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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JLO2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00175

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

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

6. DATE OF SURVEY **08/28/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susan Haben, Unit Supervisor 09/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/15/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/04/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245203 September 15, 2017

Mr. Michael Marchant, Administrator
The Villa At Bryn Mawr
275 Penn Avenue North
Minneapolis, MN 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 August 2, 2017 the above facility is recommended for:

120 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 15, 2017

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

RE: Project Number S5203026

Dear Mr. Marchant:

On July 14, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 28, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)whereby corrections were required.

On August 28, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 14, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 2, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 28, 2017, effective August 2, 2017 and therefore remedies outlined in our letter to you dated July 14, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JLO2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L4) **275 PENN AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55405**

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

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

6. DATE OF SURVEY **06/28/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NEII 07/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/04/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00270 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
08/04/2017 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 14, 2017

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

RE: Project Number

Dear Mr. Carlson:

On June 28, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susie Haben, 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: susie.haben@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 August 7, 2017, 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 August 7, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 28, 2017 (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 December 28, 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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	06/28/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/25, 26, 27 and 28, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC (electronic plan of correction), your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 204 SS=D	483.15(c)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG (c)(7) Orientation for Transfer or Discharge A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a safe, orderly and timely discharge for 1 of 1 resident (R66) who was seeking to discharge from the facility.	F 204	The Villa of Bryn Mawr submits this plan of correction because it is required by State and Federal Regulation and is not a legal admission that this statement of	8/2/17

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

Electronically Signed | 07/21/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	06/28/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 1 Findings include: During a conversation on 6/26/17, at 14:36 p.m. R66 stated he was concerned regarding discharge orders that were obtained on 6/13/17. He was not aware of a planned discharge process or a pending discharge date. On 6/27/17 at 10:53 a.m. a social worker, (SW)-A explained that she had only worked in the facility four days but was aware that R66 was in the process of discharging from the facility to an apartment. She stated there had been "set-backs" related to equipment and a sufficient physician's order for discharge. SW-A stated R66's relocation worker (RW) was coordinating the majority of the discharge. SW-A further stated height and weight should have been provided with the order for bariatric equipment, "It's standard." On 6/27/17, at 2:20 p.m. the RW stated the following: she had been working toward a discharge plan for R66 since 11/16 she found housing for R66 in 5/17 R66 signed a lease on 5/31/17 the facility social worker at the time (SW)-B scheduled a discharge meeting for 6/1/17 SW-A stated that R66 and SW-B did not "get along" RW and the nurse manager attended the discharge meeting where it was decided R66 would need a hospital bed, diabetic equipment and supplies as well as bariatric equipment including a commode, hospital bed and shower chair a face-to-face physicians visit was scheduled for	F 204	deficiencies is correctly cited, and is not to be construed as an admission against the interest by the Center, the Administrator or any employees, agents or other individuals who draft or may be discussed in the response and plan of correction. The Villa of Villa Bryn Mawr respectfully submits this plan of correction and our allegation of compliance as of August 2, 2017. F204 □ PREPARATION FOR SAFE / ORDERLY TRANSFER / DISCHARGE Resident identified R66 has successfully discharged. All residents in house with active discharge plans will be reviewed by Social Service/designee to be completed by August 2. Review to be done using the new discharge audit tool. Discharge Summary and Plan Policy reviewed and updated as appropriate. New Discharge / Orders Form to be used by Social Services at Discharge Care Conferences. Re-education of appropriate staff completed by the LNHA (Licensed Nursing Home Administrator) or Designee. Weekly audits of all Discharge Care Conferences / Discharge Charts to be completed by Social Services or Designee to ensure compliance. Audits to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	06/28/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 2 6/6/17. RWstated she was "not getting any assistance from The Villa staff" SW-B told RW the order did not meet the standards for discharge because it did not provide evidence (weight/height) to justify the need for specialized (baraiatric) equipment upon discharge RW stated it was not her job to obtain discharge orders, make appointments or ensure adequate equipment was obtained for residents prior to discharge The RW continued to explain,"This went on through the following week. It was very confusing. [SW-B] put the blame on the doctor. I was so frustrated." She further explained an order was placed by the medical supply company but when the equipment was delivered on 6/22/17, it was not bariatric equipment. New orders had to be requested from the physician. The RW stated,"This is not my normal job. The facility did not take responsibility. I felt like I had to take matters into my own hands in order for [R66] to discharge." The RW stated she went to the clinic to provide a letter to R66's physician to obtain the required orders. She further stated the medical supply company indicated the medical record needed to reflect the need for the bariatric equipment. RW further stated because of the mistakes made in the discharge orders, "the very earliest he will be able to discharge will be around July 11, but could be much later." When speaking with R66 on 6/28/17, at 10:21 a.m. he stated, "I am pissed-off because I have paid June rent and July is due on the first. [SW-B] actively put things in the back file." R66 stated SW-B tried to "disrupt my discharge at every	F 204	reviewed by the program manager. Audits to be referred to QAPI (Quality Improvement Performance Improvement) for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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	245203	A. BUILDING _____ B. WING _____	06/28/2017

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F 204	Continued From page 3	F 204		

turn." R66 referred to his care conference on 6/1/17, when asked what he would need at home. R66 told them he would need "meds (medication), diabetic equipment, a sturdy steel commode and shower chair, and a hospital bed." R66 said they brought him a regular bed stating "I am 7 feet tall and weigh 375 pounds." R66 also said the RW called yesterday and she filed a complaint with the ombudsman and he had an appointment with his doctor today. R66 said he would get the right physician's order of he would "self-checkout." R66 clarified there was no need for him to be in the facility for this period of time stating the facility "dropped the ball" on him when they failed to follow through on the discharge orders/planning. "I should be living in my own apartment now."

