DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 7, 2020

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

RE: CCN: 245203
Cycle Start Date: June 10, 2020

Dear Administrator:

On August 6, 2020, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
July 7, 2020

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

RE: CCN: 245203
Cycle Start Date: June 10, 2020

Dear Administrator:

On June 10, 2020, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Sarah Grebenc, 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: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 10, 2020 (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).

In addition, if substantial compliance with the regulations is not verified by December 10, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	C 06/10/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 6/9/20 - 6/10/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/9/20 -6/10/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be substantiated: H5203123C with deficiencies cited F580, F610 H5203124C with deficiencies cited F880 H5203126C with deficiencies cited F880 H5203127C with deficiencies cited F558, F689, F690 The following complaint was found to be not-substantiated: H5203125C Additionally, A COVID-19 Focused Infection Control survey was conducted 6/9/20 - 6/10/20, at your facility by the Minnesota Department of	F 000		

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

Electronically Signed | 07/17/2020

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F 000	Continued From page 1 Health to determine compliance with §483.80 Infection Control. The facility was determined not to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a call light was within reach for 2 of 4 residents (R21, R20) reviewed for accidents. Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/30/20, indicated R21 was severely cognitively impaired. R21's quarterly MDS dated 4/21/20,	F 558	Corrective Action: R21's call light was placed in reach of resident on 6.9.2020 and resident was provided with a soft touch call light on 7/8/2020. R21's fall care plan was updated to include call light within reach R20 has discharged from the facility, no further action can be taken Identification of Other Residents:	7/31/20

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F 558	Continued From page 2 indicated R21, had severely impaired vision, required assistance of one to two staff members for bed mobility, and transfers and had fallen in the previous quarter. R21's medical diagnosis printed 6/10/20, included diagnosis of COVID 19, dementia, muscle weakness and unsteady gait. R21's care plan printed 6/10/20, indicated R21 was at risk for falls but did not address the use of call light to prevent falls. R21 was observed on 6/9/20, at 10:27 a.m. lying in bed with the head of the bed raised, R21 laid in bed with feet all the way to the footboard of the bed and knees bent up toward the ceiling. The bed was in low position and left side of the bed was up against the wall. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light. NA-G fastened R21's call light to pillow above head. The call light fell part way to the floor, NA-G put the call light in R21's hand and told R21 it was his call light. NA-G explained staff were to put the the call light in R21's hand and tell him where it was because he could not see. NA-G verified R21 was able to use the call light if it was available. R20's admission MDS dated 5/22/20, indicated R20 was cognitively intact, required assistance of two staff members for bed mobility, and transfers and on staff member to walk in room. R20's MDS also indicated he had not fallen prior to admission but had fallen once since admission with no injury. R20's medical diagnosis printed 6/10/20, included diagnosis of heart failure impulsivity and traumatic brain injury. R20's care plan printed	F 558	Nursing staff will be educated on having call lights within reach for residents. 10% of residents will be monitored for call light placement weekly Monitoring Mechanisms: 10% of residents will be monitored for call light placement weekly Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 558	Continued From page 3	F 558		

6/10/20, indicated R20 had a self care deficit and instructed staff to encourage resident to use the call light for assistance.

R20 was observed on 6/9/20, at 2:19 p.m. lying in bed with his eyes open. The head of the bed was elevated and R20's call light laid on top of the portable stereo on R20's nightstand. The night stand was against the wall and to the right of the head of the bed. When asked what brought him to the facility R20 stated he fell before and since admission. R20 stated when he put on the call light staff would come at their convenience. R20 stated he had fallen because he could not wait for staff to answer his call light. R20 attempted to reach his call light but was unable. R20 asked for his call light.

On 6/9/20, at 2:25 p.m., NA-E entered room and gave R20 his call light and asked if there was anything else she could do for him. NA-E verified call light had been out of R20's reach. NA-E verified R20 was able to use the call light and would use it if he had it. NA-E stated they must have forgotten to give it back to him when they helped him repositioned. NA-E verified there were no signs on the wall to remind R20 to use the call light. NA-E stated sometimes the lights get busy but we answer them as fast as we can.

During interview on 6/10/20, on 10:52 a.m. the director of nurses (DON) stated call lights should be in reach for all residents, unless it was specifically care planned that the resident should not have a call light because of safety issues or they were unable to use it.

Call light policy was requested but not received.

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F 580	Continued From page 4	F 580		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and	F 580		7/31/20

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F 580	Continued From page 5 phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to timely notify a family member/responsible party of resident to resident sexual abuse for 1 of 3 residents (R2) reviewed for abuse. Findings include: According to Nursing Home Incident Reporting documents, a report was submitted to the state agency (SA) on 5/29/20, which indicated R2 had touched another resident inappropriately while in the elevator. R2 was placed on 1:1. R2's quarterly Minimum Data Set (MDS) dated 6/1/20, indicated moderately impaired cognition. R2 had verbal and physical behavioral symptoms directed toward others 1-3 days. R2 had other behavioral symptoms not directed toward others 1-3 days. R2 had not rejected cares. R2 had wandered 1-3 days. R2 required supervision with transfers and was independent with walking in corridor and on and off the unit. R2 used a walker. R2's diagnoses included non-Alzheimer's dementia and diabetes.	F 580	Corrective Action: R2's guardian was updated on allegation of abuse on 6/5/2020 Nursing and SS staff will be educated on informing both residents responsible party of an allegation of abuse as soon as possible by date certain Identification of other Residents: Review was completed on all OHFC within the last 30 days to ensure facility is in compliance with notifying resident responsible party Monitoring Mechanism: NHA/DON/Designee will audit all OHFC reports for timely notification of resident responsibly party Audit results will be reviewed at	

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F 580	Continued From page 6	F 580		

R2's care plan dated 11/19/18, identified R2 had a behavior problem related to history of reaching out to others and grabbing at them, inappropriate grabbing and touching toward staff and residents. Screaming and yelling when reeducated. R2's care plan directed staff to psychology consult, explain to R2 this is not acceptable behavior, remove from others if applicable, explain risk vs benefit, animal crackers are at the nursing station used for deescalating. R2's care plan dated 12/3/18, indicated R2 had areas of vulnerability related to behaviors, agitation, communication, dementia, irritating to others. The care plan directed staff to notify administrator, director of nursing (DON) and social worker of an adverse event and to observe and provide a safe environment. The care plan lacked instruction to notify R2's guardian.

A review of R2's medical record progress notes indicated the guardian was notified of the incident that was reported to the State Agency on 5/29/20, on 6/5/20, seven days after the incident occurred.

During a telephone interview on 6/10/20, at 9:26 a.m. with family member/guardian (FM)-A, FM-A stated the facility called and had stated R2 grabbed another resident (R1). FM-A did not know what date had been notified nor what date the incident occurred. FM-A stated had been notified R2 had done that in the past and that R2 would grab people when they needed something.

