 medic	OF CORRECTION         IDENTIFICATION NUMBER:         A. BUILDING:           00175         B. WING           PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, S           AAT BRYN MAWR         275 PENN AVENUE NC MINNEAPOLIS, MN 55           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           Continued From page 51         21565           4658.0405 indicate this practice is safe and there is a written order from the attending physician.         21565           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. Findings include:         2017 (Free State) (Free State	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00175       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         AAT BRYN MAWR       275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX (EACH CORRECTIVE ACI (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 51       21565         4658.0.405 indicate this practice is safe and there is a written order from the attending physician.       D PREFIX TAG         This MN Requirement is not met as evidenced by:       21565         Based on interview and document review, the facility failed to ensure residents who self-administration of medications.       Sincidate: this practice is safe to do so for 2 of 2 residents (R47, R20) reviewed for self administration of medications.         R47 was interviewed on 8/2/16, at 4:15 p.m. R47 stated he attended renal dialysis and coses site."       R47 explained that one hour prior to dialysis care by the facility staff stating, "the nursing staff here does nothing for my dialysis access site. He stated, "this never happers. I have to do in." 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 dont. It's been going on like this for some time now." R47 exp	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:       COM         00175       B. WING       08/         PROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE         AAT BRYN MAWR       275 PENN AVENUE NORTH         MINNEAPY STATEMENT OF DEFICIENCIES       ID         I REQUARTIVE NUST DE PRICIENCY MUST DE PRICIENCY MUST DE PRIVE POLY OF MUST DE PRIVE POLY       PROVIDERS PLAND OF CORRECTION         I REQUARTIVE NUST DE PRIVE POLY OF LSC IDENTIFICATION       ID       PROVIDERS PLAND OF CORRECTION         I REQUARTIVE NUST DE PRIVE POLY OF LSC IDENTIFICATION (INTERPRICIENCY MUST DE PRIVE POLY OF MUST DE PRIVE POLY OF DEFICIENCY)       PROVIDERS PLAND OF CORRECTION         Continued From page 51       21565       Continued From page 51       21565         Continued From page 51       21565       21565       DEFICIENCY)         Continued From the attending physician.       This MN Requirement is not met as evidenced by:       DEFICIENCY       DEFICIENCY)         Self-administred medications had been assessed and/or reassessed as afe to do so for 2 of 2 residents (R47, R2) reviewed on Si2/16, at 4:15 p.m. R47       Stated he attended renal dialysis to Mondays, Wednedsays and Fridays. At that time, R47       Explained that one houry provo to dialysis the nurse was suppose to apply a numbing medication. Lidocatine, to this access site. He 7 stated he attended that one hours provided the resident with gauze to cover the site. R47 stated, "I don't know why I have to do this. Nursing

STATEME	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00175	B. WING		08/05/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	age 52	21565			
nnesota D	cream, but the nurse cream prior to his a A Quarterly Review dated 6/16/2016 re Interview of Mental indicating a good m to communicate ne care plan dated 6/2 were to complete d Licensed practical worked with R47 w 1:07 p.m. LPN-H ve the Lidocaine crear explained that the o resident with a tube and he performed t stated she used to dialysis appointmen "now he goes befor Registered nurse (I was unaware R47 v topical medication to verified anyone tak should have been a nurse, and R47 had medication self-adm the surveyor that in order from the dialy the access site one RN-A said sometim the paperwork to th from dialysis. Later that day R47' interviewed by telep obtained the order dialysis center, whi access site one ho RN-C stated, "I dor	Minimum Data Set (MDS) vealed the resident had a Brier Status (BIMS) score of 15 nemory. The resident was able eds. The resident's current 25/2015 indicated facility staff ialysis access site care daily. nurse (LPN)-H who routinely as interviewed on 8/3/16, at erified R47 self-administered m prior to dialysis. She dialysis clinic had provided the e of the cream and a bandage, the treatment "himself." LPN-H help the resident when his nts were at 10:00 a.m. adding,				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
THE VIL	LA AT BRYN MAWR		N AVENUE NC POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	ige 53	21565			
	found out that if we needs to be address call the facility direct don't think the facility back with [R47]." On 8/4/16, at 10:38 been moved to a ma asked if he had the "Yescome, I will s opened the drawer RN-D who worked could not locate the treatment cart. RN- in the treatment car resided until last ev LPN-H reported shad cream." Later, at 2:14 p.m. verified R47 should self-administering r R20 R20 was observed on bed on right side mask over face, wi continuous observat observed with eyes place, machine run medication assistant hall and looked in F away. At 10:26 a.m the right side with the machine running w mask. R20's quarterly Min indicated R20 had sever making skills, and F	Ve [dialysis nurses] have have something that really seed or changed. we have to ctly." RN-C restated, "I really ty looks at the sheets we send a.m. R47 stated he had just ew room last evening. When Lidocaine cream he replied, how you." However, when R47 he could no find the cream. on the resident's new unit e Lidocaine cream in the D said it would have been left rt on the unit where R47 rening. At 12:58 p.m. however, e was unable to find the the administrator and RN-E I have been assessed prior to medication. on 8/3/16, at 10:01 a.m. lying e, eyes open, with nebulizer th machine running. During ation at 10:07 a.m. R20 was closed nebulizer mask still in ning. One minute later trained ht (TMA)-C walked down the R20's room and then walked . R20 was observed lying on he nebulizer mask on face, ith no steam going into the				