Upon review of R66's progress notes and communication related to his pending discharge revealed the following:
-9/12/16 "[R66] is admitted post knee surgery for rehab. Is homeless at this time and needs housing services." Signed by SW-B
-3/2/17 "[R66's] rental bed replaced with bariatric facility bed." Signed by SW-B
-3/24/17 "[R66] is on relocation services to find apartment in community." Signed by SW-B
-6/1/17 "SW called Dr. office to get orders for discharge on June 12th and medical equipment including Hospital bed Shower chair, diabetic supplies including glucometer and lancets, commode and wheelchair." Signed by SW-B
-6/1/17 "SW met with program manager and [RW] to discuss discharge planning. He will be receiving keys for his new place tomorrow and anticipating a move in date of June 12. He would prefer a steel commode and a steel shower chair if possible." Signed by SW-B

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F 204	Continued From page 4 -6/2/17 "SW talked to Dr.'s office and they state they want to see him [R66] in the clinic before he discharges. SW went ahead and scheduled him for 6/6/17 @ 3pm. [RW] was notified and requested to pass the message along to him, as [R66] prefers not to work directly with this writer." Signed by SW-B -6/7/17 "SW called Dr. office to request a face-to-face visit note from Dr. office so SW can order a hospital bed and wheelchair for [R66] as well as other medical supplies for discharge." Signed by SW-B -6/7/17 "SW received call back from the clinic, and stated face-to-face visit sheet is incomplete, and [primary doctor] won't be back in house until the 16th. Nurse going to attempt to see if she can have one of the other docs (doctors) finish it and will fax orders over for the medical supplies." Signed by SW-B -6/26/17 A progress note signed by SW-A stated she had met with R66 and was updated regarding his plans to discharge pending the correct equipment to be delivered to his apartment. SW-A further stated the RW indicated the equipment delivered on 6/22/17, was not bariatric and had to be returned. The RW stated she would get orders for bariatric equipment "which again requires approval by the state and then again wait for a delivery date." SW-A's note continued to explain she attempted to update R66 on his pending discharge from the facility, however he refused stating, "I don't want to hear it. I will be waiting on the edge of my seat for when you know something real." Signed by SW-A On 6/28/17, at 1:56 p.m. the regional consultant (RC) stated she spoke with the RW to inquire why she was handling R66's discharge and not the	F 204		

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F 204	Continued From page 5 facility. She was told she wasn't getting "any traction, not getting any response from [SW-B]." The RC further stated R66's height and weight should have been provided with the order for bariatric equipment. She confirmed R66 qualified for bariatric equipment based on his height and weight. She further stated she would expect the facility social worker and nurses to handle the discharge process and ensure adequate equipment was supplied in a timely manner. The RC stated R66 was discharging today, without bariatric equipment. "He has had discharge orders for weeks. He was free to go but stayed because he was waiting for the bariatric equipment. We offered to privately rent him a bariatric hospital bed but he refused. Residents should have what they need when they discharge." At 3:30 p.m., the RC stated R66's "discharge was definitely a problem." The discharge plan and summary for R66 was requested but not provided. Review of the facility policy Discharge Summary and Plan, revised 4/09, did not address ordering or obtaining equipment or supplies prior to discharge. This specific policy was requested but not obtained.	F 204		
F 244 SS=C	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 244		8/2/17

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F 244	Continued From page 6 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide follow up to the resident council related to complaints about food being delivered late and hot food being delivered cold. This had the capability of affecting all 97 residents eating meals in the facility. Findings include: The facility held resident council meetings monthly. A Resident Council Agenda form was used for recording the minutes and contained specific New Business agenda items. Old Business was covered at each meeting however, the agenda identified the minutes were reviewed from the meeting but did not address resident concerns from the previous meetings. Complaints related to food being delivered late and/or cold were included in the Resident Council Dietary Department Review in the resident council minutes from 12/16, 1/17, 2/17, 4/17 and 6/17. Specific resident and/or resident council concerns were not followed up on or actions documented in response to the concerns. During an interview on 6/26/17, at 3:09 p.m. the resident council president (RCP) stated the resident council usually met on the third Wednesday of every month. The RCP further	F 244	F244 LISTEN / ACT ON GROUP GREIVANCE / RECOMMENDATION There was no individual identified with adverse outcome. The NHA and program director met with RCP, reviewed all the survey findings and all suggested Plan of Correction. The Facility was not able to identify any residents adversely affected by the observations identified in the MDH (Minnesota Department of Health) survey. The RCP was satisfied and appreciative of the Plan of Correction and information shared. Resident Council Agenda and the Policy and Procedures were reviewed with the IDT (Inter Disciplinary team) and the Resident Council, completed by the LNHA. Food and dietary plan of correction, interventions, and audits were reviewed with resident council and RCP. Audits of meal service and food concerns will be addressed and reviewed at each resident council meeting. Staff educated on the process for the follow up of concerns identified at the Resident Council Meeting.	

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F 244	Continued From page 7 stated they have talked about food being delivered late and cold many times. She further clarified the food is served slow/late at most meals so it is often cold. The RCP identified that although issues with meals were identified at nearly every council meeting, she had not been informed of actions being taken to address the concern, nor had the facility's response to the concerns been addressed at each resident council meetings. On 6/27/2017, at 2:42 p.m. the Life Skills Program Manager and the Admissions Director were interviewed. They verified the resident council minutes indicated consistent resident concerns regarding food being delivered late and cold each month but the minutes did not include any resolutions or follow-up with the concerns. They further explained the Old Business only included the minutes were reviewed without specific recommendations or resolution. In addition, they stated responses to previous concerns were not reported at follow-up resident council meetings. The Life Skills Program Manager confirmed they were not following the facility resident council policy regarding facilitating and responding to concerns discussed at the council meetings. Additionally, they did not have records for actions taken in response to the concerns related to food being delivered late and cold. The facility's undated Resident Council Policy and Procedure, indicated Social Services was responsible for facilitating and responding to requests/concerns discussed at the council meeting, as well as document and retain records for actions taken in response to the concerns. The policy indicated recommendations/solutions	F 244	Completed by the LNHA. Monthly audits to be done of the Resident Council Minutes and of the resident council grievances identified to ensure follow up, completed by the Life Enrichment or Designee. Identified kitchen and food concerns are reviewed by dietary manager for immediate follow up. The satisfaction of that follow up to be monitored by Program Manager/designee. All other grievances will be reviewed by the IDT at the daily stand up meeting to ensure timely follow up and resolution. Resident signature or validation to be identified on the grievances and all reviewed by LNHA. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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F 244	Continued From page 8 must be documented and reported at the following council meetings.	F 244		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were provided activities in accordance with their individual past preferences for 1 of 3 residents (R21) reviewed for activities. Findings include: On 6/26/17, at 2:50 p.m. R21 was observed laying in bed with eyes closed. A group activity of manicures was going on in the dining room at that time. Interview with R21's guardian was attempted on 6/26/17, at 10:28 a.m. but was unable to be reached and did not return call. A care conference note dated 9/8/16, indicated the guardian had suggested bringing R21 to manicures as she used to love those.	F 248	F248 ACTIVITIES MEET INTEREST / NEED OF EACH RESIDENT R21□s Activities Assessment, NAR Group Sheet, and Care Plan will be reviewed and updated as appropriate. Completed by the Activity Staff. All residents will have their care plan reviewed and updated to identify individual activity programs, residents unable to identify activity preferences will have their guardians consulted for input. Resident activity participation will be logged to validate that the care plan interventions are being implemented. Care plans are reviewed quarterly at care conferences and PRN with significant changes to ensure appropriate interventions are	8/2/17