During interview on 6/10/20, at 10:16 a.m. social services (SS)-B stated had not worked the day the incident occurred. SS-B stated it would be the expectation for the staff working that day to notify family. SS-B stated "I spoke to the family as soon

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F 580	Continued From page 7 as I was notified." SS-B noted in a progress note on 6/5/20 of notification to family, which was six days after the incident occurred. During interview on 6/10/20, at 11:37 a.m. the director of nursing (DON) stated as part of the investigation the family would be updated right away and documentation should be in a progress note or interdisciplinary note in the medical record. During interview on 6/10/20, at 12:00 p.m. the facility administrator stated it would be the expectation to update the family following an incident as soon as possible but within 5 days. The facility policy titled Notification of Changes Guideline, dated 11/28/17, directed staff to notify the resident representative for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. Document the notification in the resident's medical record. The nurse would immediately notify the resident's representative of an accident with injury, significant change, need to alter treatment significantly or decision to transfer or discharge.	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		7/31/20

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F 610	Continued From page 8 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a thorough investigation for resident to resident sexual abuse when 1 of 1 residents (R1) was touched inappropriately by another resident (R2). Findings include: R1's investigative file dated 5/29/20, indicated R1 reported R2 touched R1 inappropriately while in the elevator. R1's statement record dated 5/29/20, indicated "I was waiting for the elevator to come when I felt someone touch my back. I looked back when [R2] brushed hand down. I got on the elevator and [R2] got on with me. We were the only two on the elevator. [R2] was standing in front of me then reached down and grabbed my crotch. I told [R2] if you ever do that again I will kick you in the balls. I then got off the elevator, so did [R2]. I went to have a cigarette then I told staff. I was raped before, years ago and I am not going through that again." The facility investigative file lacked evidence that R2 was interviewed or that staff had been interviewed. R1's quarterly MDS dated 5/4/20, indicated intact cognition. R1 had no behavioral symptoms. R1	F 610	Corrective Action: R2's care plan was updated to include interventions related to resident to resident on 5/29/2020. R2 was seen by psychology on 6/19/2020 Abuse investigations will include interviews from staff and other residents NHA, DON, and Social service were educated by regional nurse to investigate allegations of abuse fully Identification of other Residents: Nursing and Social service was educated on documenting allegation of abuse in residents' chart and putting immediate interventions to protect the resident NHA reviewed past 3 months of OHFC to ensure responsible party was notified and resident(s) were satisfied with intervention All residents are at risk for abuse Monitoring Mechanism: NHA/DON/Designee will audit all OHFC reports for interviews from staff, residents and updated care plans. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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was independent with activities of daily living (ADLs). R1's diagnoses included diabetes and musculoskeletal fracture.

R1's undated care plan, indicated R1 was vulnerable related to mental illness. R1's care plan directed staff to notify administrator, DON and social worker of an adverse event and to observe and provide a safe environment. R1's care plan lacked documentation and/or interventions related to the resident to resident sexual abuse on 5/29/20. R1's care plan lacked documentation to keep R2 separate from R1.

R2's quarterly Minimum Data Set (MDS) dated 6/1/20, indicated moderately impaired cognition. R2 had verbal and physical behavioral symptoms directed toward others 1-3 days. R2 had other behavioral symptoms not directed toward others 1-3 days. R2 had not rejected cares. R2 had wandered 1-3 days. R2 required supervision with transfers and was independent with walking in corridor and on and off the unit. R2 used a walker. R2' diagnoses included non-Alzheimer's dementia and diabetes.

R2's care plan dated 11/19/18, identified R2 had a behavior problem related to history of reaching out to others and grabbing at them, inappropriate grabbing and touching toward staff and residents. Screaming and yelling when reeducated. R2's care plan directed staff to psychology consult, explain to R2 this is not acceptable behavior, remove from others if applicable, explain risk vs benefit, animal crackers are at the nursing station used for deescalating. R2's care plan dated 12/3/18, indicated R2 had areas of vulnerability related to behaviors, agitation, communication, dementia, irritating to others. The care plan

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directed staff to notify administrator, director of nursing (DON) and social worker of an adverse event and to observe and provide a safe environment. R2's care plan lacked documentation and/or interventions related to the resident to resident sexual abuse on 5/29/20. R2's care plan lacked documentation to keep R2 separate from R1.

R1's medical record progress notes (PN) was reviewed on 6/9/20. The PN lacked documentation of the resident to resident sexual abuse from 5/29/20. On 6/10/20, the following "late entry note" was noted: 5/29/20, at 3:57 p.m. Resident reported R2 touched R1 inappropriately in the elevator. R1 reported incident to social services and nursing home administrator.

R2's medical record PN lacked documentation of the resident to resident sexual abuse on 5/29/20.

During interview 6/9/20, at 9:44 a.m. R1 sated R2 had "swiped my bare skin over my shoulders and back before I got in the elevator. Then [R2] grabbed my crotch when I got in the elevator." R1 then stated to R2 "I don't know you, if you f-ing ever touch me again your balls are gone!" R1 stated "I know [R2] has Alzheimer's but I don't care. Nobody should touch anybody like that period. If [R2] comes near me again, [R2] will get it in the f-ing crotch and I will call the police. There is nothing the facility has or can do to keep me safe. I go out to smoke and that is it. I stay shut in my room with the door closed. They (administration staff) told me [R2] has done that to other people. Well, I don't care. My feelings are if [R2] has done it to other people before then they (administrative staff) need to f-ing do something about it."

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Interview was attempted with R2 on 6/9/20, at 1:56 p.m. R2 was unable to comment. R2 walked past surveyor out of his room to the nurse station. R2 slammed his hands on the nurse's station desk and asked nursing staff for a cigarette.

During interview on 6/9/20, at 2:16 p.m. licensed practical nurse (LPN)-B stated R2 would hit staff and residents and would touch "anyone" inappropriately. LPN-B stated this had not happened recently. LPN-B stated there was an "issue" with a female resident "about a week ago." LPN-B stated was not aware if staff were to do anything specific with those residents. LPN-B reviewed the kardex and orders and was unable to find an information related to that event or ongoing monitoring.

During interview on 6/10/20 at 8:38 a.m. trained medication aide (TMA)-A stated had worked with R2 in the past and today. TMA-A stated R2 will daily bang on the desk "when [R2] wants something [R2] will scream." TMA-A stated was not aware if R2 had issues with other residents or if there were any residents R2 needed to be kept away from.

During interview on 6/10/20 at 8:43 a.m. licensed practical nurse (LPN)-C stated had worked with R2 in the past. LPN-C was not aware of any residents R2 would need to be kept away from. LPN-C stated R2 had behavior history of reaching out and grabbing staff and residents. Staff are to intervene by "redirecting him, give him space and keep him away from what is annoying him."

During interview on 6/10/20, at 8:57 a.m. nursing

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assistant (NA)-C stated had worked with R2 in the past and today. NA-C stated R2 is not supposed to be around female residents. R2 was not aware of any recent events with female residents.

During interview on 6/10/20, at 10:16 a.m. social services director (SS)-C stated R1 had come to SS-C to report the event and SS-C had written R1's statement record. When asked who else had been interviewed, SS-C stated R2 had been interviewed and the interview should be in the investigative report. SS-C reviewed the investigative report and found R2's interview was not included. SS-C stated staff were not interviewed because there were no staff witnesses. SS-C stated other residents were interviewed and their interviews were observed in the investigative file. SS-C stated when SS-C started employment six months ago was advised not to chart incidents or follow up in the medical record. As a result, the medical record lacked information regarding the event with R1 and R2 on 5/29/20. SS-C stated the nurse manager should have updated the care plan. SS-C added was unsure if the nurse manager had been in that role on 5/29/20. SS-C stated the administrator would then be the person to follow up with the residents after an event. SS-C stated R2 was seen by Associated Clinic of Psychology (ACP) on 6/8/20 but could not recall if there were new recommendations.

During interview on 6/10/20, at 11:37 a.m. the director of nursing (DON) stated was aware of the incident with R1 and R1 on 5/20/20, but had not been DON at that time. DON stated the expectation would be for "increased monitoring, keep R1 and R2 away from each other, provide

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education and update family and physician." It was the expectation that documentation should be in progress notes or interdisciplinary team (IDT) notes. DON reviewed the medical records and stated there were neither IDT notes, nor orders for increased monitoring nor updates to the care plan for R1 and R2 involving the 5/29/20 incident.

During interview on 6/10/20, at 12:00 p.m. the facility administrator stated R2 was on 1:1 and then 15 minute checks after the incident on 5/29/20. Additionally, administrator had updated the nurse working at the time. Administrator stated was not aware if the nurse implemented the ongoing 1:1 or 15 minute checks as there was no documentation. Administrator stated this would be documented on a 15 minute checks sheet. A copy of the 15 minute check sheet was requested and not provided. Further, the administrator stated was unaware if anyone had followed up with R1 between 5/29/20 and 6/3/20 until R1 was seen by ACP on 6/3/20. Administrator stated SS-C had followed up at some point but was unable to locate documentation.

The facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/28/17, indicated sexual abuse was "non-consensual sexual contact of any type with a resident." Additionally, residents will be protected from abuse while they are residing at the facility. Residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties. The facility leadership will assess the needs of the residents to be able to identify concerns in order to prevent

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F 610	Continued From page 14 potential abuse. The IDT will identify the vulnerabilities and interventions on the resident care plan. The facility policy titled Event Management Process, undated, directed staff to immediately act and document actions taken to eliminate any potential for a continued occurrence. Further, to communicate and amend plans of care and assignment sheets as necessary.	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow care planned interventions to reduce the risk for falls for 2 of 4 residents (R21, R20) reviewed for accidents. Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/30/20, indicated R21 was severely cognitively impaired. R21's quarterly MDS dated 4/21/20, indicated R21, had severely impaired vision, required assistance of one to two staff members for bed mobility, and transfers and had fallen in the previous quarter. R21's medical diagnosis printed 6/10/20, included diagnosis of COVID 19,	F 689	Corrective Action: R21's call light was placed in reach of resident on 6.9.2020 R21's floor mat was placed on the on the floor next to bed on 6.9.2020 R21's fall care plan was updated to include call light within reach R20's call light was placed in reach on 6.9.2020 R20's floor mat was placed on the floor next to bed on 6.9.2020 R20 discharged from the facility no further action can be taken Identification of other Residents: Residents who are at risk for falls were	7/31/20

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F 689	Continued From page 15 dementia, muscle weakness and unsteady gait. R21's care plan printed 6/10/20, indicated R21 had an actual fall with no injury. Interventions included Hi-lo bed, concave mattress and mat on the floor. Care plan did not address the use of a call light. R21 was observed on 6/9/20, at 10:27 a.m. in bed with the head of the bed raised, R21 laid with feet all the way to the foot of the bed and touched the footboard and knees bent up toward the ceiling. R21 had an air mattress on his bed. The bed was in low position and left side of the bed was up against the wall. A blue fall mat leaned against the wall in room, there was not a fall mat on the floor beside the bed. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light. NA-G fastened R21's call light to pillow above head. The call light fell part way to the floor, NA-G put the call light in R21's hand and told R21 it was his call light. NA-G explained staff were to put the call light in R21's hand and tell him where it was because he could not see. NA-G verified R21 was able to use the call light if it was available. NA-G verified fall mat should be on the floor by bed, but did not place it there prior to leaving the room. R20's admission MDS dated 5/22/20, indicated R20 was cognitively intact, required assistance of two staff members for bed mobility, and transfers and on staff member to walk in room. R20's MDS also indicated he had not fallen prior to admission but had fallen once since admission with no injury. R20's medical diagnosis printed 6/10/20,	F 689	reviewed by IDT and resident care plans were updated with appropriate interventions Nursing staff was education on following residents care plans and fall interventions Monitoring Mechanism: NHA/DON/Designee will complete weekly audits of 10% of residents who are at risk for falls and ensure care plan interventions are in place Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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included diagnosis of heart failure impulsivity and traumatic brain injury.

R20's care plan printed 6/10/20, indicated R20 had a self care deficit and instructed staff to encourage resident to use the call light for assistance.

R20's unlabeled nursing assistant care sheet printed 6/10/20, listed safety interventions that included encourage resident to allow staff to assist with ambulation, encourage resident to use call light for assist with transfers and ambulation, and place fall mat next to bed when in bed.

R20's Report of Resident Fall event date 5/21/20, at 3:31 p.m., indicated R20 was found on the floor in the dining room. R20 indicated he lowered himself to the floor. Report indicated R20 ambulated to the dining room at the time of the fall. Preventive measures were: encourage use of call light, keep call light within reach. Causative factor was identified as R20 did not ask for help. Report did not identify why R20 needed to lower himself to the floor.

R20's Report of Resident Fall event date 6/8/20, at 1:00 a.m., indicated R20 called for help at 2:00 a.m. Staff arrived and found R20 on the floor. The report indicated R20 had a deep laceration on his right right eyebrow, and that R20 was sent to Hennepin County Medical center for stitches. Report indicated R20 had been dozing while sitting in a chair and had refused three times to go to bed when offered. Preventive measures included call light kept within reach, night light, and bed in low position. Report indicated interventions that were in place at time of the fall were wheelchair. Possible causative factor listed

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on Report of Resident Fall was refusing to go to bed and sleeping while sitting down in a chair. New intervention listed on fall report was "placing a call don't fall sign in resident's room. Staff will Remind resident to use call light for assistance."

R20 was observed on 6/9/20, at 2:19 p.m. lying in bed with his eyes open. The head of the bed was elevated and R20's call light was lying on top of the portable stereo on R20's nightstand. The night stand was against the wall and to the right of the head of the bed. The left side of bed up was against the wall with a folded blue mat between the foot of the bed and the wall. When asked what brought him to the facility R20 stated he had fallen and could not get up. He stated he had hurt himself. R20 verified he fell before and since admission. R20 stated his balance was not right and that it worried him that he kept falling. R20 stated he had trouble when he walked and had hurt himself when he fell the other night. R20 stated he was sitting up in his chair because sometimes that was the only way to sleep when it is hard to breath. R20 stated he did not have his call light while he was up in his chair. R20 stated when he put on the call light staff would come at their convenience. R20 stated he had fallen because he could not wait for staff to answer his call light. R20 asked for his call light. Notified staff of R20's request.

On 6/9/20, at 2:25 p.m. NA-E entered room and gave R20 his call light and asked if there was anything else she could do for him. NA-E verified call light had been out of R20's reach. NA-E verified R20 was able to use the call light and would use it if he had it. NA-E stated they must have forgotten to give it back to him when they helped him repositioned. NA-E verified fall mat

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was against the wall,and was to be on the floor when R 20 was in bed, but did not put it on the floor. NA-E verified there were no signs on the wall to remind R20 to use the call light. NA-E stated sometimes the lights get busy but we answer them as fast as we can.

On 6/10/20, at 8:12 a.m. R20 was lying in bed awake. His call light was in reach. Oxygen tubing was on his forehead not in his nose. Blue floor mat up against the wall between the bed and the wall. There was no sign on walls of the room to use call light. There was a strong odor of urine in room. Resident lying in bed stated he was okay.

On 6/10/20, at 9:16 a.m. licensed Practical nurse (LPN)-G entered R20's. LPN G carried medications and a glass of water. LPN- G asked R20 about his oxygen tubing which was still on his forehead. R20 stated he had removed it about half an hour ago. LPN-G put the oxygen tubing into R20's nose and told him they were waiting on hospice nurse to arrive. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, putting her hands under his shoulders and legs. R20 said "I was just sitting up." (R20 was in the same position since 8:12 a.m.).
-At 9:23 a.m. LPN-G left R20's room with the head of bed up, bed not in low position, The level was slightly higher than knee height.
-At 9:36 a.m. LPN-G returned to the room with two glasses of water and a pill cup. R20's feet hung off edge of bed and his feet did not touch the floor. The bed not in low position. R20's hips were twisted. LPN-G did not reposition R20's legs or lower the bed height. Floor mat was not in place.