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00175	B. WING		08/05/201			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	T ADDRESS, CITY, STATE, ZIP CODE					
THE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
21565	Continued From pa	age 54	21565					
	dated 4/06/16, triggered for Cognitive Loss/Dementia and indicated R20 had, "Decreased ability to make self understood or to understand others."							
	came down from st feedings and insulit trained to pass meet nebulizer treatment R20 got up for breat medications and we R20 would put on the TMA-C stated she off of R20. TMA-C nebulizer treatment put it on himself. A the nebulizer mask the machine was ru partially full with me going into the mask given R20 his nebut the cylinder with me written on the outsi marker, "8/2/16, 2 not been aware the cylinder nor had sh nebulizer in place w TMA-C stated R20	a.m. TMA-C stated the nurse tation 3 and did residents' tube ns. TMA-C stated she was dications and administer ts. At 10:26 a.m. TMA-C stated akfast, had his morning ent back to bed. TMA-C stated he nebulizer mask himself. would go and take the mask stated she had not applied the t for R20, that he must have at 10:33 a.m. TMA-C verified was on R20's face and that unning, that the cylinder was edication and no steam was k. TMA-C stated she had not dizer mask, nor had she filled edication. TMA-C verified de of the cylinder in black p.m." TMA-C stated she had pre was medication in the e been aware that R20 had his with the machine running. only received prn (as needed) ts and that she would call						

STATEME	Dia Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
			N AVENUE NO			
THE VIL	LA AT BRYN MAWR	MINNEAR	POLIS, MN 55	405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21565	Continued From pa	ge 55	21565			
	when the cylinder w would be the day m have exchanged cy not know who gave R20 as it had not be TMA-C stated when treatment, she wou cylinder and put the leave the room and treatment was finish come back in about did not take long to giving R20 a nebuli on the front of the T was a PRN treatment	ad written the date and time vas replaced. TMA-C stated it urse yesterday who would dinders.TMA-C stated she did the last nebulizer treatment to een initialed in the TAR. In she gave R20 a nebulizer ld put the medication in the e mask on R20's face and come back when the hed. TMA-C stated she would t 2-3 minutes as the treatment run. TMA-C stated when zer treatment she would initial TAR and write on the back as it ent. TMA-C stated R20 was not own nebulizer treatment.				
	worked the previou R20's cylinder at 2 nebulizer treatment R20 a nebulizer tre in R20's room durin take the mask off a	b.m. LPN-I stated she had s evening, had not changed p.m. and had not given R20 a LPN-I stated when she gave atment she would have to stay ig the treatment as R20 would nd throw it on the floor. LPN-I rere chronic obstruction (COPD).				
	replaced R20's tubi the new cylinder 8/2 date and time. LPN nebulizer treatment and when he exerte had checked R20's had been a little low treatment. LPN-J ve	a.m. LPN-J stated she had ng and cylinder and labeled 2/16, 2 p.m. as that was the -J stated she had given R20 a as R20 was kind of wheezing ed himself. LPN-J stated she oxygen saturations and they v before applying the nebulizer erified she had not ng about the PRN nebulizer				

	NT OF DEFICIENCIES I OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		08/	05/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		NAVENUE NO POLIS, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21565	minutes there was a cylinder and she no working correctly. S who to tell about the had told the oncom LPN-J stated she h treatment to R20 at verified she had no R20 will put his neb when then, "asked shake his head and will keep his mask stated she thought treatment as she th assessment had be but had not seen th indication of a self a the resident's chart On 8/4/16, at 10:40 not given R20 a nel TMA-C asked her to normally left R20 al on as she believed completed at one ti could not verify in th completed for R20. R20's August 2016 "Ipratropium-Albute Nebulize 1 vial by n dated 7/16/16" and Before And After Tr Respirations Before R20's August MAR TMA regarding any	still medication left in R20's stilced the machine was not she stated she had not known e machine not working and ing evening nurse about it. ad not given a nebulizer : 2 p.m. but at 10:00 a.m. and t documented it. LPN-J stated pulizer mask on himself and if he wants a treatment will d say yes " LPN-J stated R20 on until she returns and LPN-J R20 could be alone with his pought a self-administration een completed on R20 in July. e assessment or any administration assessment in a.m. LPN-E stated she had bulizer the day before nor had o give one. LPN-E stated she one in his room with the mask R20 had an assessment me to self-administer but he record one had been physician orders included: rol 0.5-3 mg/3 Ampu-Neb nouth every 4 hours as needed d "Document Heart Rate eatment, Document e And After Treatment." showed no initials by nurse or nebulizer treatment given or pulizer treatment respiratory	21565			

					(X3) DATE SURVE COMPLETED			
		00175	B. WING		08/05/2016			
AME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE					
	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
21565	R20's current care [R20] has a physici self-administration Nebs" date initiate for Goal, "The resi medications safely review date, " date indicated, "Review with resident [R20] reassess abilities," On 8/4/16, at 10:47 had been talking at assessments and v educate staff regar assessments. ADC assessment compl safe to administer of SUGGESTED MET The DON or design staff regarding Self assessments for re- random audits of re-	plan indicated, "The resident an's order for supervised of the following medications: d 4/28/14, and also indicated dent [R20] will take and as prescribed through the d initiated 4/28/14 and also medication self-administration /monthly and as needed to Dated initiated 4/28/14. Y a.m. ADON stated the facility pout the self-administration would need to correct and ding self-administration DN stated there had to be an eted to know the resident is						
		R CORRECTION: Twenty-one						