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F 248	Continued From page 9 On 6/27/17, at 10:12 a.m. R21 was observed lying in bed. R21 was awake and able to make eye contact but unable to answer questions. No activities were observed going on in the resident's room. On 6/27/17, at 2:03 p.m. R21 was observed in her room by herself. R21 was awake and sitting in her wheelchair slightly reclined with the lights on. No activities were observed going on in the resident's room. During an interview on 6/27/17, at 2:07 p.m. nursing assistant (NA)-D stated she was not aware of any activity schedule for R21 and stated R21 slept a lot during the day. NA-D confirmed R21 was not able to communicate much, she will answer questions sometimes with yes or no but other than that cannot say many words. During an interview on 6/28/17, at 8:27 NA-E confirmed R21 went back to bed after each meal. NA-E stated she has not seen R21 attend group or 1:1 activities. She further stated she was not aware of any activities nursing staff should be providing R21 in her room. During an interview on 6/28/17, at 8:52 a.m. the admissions director (AD), who had recently transferred from the activities department, explained it was difficult for R21 to participate in group activities because she needed to lay down to prevent skin breakdown. The AD stated activity staff sometimes did hand massages or read to R21. The AD stated R21 did not watch much television. She further stated she thought the activities staff were doing 1:1 activities with R21 weekly.	F 248	completed by the IDT. Re-education of appropriate staff, completed by the DON (Director of Nursing) and the LNHA. Weekly audits of Activities and the logs to be completed for the proper follow up. Completed by the Program Manager/Designee. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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F 248	Continued From page 10	F 248		

On 6/28/17, at 10:02 a.m. two NAs were observed to take R21 from the dining room to her room, and put her into bed. A few minutes later, R21 was observed lying in bed awake with the lights off.

During interview on 6/28/17, at 1:14 p.m. the director of nursing (DON) stated every resident should have an activities assessment completed by activities staff. The DON also stated the care plan should be used by both activities and nursing staff to ensure residents are being offered activities according to their preferences.

R21's Order Summary Report, indicated she had been admitted to the facility on 1/26/09 and had medical diagnosis including: cognitive deficit following unspecified cerebrovascular disease (restricted blood flow to brain causing thinking and perception deficits) and aphasia (loss of ability to understand or express speech).

Review of the facility's group activity logs for the month of June 2017, indicated R21 was observed in a resident council meeting on 6/14/17.

A review of 1:1 activities indicated R21 had a hand massage on 6/7/17 for 15 minutes.

Although no individualized resident assessment for activities was available, R21's care plan dated 6/13/17, indicated activities was a focus. The goal included: "The resident will participate in activities of choice for spiritual and sensory stimulation 1-2 times weekly by review date." Interventions included, "The resident's preferred activities are: Resident watches TV in her room. Bible Study, Birthday Party, Manicures, church."

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F 248	Continued From page 11 The June 2017 activity schedule indicated manicures were offered on 6/5, 6/8, 6/12, 6/19, 6/26, a birthday party on 6/28, and visits from the Missionaries of Charity on 6/11 and 6/25, however did not indicate R21 had been invited/attended these.	F 248		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the care plan to ensure safe smoking for 1 of 2 residents (R11); and failed to ensure an activity program was implemented for 1 of 3 residents (R21) reviewed for activities. Findings include: R11's care plan included focus problem areas including: potential for alteration of skin integrity due to unsafe smoking (cannot control ash), and smoking. Interventions included for "staff to assure his smoking apron is on when smoking." On 6/25/17, at 3:00 p.m. the North Cart on 2nd floor had a note on the top stating "[R11] do NOT give cigarettes unless smoke apron is on".	F 282	F282 SERVICES BY QUALIFIED PERSONS / PER CARE PLAN. R21□s Care Plan was reviewed and updated as appropriate, residents involvement in activities and activity log have been implemented and reviewed. R21 has no adverse outcome. R11□s smoking assessment and care plan to be reviewed and updated with additional interventions as appropriate. R11 has no adverse outcome. All residents will have their care plan reviewed and updated to identify individual activity programs, residents unable to identify activity preferences will have their guardians consulted for input. Resident	8/2/17