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F 689	Continued From page 19 During interview on 6/10/20 at 10:52 a.m. the DON stated R20's floor mat should have been on the floor, and the bed should have been in low position except when staff worked with him. The DON stated care plans should be followed for all residents. The DON stated fall interventions should be in place and call lights should be in place. The DON stated interventions should be updated to the care plan, but if they are in the chart they should be followed. Facility Fall Evaluation Guidelines dated 11/28/17 indicated the purpose was to consistently identify and evaluate residents at risks for falls and those who have fallen to prevent or reduce injuries for falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		7/31/20

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F 690	Continued From page 20 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide incontinence cares to a dependent resident for 1 of 3 residents (R20) reviewed for urinary incontinence. Findings include: R20's admission Minimum Data Set (MDS) dated 5/22/20, indicated R20 was cognitively intact, required assistance of two staff members for toileting and personal hygiene. R20's MDS indicated he was frequently incontinent of bowel and bladder. R20's medical diagnosis printed 6/10/20, included diagnosis of heart failure impulsivity and traumatic brain injury. R20's care plan printed 6/10/20, indicated R20 had bladder incontinence and instructed staff to clean peri-area with each incontinence episode, but lacked time frame for offering assistance. R20's unlabeled nursing assistant care sheet	F 690	Corrective Action: R20 was proved incontinence cares, fresh linen and repositioned on 6.10.2020 R20 care plan was reviewed for toileting needs and interventions on 06.10.20 R20 has discharged from facility, no further action can be taken Nursing was educated on frequency of providing peri-cares to residents Identification of other Residents: Residents who are incontinent of bowel/bladder were reviewed by IDT and resident care plans were updated. Monitoring Mechanism: DON/Designee will completely weekly audits on ID residents on incontinent care. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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printed 6/10/20, did not address urinary incontinence or interventions to reduce episodes.

Continuous observation on 6/10/20, from 8:12 a.m.-9:45 a.m.
-At 8:12 a.m. R20 was lying in bed awake. His call light was in reach. Oxygen tubing was on his forehead not in his nose. Blue floor mat up against the wall between the bed and the wall. There was no sign on walls of the room to use call light. There was a strong odor of urine in room. Resident lying in bed stated he was ok.
-At 8:44 a.m. R20's door remained shut. Surveyor knocked and with permission entered room. The oxygen tubing was still on the top of R20's head, mask still under his chin. R20 stated sometimes he liked it like that.
-At 9:16 a.m. licensed practical nurse (LPN)-G entered R20's room wore a face mask, face shield and gloves. LPN G carried medications and a glass of water. LPN-G set medication on table and took R20's vital signs blood pressure. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, put her hands under his shoulders and legs. R20 said "I was just sitting up." (R20 was in the same position since 8:12 a.m.).There was a strong odor of urine in room.
-At 9:23 a.m. LPN-G left R20's room.
-At 9:36 a.m. LPN-G returned to the room with two glasses of water and a pill cup. LPN-G gave the medication to R20.
-At 9:48 a.m. the director of nurses(DON) entered R20's room. The DON lowered bed as she stated the bed needs to be lower when no one is in the room. The DON attempted to assist R20 to sit up on edge of bed.
-At 9:49 a.m. LPN-D entered R20's room to help the DON sit up R20. LPN-D asked R20 if he

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wanted to sit in his wheel chair. R20 said he did not want to sit up. LPN-D left to get supplies. Floor mat not on the floor, call light in place. Strong odor of urine in room.
-At 9:54 a.m. breakfast tray arrived. Scrambled eggs, apple juice toast hot cereal put on over bed table out of reach of resident
-At 9:56 a.m. LPN-G entered R20's room.
- At 9:57 a.m. LPN-D returned to the room. LPN-D and the DON attempted to transfer R20 with a gait belt. R20 was not able to stand all the way up, so he could move up in bed. The DON said to R20, "you need to be changed. I will get someone in to help change you." R20 stated he wanted to eat. LPN-D said trained medication aide (TMA)-A is going to come and get him cleaned up. The DON left the room. LPN-D put jelly on R20's toast. LPN-D left the room. R20 sat on edge of bed ate breakfast and bent forward at waist so head was at height of bedside table.
-At 10:02 a.m. NA-H entered the room.
-At 10:04 a.m. NA-H was in room R20 was eating breakfast. R20 stated he was done. NA-H helped R20 to lie back in bed. NA-H prepared to give R20 a bed bath. NA-H removed two incontinence pads. R20 refused to allow NA-H to wash peri area, but did allowed legs to be washed. R20 did not want to open legs. R20 refused to roll on side.
-At 10:25 a.m. NA-H pushed call light for help to roll resident. NA-H stated R20 wore two incontinence briefs, one over the other. NA-H stated both pads were very wet. NA-H stated the bed was soaking wet.
-At 10:27 a.m. LPN-D entered R20's room and left to get gloves. LPN-D returned put on gloves on and put anti slip socks on R20's feet. LPN-D assisted R20 to turn toward the wall. Transfer sheet was yellow with urine mid way up R20's back. R20's bottom was pink and intact.

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F 690	Continued From page 23 -At 10:29 NA-B brought a new transfer sheet to NA-H. NA-B cleaned up clutter in R20's room and put soiled linens in a plastic bag. NA-B stated the sheets were yellow and very wet. NA-B stated two incontinence products were not to be placed on a resident (one on top of the other. NA-H stated R20 was to be checked and changed every two hours at least. NA-H verified resident was to have a floor mat on the floor and they were always have two aides for cares. NA-H put the floor mat down on the floor and verified there was not a sign regarding call lights on the walls of the room. -At 10:50 a.m. NA-D stated R20 was changed at about 6:30 a.m. NA-D denied offering incontinence cares to R20 since. NA-D stated staff check R20 every 10 to 15 minutes and he is to be changed at least every two hours. The DON was present for interview. During interview on 6/10/20, at 10:52 a.m. the DON verified there was a strong urine odor in R20's room and the sheets had been saturated with urine. The DON verified resident was not checked and changed for greater than two hours. The DON stated it was her expectation that residents would be toileted or checked and changed every two hours unless their care plan indicated they had a different toileting plan or were independent. The DON stated care plan should be followed for all residents. The DON stated residents should not wear two incontinence pads at the same time.	F 690		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		7/31/20

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F 880	Continued From page 24 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 25 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the smoking patio was appropriately monitored and smoking schedule enforced for 2 COVID negative residents (R10, R12) observed smoking. The facility further failed to sanitize surfaces between residents for 1 resident (R22) observed touching the handicap button after a COVID positive resident. These practices had the potential to affect 38 COVID negative residents identified as smokers. In addition the facility failed to follow isolation precautions for new admissions (R19) and use personal protective equipment (PPE) appropriately when working with residents (R16, R21, R2 and R20).	F 880	Corrective Action: R22 was placed on increased COVID-19 symptom monitoring R10, R7, R11 and R12 were re-educated on facilities smoking policy R19 was placed on contact precautions on 6/9/2020 Universal worker was educated on enforcing COVID-19 smoking policy and designated times with residents Hand sanitizer was placed next to smoking patio door on 6/9/2020 Staff were educated on the cleaning of surfaces between infections and noninfectious residents	

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F 880	Continued From page 26 R7's quarterly MDS dated, 5/15/20, identified R7 with severely impaired cognition and independent with ADLs. R7's diagnoses included COVID-19, dementia and schizophrenia. R7's smoking assessment dated, 4/4/20, identified R7 was an unsafe smoker. R12's quarterly MDS dated, 4/13/20, identified R12 was cognitively intact and required one to two person assist with most ADLs. R12's diagnoses included paraplegia (lower body paralysis), Human Immunodeficiency Virus and chronic viral hepatitis B. R12's smoking assessment dated, 4/4/20, identified R12 was a potentially unsafe smoker. R10's admission MDS dated, 5/26/20, identified R10 was cognitively intact and independent with ADLs. R10's diagnoses included stress fracture of right leg, nicotine dependence and major depressive disorder. R10's smoking assessment dated, 5/20/20, identified R10 was a potentially unsafe smoker. R11's quarterly MDS dated, 5/12/20, identified R11 with moderately impaired cognition and independent with ADLs. R11's diagnoses included COVID-19 and schizophrenia. R11's smoking assessment dated, 4/4/20, identified R11 was an unsafe smoker. R1's quarterly MDS dated, 5/4/20, identified R1 was cognitively intact and independent with ADLs. R1's diagnoses included diabetes and musculoskeletal fracture. R8's admission MDS dated, 2/28/20, identified R8 with moderately impaired cognition and required	F 880	Universal team member and nursing staff were educated on sanitizing surfaces after use from COVID-19 positive residents Admissions and nursing team was educated on the need for 14-day transmission-based precautions on all new admissions All staff were educated on CDC guidance on how to wear PPE Identification of other Residents: All residents are at risk for communicable transmission Monitoring Mechanism: NHA/DON/designee will audit new admissions and ensure transmission-based precautions are in place NHA/DON/designee will audit staff weekly on proper use of PPE NHA/DON/designee will audit sanitation practices throughout the building weekly Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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minimal assistance with ADLs. R8's diagnoses included COVID-19, anxiety disorder and depression. R7's smoking assessment dated, 4/4/20, identified R7 was a safe smoker.

