DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 29, 2019

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

RE: Project Numbers H5203072C, H5203075C, H5203076C

Dear Administrator:

On March 8, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 5, 2019.

This was based on the deficiencies cited by this Department for an abbreviated survey completed on February 14, 2019. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 19, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated survey, completed on February 14, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 1, 2019. We have determined, based on our visit, that your facility has corrected as of April 1, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 5, 2019 be rescinded as of April 1, 2019. (42 CFR 488.417 (b))

In our letter of March 8, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 5, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 1, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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May 29, 2019

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

Re: Reinspection Results - Project Number H5203072C, H5203075C, H5203076C

Dear Administrator:

On April 19, 2019 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 19, 2019, with orders received by you on March 11, 2019. At this time these correction orders were found corrected.

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

Electronically delivered
March 8, 2019

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

RE: Project Number H5203068, H5203071C, H5203072C, H5203073C, H5203074C, H5203075C, H5203076C

Dear Administrator:

On February 14, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 5, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 5, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 5, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villa At Bryn Mawr will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 5, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	C 02/14/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted 2/13/19-2/14/19 to investigate complaints H5203074C, H5203072C, H5203073C, H5203071C, H5203076C, H5203068, H5203075C. The Villa at Bryn Mawr is not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. H5203072C and H5203076C were substantiated at F600. H5203075C was substantiated at F921. H5203074C, H5203073C, H5203071C, and H5203068 were not substantiated. The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a 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 you acknowledge receipt of the electronic documents.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		4/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2019

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

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 resident (R1) was free from abuse when another resident (R2) pushed him, resulting in a fall. This resulted in actual harm for R1 who suffered a hip fracture as a result of the fall. In addition, the facility failed to ensure 1 of 1 resident (R1) was free from verbal abuse when a staff member verbally abused R1 following the fall. Findings include: R1's diagnoses as identified on the face sheet dated 2/18/19, included dementia, and a psychotic disorder with hallucinations. R1's quarterly Minimum Data Set (MDS) dated 10/20/18, indicated R1 had severe cognitive impairment, and had delusional behavior. The MDS indicated R1 sometimes could make self understood and could understand others, and responded adequately to simple, direct communication. The MDS indicated R1 had delusional behavior, but during the look back period ending 10/20/18 exhibited no wandering behavior. The MDS further indicated R1 required supervision with transferring, and needed help, supervision and the physical assistance of one staff to ambulate in the room or corridor. R1's care plan, updated 7/19/18, identified focus areas of impaired cognitive function/dementia or impaired thought process, R1 was a wanderer, related to impaired safety awareness, and listed various interventions which included: secured unit; re-direct when wandering into other rooms; and intervene as necessary and remove from	F 600	Resident #1 has discharged from the facility. All residents with behavioral disturbances negatively affecting others have been reviewed and care plans updated with interventions as appropriate. All staff have been re-educated regarding abuse and neglect. SS/Designee will audit 5 residents per week x 4 weeks and 3 residents per week x 4 weeks to ensure behavioral interventions are implemented and effective to prevent abuse and neglect. ADON/ Designees will audit 5 staff/ resident interactions per week x 4 weeks and 3 interactions per week x 4 weeks to ensure interactions are appropriate and no evidence of abuse/ neglect is present. Audit results will be reviewed at QAPI.	

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F 600	Continued From page 2	F 600		

situation and take to alternate location as needed. The care plan indicated staff were aware of R1's wandering.

R2's annual MDS dated 9/27/18, indicated severe cognitive impairment. R2's diagnoses as identified on the care plan revised 7/27/18, included restlessness and agitation, Wernicke's encephalopathy (brain disorder due to vitamin B1 deficiency), cognitive communication deficit, and psychotic disorder with delusions due to known physiological condition.

R2's care plan identified a history of showing physical and/or verbal aggressiveness towards staff/others related to anger, depression, poor impulse control, and history of delusions/paranoid thinking. R2's care plan directed staff when R2 became agitated, intervene before agitation escalates.