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F 282	Continued From page 12 R11 was observed on the first floor patio on 6/25/17, at 4:55 p.m. R11's smoking apron was hanging on the handle of his wheelchair. R11 was observed to light a cigarette and smoke it. On 6/25/17, at 5:50 p.m. R11 was again observed to be on the first floor patio area smoking. At that time, the smoking apron was laying across R11's legs but did not cover his chest area. On 6/27/17, at 2:17 p.m. the clinical manager (CM)-A stated R11 was able to take his smoking apron off independently but had been told in the past he would not be allowed to smoke unless he wore the apron. On 6/28/17 at 7:50 a.m., R11 asked licensed practical nurse (LPN)-C for a cigarette. LPN-C was observed to take a cigarette out of a locked room and give it to R11. R11 placed the cigarette behind his ear and took the elevator downstairs. R11's smoking apron was observed hanging on the handle of wheelchair. At 7:59 a.m., R11 was wheeling himself back in from the outside patio. When questioned by the surveyor, R11 would not confirm whether he had just smoked, however the cigarette was no longer observed behind his ear. The smoking apron continued to be hanging on the handle of his wheelchair. At that time, R11 told the surveyor he was able to smoke independently. He further stated he "usually" wore his smoking apron but acknowledged it was not on him at that time. During the observation and interview with R11, no burn areas were observed on his skin or clothing. On 6/28/17 at 9:55 a.m., LPN-C stated staff were responsible for ensuring R11 put the smoking	F 282	activity participation will be logged to validate that the care plan interventions are being implemented. Care plans are reviewed quarterly at care conferences and PRN with significant changes to ensure appropriate interventions are completed by the IDT. All residents who smoke have been reviewed to ensure safety and their care plan is current with appropriate interventions. Smoking audits to be done of residents who smoke on a weekly basis. To be completed by IDT. Re-education of appropriate staff, completed by the DON (Director of Nursing) and the LNHA. Weekly audits of Activities and the logs to be completed for the proper follow up. Completed by the Program Manager/Designee. Weekly audits of the smoking audits to be completed by DON/designee. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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F 282	Continued From page 13 apron on when they gave him a cigarette. On 6/28/17, at 1:03 p.m. the director of nursing (DON) stated residents who smoke were assessed quarterly for safe smoking. The DON stated a resident's care plan should address safe smoking interventions such as using a smoking apron, and who should apply the smoking apron if needed. On 6/28/17, at 1:33 p.m. R11 was observed on the patio wearing the smoking apron without a cigarette in his hand. R11 was seated in his wheelchair with his eyes closed, ashes were observed on the apron. R11's Physician Order's initiated 2/28/16 included, "Resident to wear smoking apron when up due to unsafe smoking." A Smoking Risk Observation document dated 5/30/17, categorized R11 as a potentially unsafe smoker. R21's care plan dated 6/13/17, indicated activities was a focus. The goal included: "The resident will participate in activities of choice for spiritual and sensory stimulation 1-2 times weekly by review date." Interventions included, "The resident's preferred activities are: Resident watches TV in her room. Bible Study, Birthday Party, Manicures, church." Another care plan focus for R21 indicated R21 had an alteration in skin integrity, and the plan indicated R21 could sit for 3 hours at a time with no adverse effects. On 6/26/17, at 2:50 p.m. R21 was observed laying in bed with eyes closed. A group activity of manicures was going on in the dining room at that	F 282		

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F 282	Continued From page 14	F 282		

time.

On 6/27/17, at 10:12 a.m. R21 was observed lying in bed. R21 was awake and able to make eye contact but unable to answer questions. No activities were observed going on in the resident's room.

On 6/27/17, at 2:03 p.m. R21 was observed in her room by herself. R21 was awake and sitting in her wheelchair slightly reclined with the lights on. No activities were observed going on in the resident's room.

During an interview on 6/27/17, at 2:07 p.m. nursing assistant (NA)-D stated she was not aware of any activity schedule for R21 and stated R21 slept a lot during the day.

During an interview on 6/28/17, at 8:27 NA-E confirmed R21 went back to bed after each meal. NA-E stated she has not seen R21 attend group or 1:1 activities. She further stated she was not aware of any activities nursing staff should be providing R21 in her room.

During an interview on 6/28/17, at 8:52 a.m. the admissions director (AD), who had recently transferred from the activities department, explained it was difficult for R21 to participate in group activities because she needed to lay down to prevent skin breakdown. The AD stated activity staff sometimes did hand massages or read to R21. The AD stated R21 did not watch much television. She further stated she thought the activities staff were doing 1:1 activities with R21 weekly.

On 6/28/17, at 10:02 a.m. two NAs were

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F 282	Continued From page 15 observed to take R21 from the dining room to her room, and put her into bed. A few minutes later, R21 was observed lying in bed awake with the lights off. Review of the group activity's log for the month of June indicated R21 was observed in a resident council meeting on 6/14/17. A review of 1:1 activities indicated R21 had a hand massage on 6/7/17 for 15 minutes. The June 2017 activity schedule indicated manicures had been available on 6/5, 6/8, 6/12, 6/19, 6/26, a birthday party on 6/28, and visits from the Missionaries of Charity on 6/11 and 6/25, there was no indication R21 had been invited/included in these.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with bathing for 1 of 3 dependent residents (R139) reviewed for activities of daily living (ADLs). Findings include: R139's admission Minimum Data Set (MDS), dated 6/8/17, indicated R139 was cognitively intact. The MDS indicated R139 required	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident R139 individualized care sheets reviewed and revised indicating resident specific bathing cares and ADL (Activities of Daily Living) cares as related to MDS (Minimum Data Set) significant change. R139 has no adverse outcome. Review of bathing preferences completed	8/2/17

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F 312	Continued From page 16 extensive assist of 1 with transferring, locomotion, dressing, toileting use, and personal hygiene. R139's care plan dated 6/16/17, indicated R139 required physical assistance of 1 staff with bathing and showering. During interview with R139 at 10:56 a.m. on 6/27/17, R139 stated she'd been admitted to the facility on 6/1/17 and had only received one shower since then. R139 denied being offered any other bathing opportunities. In addition, R139 indicated she was unaware of when her scheduled bath days were. On 6/27/17, at 7:12 a.m. nursing assistant (NA)-A stated R139 needed assist of 1 with all ADLs including bathing. NA-A explained resident's assigned bath days are identified on the NA group sheets, and stated R139's bath days are Sunday and Thursday mornings. At 7:27 a.m. on 6/27/17, NA-B stated R139 required extensive assist of 1 with all ADLs and stated all completed baths/showers were charted in the facility's electronic medical record, point of care. At 10:39 a.m. on 6/27/17, licensed practical nurse (LPN)-A verified R139 required assist of 1 with bathing and should have received two baths/showers per week. LPN-A stated the bath/shower days were set up based on room number. LPN-A further stated on bath days skin checks are completed and documented on the medication administration record (MAR) or treatment administration record (TAR). LPN-A confirmed R139 had no bathing or skin checks recorded on the MAR/TAR or in the progress notes.	F 312	for all residents by the Nursing, Activity Staff and or Designee. Bathing preferences identified on resident care plan. Completed by nurse manager or designee. Re-education of appropriate staff, completed by the DON or Designee. Nursing staff to identify bathing preferences on the assignment sheets. Nursing Managers to audit bath completion on a minimum of half the residents on the unit every week. DON to review audits. Review of resident bathing preferences quarterly at care conferences and PRN (As needed). Care plan interventions updated as needed. Completed by the IDT. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the NHA. All items to be completed by August 2, 2017.	