R13's admission MDS dated, 2/4/20, identified R13 was cognitively intact and required one person assist with most ADLs. R13's diagnoses included COVID-19, hemiplegia and hemiparesis (paralysis or weakness affecting one side of the body), major depressive disorder and COPD (chronic obstructive pulmonary disease-a lung disease that affects airflow and makes it hard to breathe). R13's smoking assessment dated, 4/4/20, identified R13 was a potentially unsafe smoker.

Smoking monitor
During observation on 6/9/20, at 1:56 p.m. R10 wheeled self to smoking patio door. R10 asked, "What time are they done? Is that the COVIDs out there?" Universal team member (UTM)-A stated, "No, it is not." R10 then stated there were positive COVID residents out on the patio. R7 and R11 were on the smoking patio.

When interviewed on 6/9/20, at 1:59 p.m. R10 stated there was supposed to be a schedule so that the residents that were COVID positive would not be on the patio at the same time as the COVID negative residents. "But they only really do that when you [the state] are here."

When interviewed on 6/9/20, at 2:02 p.m. UTM-A stated she was the smoking monitor and the facility gave her pictures of all positive COVID residents so that she could identify who was positive. "I tell them all the time they can't share materials and [R11] does it all the time."

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During observation on 6/9/20, at 2:18 p.m. R1, R7, R8, R11, R12, UTM-A and two other unidentified residents were all under the canopy on the smoking patio. R11 and R1 were sitting within three feet of each other. The administrator walked to the smoking patio door and reminded the residents to stay 6 feet apart even though it was raining. Four of the residents left the patio. R8 returned to the COVID unit. R12 and the two unidentified residents headed toward the non-COVID unit.

When interviewed on 6/9/20, at 2:22 p.m. the administrator stated the smoking monitor's job was to watch for and stop residents from sharing cigarettes and items. The monitor should also enforce the six foot rule. "This is the first time it was raining when [UTM-A] was out there so I think it was hard for her."

When interviewed on 6/10/20, at 8:21 a.m. UTM-A stated this was first job in a health care setting and her 5th day on the job. UTM-A stated she was supposed to keep the residents from sharing items and to keep six feet apart. UTM-A stated she was supposed to stop the COVID positive smokers when it was not their turn according to the schedule. A new sign was posted on the smoking patio door which indicted the COVID positive resident smoking times.

During observation on 6/10/20, at 8:29 a.m. R13 went out to smoke. R12 approached the door and stated to UTM-A, "He is COVID positive and should not be out there." UTM-A went out and spoke with R13. UTM-A stated, "So I told him it wasn't his time to be out here and he gave me a smart remark. So I will just sanitize when he

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leaves."

When interviewed on 6/10/20, at 8:30 a.m. R12 stated, "I have seen this smoking schedule before but it was not really enforced."

When interviewed on 6/10/20, at 8:47 a.m. R13 stated seeing the smoking schedule posted. "When I want a cigarette I don't want anyone telling me I can't."

Sanitizing

During observation on 6/10/20, at 8:42 a.m. R7 sat in a chair in the dining area. R7 went to the patio door and asked to go outside. No one sanitized the chair R7 sat in in the dining area. R7 sat in a chair on the patio. At 8:47 a.m. R7 returned to the dining area to the same chair. No one sanitized the R7's chair on the patio. At 8:50 a.m. R7 left the dining area and no one sanitized R7's chair.

During observation on 6/10/20, at 8:52 a.m. R11 approached the smoking patio door. UTM-A told R11 that she had eight minutes before she could go out to smoke. R11 pushed the button to open the door to the patio and went out. The button was not sanitized. At 8:54 a.m. UTM-A pushed button to open door to go out.

When interviewed on 6/10/20, at 10:21 a.m. UTM-A stated she would wipe the table when a COVID positive resident gets up. UTM-A confirmed there was no hand sanitizer outside and the closest dispenser was at the station one nurse's desk.

When interviewed on 6/10/20, at 10:24 a.m.

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administrator stated the smoking monitor should wipe the handicap button after any COVID positive resident touched it.

When interviewed on 6/10/20, at 10:32 a.m. UTM-A stated, "I will wipe the buttons like two times and hour. I will also do it if I see that someone positive touches it too."

During observation on 6/10/20, at 2:21 p.m. R7 pushed handicap button to go outside. R22 pushed the button immediately after R7. UTM-A confirmed R22 was not on the COVID positive photo list. When asked if the button was sanitized in between R7 and R22, UTM-A stated, "I don't know anything about that."

When interviewed on 6/10/20, at 3:45 p.m. administrator stated they have an in person smoking monitor whenever they have the staff for it. Otherwise the patio was under video surveillance at all times. One monitor was located in the administrator's office and the other one at the station ones nurse's desk. Administrator further stated that if anyone noticed COVID positive residents on the smoking patio, the staff should sanitize the table and chairs when they leave.

When interviewed on 6/10/2020, 3:55 p.m. LPN-F stated the smoking patio could be observed via the monitor on the desk. The monitor was black. LPN-F pushed the button and stated, "But it is not working right now."

When interviewed on 6/10/20, at 3:56 p.m. LPN-E stated the monitor at station ones nurse's desk had not been working for a few days. LPN-E stated facility security normally locked the door

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from 9:00 p.m. until 5:30 a.m. and staff would physically escort residents out to smoke during those hours. LPN-E stated they watch the monitor during other times to make sure residents did not share cigarettes, wore masks and stayed six feet apart. LPN-E also stated that maintenance was responsible for cleaning the patio.

The facility provided COVID+ Resident Smoking Times indicated residents who were COVID positive were designated to smoke during the following times: 6:00-7:00 a.m., 9:00-10:00 a.m., 12:00-1:00 p.m., 4:00-5:00 p.m., 7:00-8:00 p.m., 11:00 p.m. - 12:00 a.m., and 2:00 a.m.-3 a.m.

The facility Policy and Procedure for Safe Smoking Villa Healthcare dated, 4/1/20, indicated all residents were informed of the Resident Safe Smoking Policy and assessed for safe smoking upon admission. Residents were subject to verbal warning and then written contract if they ignored the Safe Smoking Policy.

New admissions

R19's Admission Record printed 6/10/20, indicated R19 was admitted to the facility on 6/4/20. Diagnosis included adult failure to thrive and restrictive lung disease.

R19's unlabeled nursing assistant care sheet printed 6/10/20, did not indicated R19 was on droplet Precautions, was to be encouraged to stay in her room or to be reminded wear a face mask when out of her room.

On 6/9/20, at 9:42 a.m. trained medication administration aide (TMA)-C took morning medications to R19's room. There was no

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resident name on the door. TMA-C stated R19 was a new resident admitted three days ago. There was no sign on the door indicating any precautions and no isolation cart in the hallway. R19 sat on the bed without a face mask on. TMA-C entered R19's room with medications. TMA-C wore a gown, and face mask but no gloves or eye protection. TMA-C stood within three feet of R19. TMA-C stated on 6/9/20 at 9:46 a.m. she had forgotten her shield. TMA-C stated she was unaware of any precautions R19 should be on. TMA-C stated she followed the signs posted on the doors for precautions.