An initial Incident Tracking report dated 11/5/18, indicated the facility reported an allegation of maltreatment to the State Agency (SA). The report indicated R1 was pushed by another resident (R2), which caused R1 to fall. A follow up Investigation Report Summary dated 11/12/18, indicated R1 wandered into R2's room, while R2 was sleeping, and this startled R2. R2 pushed R1 out of R2's room, causing R1 to fall. Licensed practical nurse (LPN)-A witnessed R2 push R1 from his room. LPN-A immediately separated the two residents (R1 and R2), moved R1 away from R2's door. Unidentified staff stayed with R1 until R1 was sent to the emergency room and was admitted with a hip fracture.

When interviewed on 2/13/19 at 1:18 p.m. nursing assistant (NA)-B said R1 "had his

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F 600	Continued From page 3	F 600		

moments" and stated R1 would tell people to move, or get off the phone because R1 actually believed "he owned the place." NA-B stated is was no secret R1 wandered into other residents' rooms on the unit, and likely did wander "into his former room, which is R2's room." NA-B stated R1 probably thought that was still his room, even though R1 only was in that room [R2's] for only a short time. NA-B stated R1 and R2 did not get along.

When interviewed on 2/13/19 at 1:28 p.m. LPN-C stated R2 "is aggressive" especially if he does not get what he wants, and usually the issue has to do with food. LPN-C stated you can give R2 food, for example, and he will eat it, then when he sees someone else eating, R2 thinks that food is his, and gets angry. LPN-C stated she has seen R2 stand up from the table, and get in another resident's space and get angry, "and I think sometimes R2 could be a danger to residents."

R1's Hospital Discharge Orders and Information document, printed 2/14/19, indicated R1 was admitted to the hospital on 11/5/19, had a discharge diagnosis of "Closed fracture of neck of left femur." The document indicated R1 was discharged to the nursing facility on 11/9/18.

A review of R1's nursing progress note, dated 11/6/18, indicated: "IDT (interdisciplinary team) met to review and discuss resident incident resulting in fall and hospitalization. Resident [R1] noted to be crawling on the floor out of another resident's room [R2]. Staff asked resident [R2] what happened, resident responded he pushed [R1] in order to make him leave. Resident witnessed by staff on floor. Resident complained

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F 600	Continued From page 4	F 600		

of pain and sent to hospital where it was verified he had a left hip fracture."

An additional, initial report, also dated 11/5/18, indicated "Report made by staff member that another staff member was speaking inappropriately to a resident." The follow-up report dated 11/12/18, indicated LPN-A made inappropriate statements to R1 when laying on the floor, after suffering a fall (on 11/5/18). The report indicated therapeutic recreation assistant (TRA) reported, LPN-A told R1 to "get himself off the floor" after R1 asked LPN-A for help to get up. The TRA reported LPN-A screamed at R1 not to move while LPN-A was taking R1's blood pressure and overheard LPN-A yelling at R1, saying things like "you deserve a broken hip" and "karma is always going to come back and get you" and "it's your own fault your hip is broken." TRA remained on the unit until nursing assistant (NA)-C arrived back on unit to supervise R1. The TRA notified the therapeutic recreation director (TR-D) by phone of the situation. Approximately 10 minutes later, after the administrator and director of nursing (DON) were notified, LPN-A was escorted out of the building and suspended pending further investigation. LPN-A has since been terminated.