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F 312	Continued From page 17 At 12:09 p.m. Clinical Manager-A (CM-A) stated R139 is extensive assist of 1 for bathing and cannot go into the shower room alone. CM-A reviewed the documentation, and stated it appeared R139 had only had one shower since admission. CM-A confirmed there was no bathing documented on the MAR/TAR or progress notes. Review of the NAR group assignment sheets identified R139 to be assist of 1 with ADLs, and identified her bath days as Thursday and Sunday mornings. The point of care documentation was reviewed from 6/2 through 6/27/17. The documentation dated 6/24/17, inaccurately identified R139 as independent with bathing. All other documentation indicated the activity (bathing) did not occur. Although requested, policies related to ADLs or bathing were not provided.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility	F 323		8/2/17

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F 323	Continued From page 18 must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate supervision was provided to ensure safe smoking practice for 1 of 2 residents (R11) reviewed for smoking. Findings include: On 6/25/17, at 3:00 p.m. the North Cart on 2nd floor had a note on the top stating "[R11] do NOT give cigarettes unless smoke apron is on". R11 was observed on the first floor patio on 6/25/17, at 4:55 p.m. R11's smoking apron was hanging on the handle of his wheelchair. R11 was observed to light a cigarette and smoke it. On 6/25/17, at 5:50 p.m. R11 was again observed to be on first floor patio area smoking. At that time, the smoking apron was laying across R11's legs but did not cover his chest area. On 6/27/17, at 2:17 p.m. the clinical manager (CM)-A stated R11 was able to take his smoking apron off independently but had been told in the	F 323	F323 FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES R11□s smoking assessment has been reviewed and updated as appropriate. Completed by the Social Service Staff. R11 has not experienced any adverse outcome. All residents who smoke have been reviewed and assessed for safety and appropriateness of their interventions completed by the IDT. Re-education of appropriate staff, completed by the LNHA. Review smoking assessment and care plans quarterly at care conferences and PRN, completed by the IDT. Smoking audits to be done of residents who smoke on a weekly basis. To be completed by IDT. DON to review the completion of audits.	

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F 323	Continued From page 19 past he would not be allowed to smoke unless he wore the apron. On 6/28/17 at 7:50 a.m., R11 asked licensed practical nurse (LPN)-C for a cigarette. LPN-C was observed to take a cigarette out of a locked room and give it to R11. R11 placed the cigarette behind his ear and took the elevator downstairs. R11's smoking apron was observed hanging on the handle of wheelchair. At 7:59 a.m., R11 was wheeling himself back in from the outside patio. When questioned by the surveyor, R11 would not confirm whether he had just smoked, however the cigarette was no longer observed behind his ear. The smoking apron continued to be hanging on the handle of his wheelchair. At that time, R11 told the surveyor he was able to smoke independently. He further stated he "usually" wore his smoking apron but acknowledged it was not on him at that time. During the observation and interview with R11, no burn areas were observed on his skin or clothing. On 6/28/17 at 9:55 a.m., LPN-C stated staff were responsible for ensuring R11 put the smoking apron on when they gave him a cigarette. On 6/28/17, at 1:03 p.m. the director of nursing (DON) stated residents who smoke were assessed quarterly for safe smoking. The DON stated a resident's care plan should address safe smoking interventions such as using a smoking apron, and who should apply the smoking apron if needed. On 6/28/17, at 1:33 p.m. R11 was observed on the patio wearing the smoking apron without a cigarette in his hand. R11 was seated in his wheelchair with his eyes closed, ashes were	F 323	Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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F 323	Continued From page 20 observed on the apron. R11's Physician Order's initiated 2/28/16 included, "Resident to wear smoking apron when up due to unsafe smoking." A Smoking Risk Observation document dated 5/30/17, categorized R11 as a potentially unsafe smoker. R11's care plan listed a potential for alteration in skin integrity due to unsafe smoking and inability to control ashes as a focus problem area. Another care plan focus listed smoking as a problem area with interventions indicating R11 was to wear a smoking apron while smoking. However, the care plan did not identify how staff would supervise R11 to ensure he complied with using the smoking apron.	F 323		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food palatability by serving foods at appropriate and appetizing temperatures for 9 of 97 residents (R125, R67, R71, R33, R44, R7, R139, R77, and R135)	F 364	F364 All residents have the potential to be impacted. No adverse effects were to the residents identified as a result of the	8/2/17

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F 364	Continued From page 21 observed during meals. Findings include: Dining was observed on 6/25/17, starting at 6:27 p.m. on the Garden unit. All six residents independently seated themselves in the dining room. At 6:34 p.m. the steam table was brought in by the dietary aide (DA)-C. She stated the menu consisted of turkey burgers, corn, mandarin oranges and a dessert which would be coming later. DA-C stated an alternate meal was not available but they could always get a sandwich from the kitchen. R125 added, "Well, at least tonight it will be warm. Our food is always cold. They never bring the food cart down on time." At 6:48 p.m. on 6/25/17, R125 informed DA-C she was unable to eat the turkey burger she'd been served because it had cheese on it and she did not tolerate dairy. R125 also stated she was unable to eat the corn. At 6:51 p.m., DA-C returned with a new turkey burger but no alternate vegetable. R125 removed the top of the bun and again found cheese melted on the top of the turkey burger. R125 took her spoon, turned the burger over and began to scrape the cheese off. At that time, DA-C went to get the dietary director. R125 asked the dietary director if she could just get a chef salad. At 6:53 p.m. a chef salad was brought in for R125. At 6:53 p.m. on 6/25/17, R67 stated his food was always cold and of poor quality. He further stated he did not enjoy the food and did not eat much if he "could help it." R67 then opened a small container of ice cream which was observed to be melted. R67 went over to the garbage can, dumped the melted ice cream into it and stated,	F 364	observations identified in the MDH survey. Facility has reviewed food distribution procedures. Facility has implemented surveillance of food temperature logs. Facility has evaluated functionality and operation of steam tables and convection oven. Service contractor has been contacted to review the operation and thermal regulation of food production equipment. Dietary Service Policies and Procedures have been reviewed and revised by the Regional Dietary Manager to include: -Food Committee complaint follow up. -Food temperatures -Timeliness of food delivery meal times were evaluated and modified to reflect current delivery regime. -Correct meal service Staff education provided to kitchen employees and nursing staff, Completed by the Dietary Manager and the DON. Mealtime audits, minimum of 10, to be completed weekly on an ongoing basis. Audits to evaluate meal palpability and temperature. Completed by Dietary Manager and or Designee. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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"This is what we get for dessert." He shook his head and walked away.