On 6/9/20, at 12:30 p.m. R19's name was on the door but no transmissions precaution signage was on the door. There was no isolation bin.

On 6/9/20, at 1:57 p.m., the director of nurses (DON) stated R19 had been admitted 6/4/20. The registered nurse corporate nurse consultant (RNCC) stated new admissions were placed on droplet precautions for fourteen days from admission. The RNCC stated facility would prefer all residents stay in their rooms, but if they came out, they were encouraged to wear a mask. The RNCC stated she was notified of the admission earlier in day. The DON verified an isolation bin and precaution sign were now in place.

On 6/10/20, at 8:29 a.m. nursing assistant (NA)-B looked at droplet precautions sign and isolation cart outside R19's room. NA-B stated she had worked last week and R19 was not on precautions. NA-B stated she need to ask why R19 was on precautions.

Eye protection and glove usage
R16's quarterly minimum data set (MDS) dated

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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
F 880	Continued From page 33	F 880		

1/30/20, indicated R16 was severely cognitively impaired. R16's medical diagnosis printed 6/10/20, included diagnoses of COVID 19. R16 resided on a COVID 19 isolation wing.

On 6/9/20, at 10:16 a.m. NA-G was observed to help R16 adjust her clothing and pull her pants up. NA-B was wore a gown, face mask and gloves. NA- B did not wear eye protection or a face shield. NA-B removed her gloves and put new gloves on and did not use hand sanitizer or wash her hands.

R21's quarterly MDS dated 1/30/20, indicated R21 was severely cognitively impaired. R21's medical diagnosis printed 6/10/20, included diagnoses of COVID 19. R21 resided on a COVID 19 isolation wing.

R21 was observed on 6/9/20, at 10:27 a.m. in bed. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light and verified R21 was able to use the call light if it was available. NA- B did not wear eye protection or a face shield. NA-B removed her gloves and put new gloves on and did not use hand sanitizer or wash her hands.

R2's quarterly MDS dated 6/1/20, indicated moderately impaired cognition. R2's diagnoses included non-Alzheimer's dementia. R2 resided on a COVID 19 isolation wing. R2's roommate was on droplet precautions for COVID 19.

On 6/9/20, at 10:29 a.m. NA-G entered R2's room and picked up R2's breakfast tray and removed tray from room. NA-G removed gloves and put

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F 880	Continued From page 34	F 880		

new gloves on and did not use hand sanitizer or wash her hands. NA- B did not wear eye protection or a face shield.

On 6/9/20, at 1:57 p.m. the RNNC stated staff should wear goggles or face shield as part of universal care at this time and a face mask. The DON stated staff should use hand sanitizer between glove changes for COVID 19 positive residents. The RNCC stated if one roommate has COVID 19 both roommates were treated with droplet precautions.

R20's admission MDS dated 5/22/20, indicated R20 was cognitively intact, required assistance of two staff members for bed mobility. R20's medical diagnosis printed 6/10/20, included diagnosis of heart failure impulsivity and traumatic brain injury.

On 6/10/20, at 9:16 a.m. licensed practical nurse (LPN)-G entered R20's room and wore a face mask, face shield and gloves. LPN G carried medications and a glass of water. LPN-G set medication on table and took R20's vital signs. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, and put her hands under his shoulders and legs. LPN-G removed gloves, did not wash her hands and used the crank at the foot of the bed to put the head of the bed up. LPN-G put new gloves,did not use hand sanitizer or wash her hands and gave R20 an inhaler and pills.
-At 9:36 a.m. LPN-G reentered R20's room with two glasses of water and a pill cup. LPN-G assisted R20 to take his medication and swallow the water. LPN-G's face shield was set mid head and did not come down over nose or wrap around eyes. LPN-G washed hands and looked

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F 880	Continued From page 35	F 880		

at face shield in mirror and said, "I do not know how it is supposed to be worn." LPN-G adjusted face shield so the bottom edge of the shield came down over nose, but not covering facemask. There was still a gap on both sides of LPN-G's face shield did not cover her eyes.
-At 9:45 a.m. LPN-C, the infection control nurse, looked at how LPN -G who wore the face shield and said, "I do not know how the face shield should be worn. I will get back to you."

On 6/10/20, at 8:34 a.m. NA-G stood at the nurses station wore a face mask but no eye protection NA-G stated she was sure she had her face shield on yesterday. She stated she wore her face shield every time, all the time. NA-B stated she had hand sanitizer and usually used it between glove changes.

Minnesota Department of Health Contingency Standards of Care for COVID-19 Personal Protective Equipment for Long Term Care/Assisted Living/ Other Non-Acute Care facility form dated 5/29/20, indicated healthcare providers with face to face contact with COVID-19 negative residents were to wear surgical mask, eye protection and perform hand hygiene plus standard precautions and any other posted Transmission-based Precautions. The form also indicated healthcare providers with face to face contact with COVID-19 positive residents were to wear surgical mask, eye protection, gowns, gloves and perform hand hygiene plus standard precautions and any other posted Transmission-based Precautions.

Facility provided copy of undated COVID -19 Personal Protective Equipment (PPE) for Healthcare Personnel poster put out by the

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F 880	Continued From page 36 CDC(Centers for Disease Control) as guidance for how to wear a face shield. the poster showed face shield covering face from forehead to bottom of chin and out to the front of the ears.	F 880		

Electronically delivered
July 7, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: R18U11

Dear Administrator:

The above facility was surveyed on June 9, 2020 through June 10, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, 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: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/9/20 - 6/10/20, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found to not be in compliance with the MN state licensure. The following complaint(s) were found to be substantiated: H5203123C	2 000		

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2 000	Continued From page 1 H5203124C H5203126C H5203127C The following complaint was found to be not-substantiated: H5203125C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		7/31/20

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2 265	Continued From page 2 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to timely notify a family member/responsible party of resident to resident sexual abuse for 1 of 3 residents (R2) reviewed for abuse. Findings include: According to Nursing Home Incident Reporting documents, a report was submitted to the state agency (SA) on 5/29/20, which indicated R2 had touched another resident inappropriately while in the elevator. R2 was placed on 1:1. R2's quarterly Minimum Data Set (MDS) dated 6/1/20, indicated moderately impaired cognition. R2 had verbal and physical behavioral symptoms directed toward others 1-3 days. R2 had other behavioral symptoms not directed toward others 1-3 days. R2 had not rejected cares. R2 had wandered 1-3 days. R2 required supervision with transfers and was independent with walking in corridor and on and off the unit. R2 used a walker. R2's diagnoses included non-Alzheimer's dementia and diabetes.	2 265	corrected	

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2 265	Continued From page 3	2 265		

R2's care plan dated 11/19/18, identified R2 had a behavior problem related to history of reaching out to others and grabbing at them, inappropriate grabbing and touching toward staff and residents. Screaming and yelling when reeducated. R2's care plan directed staff to psychology consult, explain to R2 this is not acceptable behavior, remove from others if applicable, explain risk vs benefit, animal crackers are at the nursing station used for deescalating. R2's care plan dated 12/3/18, indicated R2 had areas of vulnerability related to behaviors, agitation, communication, dementia, irritating to others. The care plan directed staff to notify administrator, director of nursing (DON) and social worker of an adverse event and to observe and provide a safe environment. The care plan lacked instruction to notify R2's guardian.

A review of R2's medical record progress notes indicated the guardian was notified of the incident that was reported to the State Agency on 5/29/20, on 6/5/20, seven days after the incident occurred.

During a telephone interview on 6/10/20, at 9:26 a.m. with family member/guardian (FM)-A, FM-A stated the facility called and had stated R2 grabbed another resident (R1). FM-A did not know what date had been notified nor what date the incident occurred. FM-A stated had been notified R2 had done that in the past and that R2 would grab people when they needed something.