As part of the facility's investigation, LPN-A provided a statement on 11/9/18 at 3:15 p.m. LPN-A's statement indicated the following: LPN-A reported she heard yelling at approximately 5:15 p.m. on 11/5/18, while she was in the med room. LPN-A reported she was the only nursing staff member on the unit at the time. LPN-A reported she looked in the hallway and saw R1 by R2's room. LPN-A then ran down to R2's room and by the time she got there, R2

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F 600	Continued From page 5	F 600		

had pushed R1, which caused R1 to fall. R1 was lying on the floor stating "I don't' know what happened." LPN-A reported she tried to move R1 away from R2's door. LPN-A reported R1 did not appear to be severely injured at this time and stated to R1: "This is what happens when you go into other's rooms". LPN-A reported she asked therapeutic recreation (TR) staff who was present to call another nurse's station for help and to get a blood pressure cuff. LPN-A reported the TR staff was unable to get in contact with the nurse's station and LPN-A then asked the TR staff to go down to nurse's station to get help. LPN-A reported she also placed call to the nurse manager (LPN-B) who told LPN-A not to send R1 to the ER (emergency room) because they need to get an x-ray at the facility first. LPN-A reported she called for an on-call doctor and left message to return call. As LPN-A waited, another nurse (unidentified) came from station 1 and continued to wait for a return call from the doctor. On call nurse [LPN-B] placed call to ER. LPN-A reported at this time she had been asked to leave the unit, pending investigation, and left facility around 7:15 p.m.

Review of LPN-A's personnel records were reviewed and indicated LPN-A was hired 7/2/18. The records further indicated LPN-A completed abuse prohibition training on 9/23/18.

A Physical Therapy Plan of Care document dated 11/12/18, indicated R1's diagnosis was fracture of unspecified part of neck of left femur. The document indicated R1 was a resident on the locked unit, sustained a fall on the unit with subsequent fracture of the left femur. R1 was independent with prior level of functional mobility skills.

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

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F 600	Continued From page 6 During interview on 2/14/19, at 9:08 a.m. the recreational service director (RSD) stated he recalled the incident between R1, R2 and LPN-A, that happened a few months ago. RSD stated he was in the neighborhood of the facility when he received a call from therapeutic recreation assistant (TRA)-A, who was working during the late afternoon/evening shift of the day of 11/5/18. The RSD stated TRA-A called and reported one of the residents on station 3 [the locked unit] had a fall and stated "I am very uncomfortable about how the nurse [LPN-A] was handling the situation." The RSD stated TRA-A reported the nurse who was assisting R1, was standing over R1 and telling R1 things like "[R1] you deserved what happened" and "this is what you get for coming into R2's room." The RSD stated he immediately thought there was "verbal abuse" and R1 was abused by the staff (LPN-A). RSD stated he attempted to call the administrator and DON, but both were initially unavailable, but called the nurse manager and let her know what had been reported to me, and also called former assistant administrator. The RSD stated from his stand point, his staff did the right thing, made the report, and stated he understood LPN-A was removed from the facility shortly thereafter. RSD stated he was "unaware" and had not seen any behaviors with LPN-A prior to this event that would have raised concern. The RSD stated he "heard in general" that LPN-A was quick to use profanity, but stated he personally could not verify that. The RSD stated what LPN-A was reported to have done and said and that kind of behavior and response to a resident, berating a resident after a fall "was clearly abuse," and "was not acceptable."	F 600		

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	245203	A. BUILDING _____ B. WING _____	C 02/14/2019

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

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F 600	Continued From page 7	F 600		

During interview on 2/14/19, at 10:06 a.m., therapeutic recreation assistant (TRA)-A stated she witnessed first hand the situation involving R1, R2 and LPN-A. TRA-A stated she had been employed at the facility since the beginning of October, 2018, and added she had worked at nursing homes in the past. TRA-A stated she immediately knew when she heard how LPN-A was talking to R1 "this was abuse" and also "it was immediately reportable." TRA-A stated she knew right away LPN-A had to be removed from the situation. TRA-A stated on the evening of the incident, when she came on the unit she saw R1 lying near the dining room on the floor. TRA-A stated LPN-A was facing R1 and LPN-A's back was toward TRA-A, and LPN-A "did not realize I had come on the unit right away." TRA-A stated she heard R1 say to LPN-A "Please help me get up," and LPN-A replied, in a condescending tone,"NO, get up yourself!" At that point, LPN-A turned around saw me, and then "tried to haphazardly try to assist R1." TRA-A stated LPN-A asked her to get a "vitals tree" (a portable, wheeled vital sign equipment), and did, but needed to call down and get it from another unit, so left the unit for a few minutes to get the vitals tree. TRA-A stated when she returned to the unit, R1 had scooted himself to the other side of the dining room. TRA-A stated LPN-A continued to be rude and continued to say "horrible things to R1." TRA-A stated LPN-A told R1 "Sit still," Karma is a bitch," "I hope you break your hip," and "you deserved this." TRA-A stated at this point she was crying, and at that point, "I call[ed] my supervisor." TRA-A stated she "knew right away" this was not right, and "this was abuse."