At 6:54 p.m. on 6/25/17, when DA-C was requested to check the temperature of the food in the steam table, she took the thermometer in her hands and stated, "I don't know how to do it. Do I just stick it (thermometer) in the food?" DA-C then left to obtain instructions. Upon her return at 7:02 p.m., DA-C stated she'd been instructed by the administrator how to take the food temperatures. DA-C reiterated that she'd never done it, had never seen staff take food temperatures, nor had she been instructed on the procedure. When checked, the food temperatures registered as: whole kernel corn in juice 102 degrees Fahrenheit (F); turkey burger 100 degrees F. DA-C stated she was unsure what the appropriate temperatures should be for the corn and turkey burgers. The steam table was observed to be unplugged. When asked why the steam table was not plugged in DA-C stated, "we only plug it in when it is in the kitchen, not when we bring it in here (the dining area)."

At 7:10 p.m. on 6/25/17, the administrator came into the dining room and verified for the surveyor that dietary aides were expected to take food temperatures and document the temperatures in the log book. Regarding DA-C, the administrator stated, "Maybe she just froze."

On 6/26/17 at 2:51 p.m. R71 stated, "My food is always late and cold, It (the food) is always terrible and disgraceful. There is not always an alternate to eat. Because of my religion, I can't eat certain types of fish. They give it to me any way. When I tell them they do not get me an alternative meal." R71 went on to state he had to

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provide his meal ticket the day before in order to receive the alternate meal choice. R71 further stated he just doesn't eat if he can't get the alternate meal.

On 6/26/17, at 8:36 a.m. a breakfast test tray temperature was reviewed with LPN-B on unit 3. The tray contained biscuits and gravy, scalloped potatoes, and hot cereal. LPN-B tested the food by touching it with her finger. She stated the biscuits and gravy were slightly warm to touch but the scalloped potatoes were very cold. She further stated the food is often served cold and she had mentioned it to the dietary staff on different occasions but nothing had changed. LPN-B stated the food was delivered in a non-heated cart and verified the food temperatures were not routinely checked when removed from the cart to deliver to residents.

During an interview on 6/26/2017, at 8:55 a.m. R33 stated he had just finished eating breakfast and his biscuits and gravy and potatoes had been served cold this morning. R33 further stated breakfast, lunch, and dinner are routinely served cold. R33 stated he tried to order foods which he didn't matter whether they were cold or not. Additionally, R33 stated he only ordered cheeseburgers at lunch because he knew what he was getting, "even though they are almost always cold."
On 6/25/17, at 6:31 p.m. the evening meal was observed on floor 2 station 2. The server, dietary aide (DA)-A put food on 6 trays (turkey burger with cheese and a hamburger bun with a side of corn) and sat them uncovered on the top shelf of the steam table. A nursing assistant entered the dining room at 6:39 p.m. and began to serve. Prior to the first tray being served, a temperature

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F 364	Continued From page 24 of the turkey burger was requested. It temped at 82 degrees F, however, staff proceeded to serve the trays. The first resident served informed staff the food was cold and requested it to be reheated. R44, R7, R139, R77, and R135 also stated their food was cold. A test-tray turkey burger was then requested. The temperature of the burger pulled directly from the steam table was 84 degrees. The burger was cold, bland, and difficult to chew. During unit 3 dining observations on 6/28/17, at 8:10 a.m. the dietary supervisor (DS) was asked to check the temperature of the last tray in the food transport cart. The scrambled eggs were noted to be 90 F. The DS explained when food is brought to the unit resident's aren't always available to be served. On 6/28/17 at 8:49 a.m., R33 stated the eggs were cold. R33 stated the food was cold at meals "most of the time."	F 364		
F 465 SS=C	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		8/2/17

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F 465	Continued From page 25 (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide maintenance and cleaning services necessary to maintain safe, functional, and sanitary conditions throughout the facility including resident rooms and the kitchen area. This had the potential to affect all residents in the facility. Findings Include: On 6/25/17, at 3:27 p.m. R2 was observed sitting in a chair in his room. The room had a smell of urine and feces. A built-in dresser was missing one of six drawers. A yellow colored foam insulation was observed to be exposed on the top and right sides of the air conditioner (AC) mounted on the wall. R2 stated he'd told staff 3-4 months ago about the insulation around the air conditioner. R2 stated, "they either say they don't have parts or don't have time." On 6/26/17, at 8:06 a.m. R74 was in her room watching television (TV). A shelf from the wall was observed to be broken and laid next to the TV. Two fastening bolts remained in the wall. R74 stated, "It's been that way since I moved here over a year ago." On 6/26/17, at 8:57 a.m. R142's room was observed to have the closet doors held closed by a plastic bag tied around the handles. R142's AC	F 465	F465 SAFE / FUNCTIONAL / SANITARY / COMFORTABLE ENVIRONMENT. Residents, staff and the public have the potential to be effected if not provided a safe, functional, sanitary and comfortable environment.¿ No adverse effects noted for residents residing in the facility at the time of MDH observations. Resident R2 built in dresser has been repaired and AC unit properly installed.¿ R74 shelf removed and wall patched.¿ R142 closet door handles plastic removed and magnetics adjusted and AC unit properly installed.¿ R40 room wall scrapes and scratches repaired.¿R140 room walls scrapes repaired.¿R110 room wall repaired.¿ R134 room wire conduit secured to wall, R21 room AC unit properly installed.¿R66 discharged in his own personal chair, resident aware of how to secure repairs.¿R51 room privacy curtain replaced.¿ Ice machine fan was cleaned.¿ Food transport carts are cleaned.¿ Resident rooms inspected following survey identified issues have been logged with repairs in process.¿ Ongoing facility review continues with staff providing repairs as necessary.¿ All repairs completed by the Director of	