During interview on 6/10/20, at 10:16 a.m. social services (SS)-B stated had not worked the day the incident occurred. SS-B stated it would be the expectation for the staff working that day to notify family. SS-B stated "I spoke to the family as soon as I was notified." SS-B noted in a progress note on 6/5/20 of notification to family, which was six

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2 265	Continued From page 4 days after the incident occurred. During interview on 6/10/20, at 11:37 a.m. the director of nursing (DON) stated as part of the investigation the family would be updated right away and documentation should be in a progress note or interdisciplinary note in the medical record. During interview on 6/10/20, at 12:00 p.m. the facility administrator stated it would be the expectation to update the family following an incident as soon as possible but within 5 days. The facility policy titled Notification of Changes Guideline, dated 11/28/17, directed staff to notify the resident representative for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. Document the notification in the resident's medical record. The nurse would immediately notify the resident's representative of an accident with injury, significant change, need to alter treatment significantly or decision to transfer or discharge. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to notification of change to resident representative and/or guardian and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		

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2 830	Continued From page 5	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow care planned interventions to reduce the risk for falls for 2 of 4 residents (R21, R20) reviewed for accidents. Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/30/20, indicated R21 was severely cognitively impaired. R21's quarterly MDS dated 4/21/20, indicated R21, had severely impaired vision, required assistance of one to two staff members for bed mobility, and transfers and had fallen in the previous quarter. R21's medical diagnosis printed 6/10/20, included diagnosis of COVID 19, dementia, muscle weakness and unsteady gait. R21's care plan printed 6/10/20, indicated R21 had an actual fall with no injury. Interventions included Hi-lo bed, concave mattress and mat on	2 830	corrected	7/31/20

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2 830	Continued From page 6	2 830		

the floor. Care plan did not address the use of a call light.

R21 was observed on 6/9/20, at 10:27 a.m. in bed with the head of the bed raised, R21 laid with feet all the way to the foot of the bed and touched the footboard and knees bent up toward the ceiling. R21 had an air mattress on his bed. The bed was in low position and left side of the bed was up against the wall. A blue fall mat leaned against the wall in room, there was not a fall mat on the floor beside the bed. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light. NA-G fastened R21's call light to pillow above head. The call light fell part way to the floor, NA-G put the call light in R21's hand and told R21 it was his call light. NA-G explained staff were to put the call light in R21's hand and tell him where it was because he could not see. NA-G verified R21 was able to use the call light if it was available. NA-G verified fall mat should be on the floor by bed, but did not place it there prior to leaving the room.

R20's admission MDS dated 5/22/20, indicated R20 was cognitively intact, required assistance of two staff members for bed mobility, and transfers and on staff member to walk in room. R20's MDS also indicated he had not fallen prior to admission but had fallen once since admission with no injury. R20's medical diagnosis printed 6/10/20, included diagnosis of heart failure impulsivity and traumatic brain injury.

R20's care plan printed 6/10/20, indicated R20 had a self care deficit and instructed staff to encourage resident to use the call light for

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2 830	Continued From page 7 assistance. R20's unlabeled nursing assistant care sheet printed 6/10/20, listed safety interventions that included encourage resident to allow staff to assist with ambulation, encourage resident to use call light for assist with transfers and ambulation, and place fall mat next to bed when in bed. R20's Report of Resident Fall event date 5/21/20, at 3:31 p.m., indicated R20 was found on the floor in the dining room. R20 indicated he lowered himself to the floor. Report indicated R20 ambulated to the dining room at the time of the fall. Preventive measures were: encourage use of call light, keep call light within reach. Causative factor was identified as R20 did not ask for help. Report did not identify why R20 needed to lower himself to the floor. R20's Report of Resident Fall event date 6/8/20, at 1:00 a.m., indicated R20 called for help at 2:00 a.m. Staff arrived and found R20 on the floor. The report indicated R20 had a deep laceration on his right right eyebrow, and that R20 was sent to Hennepin County Medical center for stitches. Report indicated R20 had been dozing while sitting in a chair and had refused three times to go to bed when offered. Preventive measures included call light kept within reach, night light, and bed in low position. Report indicated interventions that were in place at time of the fall were wheelchair. Possible causative factor listed on Report of Resident Fall was refusing to go to bed and sleeping while sitting down in a chair. New intervention listed on fall report was "placing a call don't fall sign in resident's room. Staff will Remind resident to use call light for assistance." R20 was observed on 6/9/20, at 2:19 p.m. lying in	2 830		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8	2 830		

bed with his eyes open. The head of the bed was elevated and R20's call light was lying on top of the portable stereo on R20's nightstand. The night stand was against the wall and to the right of the head of the bed. The left side of bed up was against the wall with a folded blue mat between the foot of the bed and the wall. When asked what brought him to the facility R20 stated he had fallen and could not get up. He stated he had hurt himself. R20 verified he fell before and since admission. R20 stated his balance was not right and that it worried him that he kept falling. R20 stated he had trouble when he walked and had hurt himself when he fell the other night. R20 stated he was sitting up in his chair because sometimes that was the only way to sleep when it is hard to breath. R20 stated he did not have his call light while he was up in his chair. R20 stated when he put on the call light staff would come at their convenience. R20 stated he had fallen because he could not wait for staff to answer his call light. R20 asked for his call light. Notified staff of R20's request.

On 6/9/20, at 2:25 p.m. NA-E entered room and gave R20 his call light and asked if there was anything else she could do for him. NA-E verified call light had been out of R20's reach. NA-E verified R20 was able to use the call light and would use it if he had it. NA-E stated they must have forgotten to give it back to him when they helped him repositioned. NA-E verified fall mat was against the wall,and was to be on the floor when R 20 was in bed, but did not put it on the floor. NA-E verified there were no signs on the wall to remind R20 to use the call light. NA-E stated sometimes the lights get busy but we answer them as fast as we can.

On 6/10/20, at 8:12 a.m. R20 was lying in bed

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2 830	Continued From page 9 awake. His call light was in reach. Oxygen tubing was on his forehead not in his nose. Blue floor mat up against the wall between the bed and the wall. There was no sign on walls of the room to use call light. There was a strong odor of urine in room. Resident lying in bed stated he was okay. On 6/10/20, at 9:16 a.m. licensed Practical nurse (LPN)-G entered R20's. LPN G carried medications and a glass of water. LPN- G asked R20 about his oxygen tubing which was still on his forehead. R20 stated he had removed it about half an hour ago. LPN-G put the oxygen tubing into R20's nose and told him they were waiting on hospice nurse to arrive. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, putting her hands under his shoulders and legs. R20 said "I was just sitting up." (R20 was in the same position since 8:12 a.m.). -At 9:23 a.m. LPN-G left R20's room with the head of bed up, bed not in low position, The level was slightly higher than knee height. -At 9:36 a.m. LPN-G returned to the room with two glasses of water and a pill cup. R20's feet hung off edge of bed and his feet did not touch the floor. The bed not in low position. R20's hips were twisted. LPN-G did not reposition R20's legs or lower the bed height. Floor mat was not in place. During interview on 6/10/20 at 10:52 a.m. the DON stated R20's floor mat should have been on the floor, and the bed should have been in low position except when staff worked with him. The DON stated care plans should be followed for all residents. The DON stated fall interventions should be in place and call lights should be in place. The DON stated interventions should be updated to the care plan, but if they are in the	2 830		

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2 830	Continued From page 10 chart they should be followed. Facility Fall Evaluation Guidelines dated 11/28/17 indicated the purpose was to consistently identify and evaluate residents at risks for falls and those who have fallen to prevent or reduce injuries for falls. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least	2 840		7/31/20

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2 840	Continued From page 11 every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide incontinence cares to a dependent resident for 1 of 3 residents (R20) reviewed for urinary incontinence. Findings include:	2 840	corrected	