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	245203	A. BUILDING _____ B. WING _____	06/28/2017

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F 465	Continued From page 26 unit was also observed to have yellow colored foam insulation observed to be exposed on the entire right side of the air conditioner unit. On 6/26/17 at 9:06 a.m., R40's room was noted to have various scrapes and scratches on the walls and a large black linear mark covering two of four walls. During the full environmental tour at 9:01 a.m. on 6/27/17, the director of nursing (DON) and housekeeping director (HD) verified R2's dresser should have been repaired or replaced in a more timely fashion since it needed repair. On 6/27/17 at 3:22 p.m., during a follow up observation, R2's room continued to have a strong urine odor. The drawer from the built in dressor was still missing, and the mounted AC unit still had insulation coming out of the sides. R2 stated, "My room stinks. The whole place stinks...It all smells the same to me. I am surprised when they clean my room. It doesn't happen much." R2 stated staff had come into his room the other day trying to fix the AC and the drawer even though they hadn't attempted to fix the issues when he'd first reported them. On 6/27/17, from 9:01-10:00 a.m. a full environmental tour of the facility was conducted with the housekeeping director (HD) and the director of nursing (DON), during the tour the following observations were made: R139's shared bathroom had a toilet riser in place which was soiled with a brown matter along the backside of the riser. R140's room had an approximate 5 inch wide dark brown/black horizontal line midway up the	F 465	Maintenance. Kitchen sanitation schedule has been reviewed and revised.¿ Staff education provided and supervision of sanitation implemented. Completed by the Regional Dietary Manager. Staff to be educated on system to identify issues as needing repair. Staff education completed by the LNHA and the Regional Dietary Manager. Daily audits of resident care areas to be completed by housekeeping. Weekly audits of care areas to be conducted by nursing and maintenance. Identified areas to be logged into TELS system (electronic maintenance repair log). NHA to review TELS log for documentation and task completion with each days stand up meeting. Quarterly room checks to inspect all rooms and other furnishings for proper operation and repair as needed.¿ Weekly kitchen sanitation schedule audits to be completed to ensure ongoing compliance, to be completed by the Dietary Manager and or designee. NHA to make monthly facility rounds with maintenance director to ensure completion of TELS task are completed appropriately. NHA to make monthly facility rounds with housekeeping manager to ensure appropriate environmental sanitation. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing	

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F 465	Continued From page 27 wall and extending for the entire length on 2 of 4 walls. The walls also had several scrapes/gouges throughout. The DON verified the findings and stated R140's room needed to be cleaned and painted. R142's closet/built in armoire, continued to have the doors tied shut with a plastic bag tied around the handles, and the wall mounted AC had exposed yellow foam on the length of the right side. The DON verified the findings and stated, "there should be a bracket to close the armoire door." R110's room had two 1 x 1 inch holes vertical to each other on one wall. The resident stated they had been there since she moved in approximately a year ago and she'd really like it fixed. R134's room had a wire conduit hanging off the wall which was not secured. R21's room had a window air conditioning unit which was surrounded by plexiglass which was not secured. It left a 2 inch gap on the length of the left side of the window. An electric wheel chair with large open areas throughout the seat and the arm rests exposing the foam cushion/padding was observed in R66's room. The DON stated a new cushion should have been ordered. The wire conduit was not secured to the wall. The wall was split in the middle of the room from the floor to the middle of the wall which left one paneling approximately 3 inches further out than the other side of the wall. The window air conditioner unit was surrounded by plexiglass and not secured. It left a 4 inch gap exposure the length of the left side of the window.	F 465	compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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The built in wall dresser was missing 2 of 6 drawers. The remaining 4 drawers were observed to be soiled with dust, dirt, hair, empty bottles, and food crumbs. The bottom left drawer was pulled out which exposed an approximate 12 x 12 inch hole in the brick wall. The DON confirmed the findings.

A privacy curtain in the middle of R51's room was soiled with dark black areas throughout and along the entire edge from top to bottom. The HD confirmed this finding and stated the privacy curtain needed to be replaced.

Maintenance Director (MD)-A and the Regional Nurse were informed of the environmental findings on 6/27/17, at 2:00 p.m. MD-A stated he was the only employee in the maintenance department and prioritized work orders according to resident's safety, and further added that room inspections were completed quarterly. MD-A stated the air conditioning units should have a plastic covering around them, the scrapes/gouges in rooms were unacceptable, the wall conduits should be rewired and secured to the wall, and the tape around the window air conditioning units should be secured so there is no exposure to the outside air. The Regional Nurse stated rooms are checked for cleanliness when employees enter and she expected housekeeping to complete daily cleaning. The Regional Nurse also stated a pest control company came to facility at least monthly and as needed.

MD-A provided an email dated 6/27/17, which stated "any Villa employee and or family member should report an issue within a Villa facility and a work order needs to be filled out in a timely

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manner by a Villa Employee through point click care or point of care." MD-A stated maintenance had no other policies or procedures.

A Housekeeping In-Service form titled "5- Step Daily Patient Room Cleaning" dated 1/1/2000, stated patient's rooms should be cleaned daily which included: collecting trash, disinfecting table tops, head boards, window sills, chairs, walls should be spot cleaned, and to dust.

A Housekeeping In-Service form titled "7-Step Daily Washroom Cleaning" dated 1/1/2000, directed staff to clean the bathroom which included: trash, dust mop the floor, clean and sanitize the sink and commode, spot clean walls, and dust mop the floor.

During an initial tour of the kitchen, conducted with the dietary supervisor (DS) and regional consultant (RC) on 6/25/17, at 11:40 a.m. A dark buildup of stained food debris was noted on the side of the oven, front oven doors and around the oven corners. The DS confirmed these findings. Across the kitchen, on the wall by the hallway, a fan with heavy dark dust accumulation was observed. The fan was attached to the wall above the ice-machine. The DS verified and stated, "It is dirty and filthy." The RC stated, "I see accumulation of dust on the fan."

A food transport cart was observed on Unit 3 on 6/28/17, at 8:30 a.m. The cart was observed to be stained with a dark, thick layer of food debris on the inside of the cart- top, bottom, and sides of the cart's interior. The DS verified and stated, "The whole cart is absolutely dirty, I think it is food, milk, and juice spilled which was not cleaned properly. It is likely from years of neglect,

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F 465	Continued From page 30 there must be a cleaning plan for the food transport cart, that is a must. This is our only food transport cart." The area manager (AM) was interviewed on 6/28/17, at 2:30 p.m.. The AM stated, "I asked [dietary staff] if the delivery [food transport] cart was on the cleaning list, then I checked and it was. The AM verified the buildup of food residue along the base and edges of the cart, and stated, "We have a staff member scraping and cleaning it right now." An undated Facility policy titled Policy Interpretation and Implementation included: "all kitchens, Kitchen area and dining areas shall be kept clean, free from litter and rubbish... All utensils, counters, shelves and equipment shall be kept clean".	F 465		
F 469 SS=C	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an effective pest control system was in place to prevent drain flies from infesting the kitchen and dish area. This had the potential to affect any of the 97 residents who received their meals from the kitchen. Findings include: An initial tour of the kitchen was conducted with the dietary supervisor (DS) on 6/25/17, at 11:40	F 469	F469 No residents were identified to sustain adverse consequences as a result of the observations identified in the MDH survey. Drains have been cleaned and treated by a professional cleaning service. Pest control services have been scheduled. Staff education has been completed, by the LNHA.	8/2/17

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F 469	Continued From page 31 a.m. During a subsequent visit to the kitchen area at 5:34 p.m. that evening, drain flies were observed on the kitchen ceiling moving from the dish washing area to the main kitchen area. On 6/27/17 at 2:58 p.m., dietary aide (DA)-B stated, "Those are fruit flies on the ceiling, we are aware of it. The pest control guy has come in and sprayed once." At that time the DS stated, "Yes, I've been aware of it for about 10 days. It does concern me. Mostly they're contained in the dish room, but they are all over the kitchen." An undated facility policy, Policy Interpretation and Implementation included: "Kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects."	F 469	Random audits to be completed weekly on an ongoing basis, to be completed by the Director of Maintenance and or Designee. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 27, 2017. At the time of this survey, The Villa at Bryn Mawr was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2017

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

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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Villa at Bryn Mawr is a 4-story building with a partial basement. The building was constructed at 2 different times. The original 4 story building was constructed in 1967 and was determined to be of Type II(222) construction. In 1969, a 3 story addition was constructed to the West that was determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The facility has a capacity of 120 beds and had a census of 101 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=E	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain self-closing doors in exit passageways, stairway enclosures, horizontal exits, smoke barriers, or hazardous areas. 19.2.2.2.7, 19.2.2.2.8. This deficient practice could affect all residents in the smoke compartment. Findings include: On a facility tour between the hours of 0900 and 1500 on June 27, 2017, observation revealed that there were several storage rooms in the basement, that were over 100 square feet containing combustible storage, and did not have self-closing devices installed.	K 223	K223 No residents were identified to have adverse consequences as a result of the observations identified in the MDH survey. Storage rooms in the basement that were over 100 square feet have self-closing devices installed, completed by the Director of Maintenance on July 19, 2017. Re-educate appropriate staff, Completed by the LNHA. Random audits to be conducted to ensure safe environmental conditions exist, Completed by the Director of Maintenance. Audits to be referred to QAPI for review of	8/2/17

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K 223	Continued From page 3 This deficient practice was verified by a Maintenance Director at the time of discovery.	K 223	trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	
K 311 SS=D	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain adequate protection of vertical openings to include stairways, elevator shafts, light and ventilation shafts, and chutes between floors. 19.3.1.1 through 19.3.1.6. This deficient practice could affect all residents in this room. Findings include: On a facility tour between the hours of 0900 and 1500 on June 27, 2017, observation revealed that Room 2-XX had a wall opening exposing the top of the linen chute that was constructed out of plywood. The opening was also covered by a none fire rated sheet of plywood. This deficient practice was verified by the	K 311	K311 No residents were identified to have adverse consequences as a result of the observations identified in the MDH survey. Opening has been covered by a fire rated covering. Completed by the Director of Maintenance on July 21, 2017. Re-educate appropriate staff. Completed by the LNHA. Random audits to be conducted to ensure safe environmental conditions exist. Completed by the LNHA, Director of Maintenance, and the Director of HSKG. Audits to be referred to QAPI for review of trends to make recommendations as	8/2/17

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K 311	Continued From page 4 Maintenance Director at the time of discovery.	K 311	necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	
K 353 SS=C	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 101 residents. Findings include: On a facility tour between the hours of 0900 and 1500 on June 27, 2017, observation revealed that the facility did not have the required amount of	K 353	K353 No residents were identified to have adverse consequences as a result of the observations identified in the MDH survey. Facility has the required amount of back up fire sprinkler heads stored at the facility, completed by the Director of Maintenance July 20, 2017. Re-educate appropriate staff. Completed	8/2/17

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 5 on-hand back-up fire sprinkler heads. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 353	by the LNHA. Random audits to be conducted to ensure safe environmental conditions exist. To be completed by the Director of Maintenance. Audits to be referred to QAPI for review of trends to make recommendations as necessary and to ensure ongoing compliance. Overseen by the LNHA. All items to be completed by August 2, 2017.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all residents in Stations 1 and 2. Findings include: On a facility tour between the hours of 0900 and 1500 on June 27, 2017, observation revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the	K 521	Please see attached K521 Waiver	8/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2017**

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K 521	Continued From page 6 corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficiency only affects Stations 1 and 2. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521		