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2 840	Continued From page 12 R20's admission Minimum Data Set (MDS) dated 5/22/20, indicated R20 was cognitively intact, required assistance of two staff members for toileting and personal hygiene. R20's MDS indicated he was frequently incontinent of bowel and bladder. R20's medical diagnosis printed 6/10/20, included diagnosis of heart failure impulsivity and traumatic brain injury. R20's care plan printed 6/10/20, indicated R20 had bladder incontinence and instructed staff to clean peri-area with each incontinence episode, but lacked time frame for offering assistance. R20's unlabeled nursing assistant care sheet printed 6/10/20, did not address urinary incontinence or interventions to reduce episodes. Continuous observation on 6/10/20, from 8:12 a.m.-9:45 a.m. -At 8:12 a.m. R20 was lying in bed awake. His call light was in reach. Oxygen tubing was on his forehead not in his nose. Blue floor mat up against the wall between the bed and the wall. There was no sign on walls of the room to use call light. There was a strong odor of urine in room. Resident lying in bed stated he was ok. -At 8:44 a.m. R20's door remained shut. Surveyor knocked and with permission entered room. The oxygen tubing was still on the top of R20's head, mask still under his chin. R20 stated sometimes he liked it like that. -At 9:16 a.m. licensed practical nurse (LPN)-G entered R20's room wore a face mask, face shield and gloves. LPN G carried medications and a glass of water. LPN-G set medication on table and took R20's vital signs blood pressure. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, put her hands	2 840		

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2 840	Continued From page 13	2 840		

under his shoulders and legs. R20 said "I was just sitting up." (R20 was in the same position since 8:12 a.m.).There was a strong odor of urine in room.
-At 9:23 a.m. LPN-G left R20's room.
-At 9:36 a.m. LPN-G returned to the room with two glasses of water and a pill cup. LPN-G gave the medication to R20.
-At 9:48 a.m. the director of nurses(DON) entered R20's room. The DON lowered bed as she stated the bed needs to be lower when no one is in the room. The DON attempted to assist R20 to sit up on edge of bed.
-At 9:49 a.m. LPN-D entered R20's room to help the DON sit up R20. LPN-D asked R20 if he wanted to sit in his wheel chair. R20 said he did not want to sit up. LPN-D left to get supplies. Floor mat not on the floor, call light in place. Strong odor of urine in room.
-At 9:54 a.m. breakfast tray arrived. Scrambled eggs, apple juice toast hot cereal put on over bed table out of reach of resident
-At 9:56 a.m. LPN-G entered R20's room.
- At 9:57 a.m. LPN-D returned to the room. LPN-D and the DON attempted to transfer R20 with a gait belt. R20 was not able to stand all the way up, so he could move up in bed. The DON said to R20, "you need to be changed. I will get someone in to help change you." R20 stated he wanted to eat. LPN-D said trained medication aide (TMA)-A is going to come and get him cleaned up. The DON left the room. LPN-D put jelly on R20's toast. LPN-D left the room. R20 sat on edge of bed ate breakfast and bent forward at waist so head was at height of bedside table.
-At 10:02 a.m. NA-H entered the room.
-At 10:04 a.m. NA-H was in room R20 was eating breakfast. R20 stated he was done. NA-H helped R20 to lie back in bed. NA-H prepared to give R20 a bed bath. NA-H removed two incontinence

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2 840	Continued From page 14 pads. R20 refused to allow NA-H to wash peri area, but did allowed legs to be washed. R20 did not want to open legs. R20 refused to roll on side. -At 10:25 a.m. NA-H pushed call light for help to roll resident. NA-H stated R20 wore two incontinence briefs, one over the other. NA-H stated both pads were very wet. NA-H stated the bed was soaking wet. -At 10:27 a.m. LPN-D entered R20's room and left to get gloves. LPN-D returned put on gloves on and put anti slip socks on R20's feet. LPN-D assisted R20 to turn toward the wall. Transfer sheet was yellow with urine mid way up R20's back. R20's bottom was pink and intact. -At 10:29 NA-B brought a new transfer sheet to NA-H. NA-B cleaned up clutter in R20's room and put soiled linens in a plastic bag. NA-B stated the sheets were yellow and very wet. NA-B stated two incontinence products were not to be placed on a resident (one on top of the other. NA-H stated R20 was to be checked and changed every two hours at least. NA-H verified resident was to have a floor mat on the floor and they were always have two aides for cares. NA-H put the floor mat down on the floor and verified there was not a sign regarding call lights on the walls of the room. -At 10:50 a.m. NA-D stated R20 was changed at about 6:30 a.m. NA-D denied offering incontinence cares to R20 since. NA-D stated staff check R20 every 10 to 15 minutes and he is to be changed at least every two hours. The DON was present for interview. During interview on 6/10/20, at 10:52 a.m. the DON verified there was a strong urine odor in R20's room and the sheets had been saturated with urine. The DON verified resident was not checked and changed for greater than two hours. The DON stated it was her expectation that residents would be toileted or checked and	2 840		

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2 840	Continued From page 15 changed every two hours unless their care plan indicated they had a different toileting plan or were independent. The DON stated care plan should be followed for all residents. The DON stated residents should not wear two incontinence pads at the same time. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a call light was within reach for 2 of 4 residents (R21, R20) reviewed for accidents.	21810	corrected	7/31/20

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21810	Continued From page 16 Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/30/20, indicated R21 was severely cognitively impaired. R21's quarterly MDS dated 4/21/20, indicated R21, had severely impaired vision, required assistance of one to two staff members for bed mobility, and transfers and had fallen in the previous quarter. R21's medical diagnosis printed 6/10/20, included diagnosis of COVID 19, dementia, muscle weakness and unsteady gait. R21's care plan printed 6/10/20, indicated R21 was at risk for falls but did not address the use of call light to prevent falls. R21 was observed on 6/9/20, at 10:27 a.m. lying in bed with the head of the bed raised, R21 laid in bed with feet all the way to the footboard of the bed and knees bent up toward the ceiling. The bed was in low position and left side of the bed was up against the wall. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light. NA-G fastened R21's call light to pillow above head. The call light fell part way to the floor, NA-G put the call light in R21's hand and told R21 it was his call light. NA-G explained staff were to put the the call light in R21's hand and tell him where it was because he could not see. NA-G verified R21 was able to use the call light if it was available. R20's admission MDS dated 5/22/20, indicated R20 was cognitively intact, required assistance of two staff members for bed mobility, and transfers and on staff member to walk in room. R20's MDS	21810		

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21810	Continued From page 17	21810		

also indicated he had not fallen prior to admission but had fallen once since admission with no injury. R20's medical diagnosis printed 6/10/20, included diagnosis of heart failure impulsivity and traumatic brain injury. R20's care plan printed 6/10/20, indicated R20 had a self care deficit and instructed staff to encourage resident to use the call light for assistance.

R20 was observed on 6/9/20, at 2:19 p.m. lying in bed with his eyes open. The head of the bed was elevated and R20's call light laid on top of the portable stereo on R20's nightstand. The night stand was against the wall and to the right of the head of the bed. When asked what brought him to the facility R20 stated he fell before and since admission. R20 stated when he put on the call light staff would come at their convenience. R20 stated he had fallen because he could not wait for staff to answer his call light. R20 attempted to reach his call light but was unable. R20 asked for his call light.

On 6/9/20, at 2:25 p.m., NA-E entered room and gave R20 his call light and asked if there was anything else she could do for him. NA-E verified call light had been out of R20's reach. NA-E verified R20 was able to use the call light and would use it if he had it. NA-E stated they must have forgotten to give it back to him when they helped him repositioned. NA-E verified there were no signs on the wall to remind R20 to use the call light. NA-E stated sometimes the lights get busy but we answer them as fast as we can.

During interview on 6/10/20, on 10:52 a.m. the director of nurses (DON) stated call lights should be in reach for all residents, unless it was specifically care planned that the resident should not have a call light because of safety issues or

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21810	Continued From page 18 they were unable to use it. Call light policy was requested but not received. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		