During interview at 2:11 p.m. on 2/14/19, the DON discussed the incident between R1, R2 and

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F 600	Continued From page 8	F 600		

LPN-A. The DON stated what was reported and investigated was the nurse, LPN-A, was "verbally inappropriate" with R1. The DON stated she would call this "verbal abuse" by a staff member. The DON also acknowledged the resident to resident incident between R1 and R2, and stated she could not say if R2's actions of pushing R1 were intentional, as both R1 and R2 had dementia. The DON stated the investigation report was, R1 wandered into R2's room, and was pushed by R2, causing R1 to fall. The DON stated R1 was then transported to the hospital and had a hip fracture. When asked if there were enough staff on the floor, DON stated she felt the supervision was adequate. DON did not know the census on the locked unit the day of the incident, but said "today we have eighteen residents, with two staff." The DON acknowledged during break times, there were was only one staff from nursing on the floor. DON explained the facility followed their policy, nurse manager was immediately notified, and LPN-A was suspended immediately, and "an OHFC" (Office of Health Facility Complaints or State Agency) report was completed. The facility administrator was also interviewed and stated the staff acted appropriately, and stated they had a system in place to respond to abuse, "and it worked. We followed our process."

A facility policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, effective 11/28/17, indicated in its purpose, that "An owner, licensee, Administrator, Licensed Nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. The policy defined abuse as "...the willful infliction of injury, unreasonable confinement, intimidation,

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F 600	Continued From page 9 or punishment with resulting physical harm, pain or mental anguish." The policy also indicated abuse included verbal abuse, indicated "Wilful, as used in this definition of abuse, means that individual must have acted deliberately, not that he individual must have intended to inflict injury or harm."	F 600		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to maintain a safe, sanitary and comfortable environment, affecting all 118 residents in the facility. Findings include: An environmental tour was conducted with the administrator on 2/13/19, at 11:00 a.m. The following items were observed and verified: - The door to unit 3 was heavily gouged and appeared very old and soiled. The window in the door had peeling paint around the trim. - Unit 3 hallway floor appeared un-mopped with a brown smear along the floor and liquid spills. - The bathroom in Unit 3 felt cold. The window was found to be un-latched. The windowsill and window track was soiled with dust and debris. - Unit 3 dining room had two movable tray tables with build up of soil on the framing. - The bathroom on unit 2 had dusty vents and there was a mess of miscellaneous items on the	F 921	Areas identified during the tour have been repaired/ resolved. Maintenance and housekeeping staff have been re-educated regarding maintaining a safe, sanitary, comfortable environment. Staff have been educated on using the TELs system to report environmental concerns. LNHA/designee will round the building 3 x week x 4 weeks and then 2 x week x 4 weeks to ensure that a safe, sanitary and comfortable environment is maintained. Audit results will be reviewed at QAPI.	4/1/19

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F 921	Continued From page 10	F 921		

floor. A shower stall area had wall covering removed exposing the interior. The administrator stated work had been done on frozen pipes.
- The door frame to the bathroom on unit 2 was loose from deterioration in the wall.
- Unit 4 dining room had a heavily smudged wall around the wall-mounted telephone.
- The front stairwell used by staff and residents, appeared un-swept or cleaned with loose debris and soil.
- First floor baseboards in the hallway at the entrance to the kitchen and the kitchen door, were soiled.
- The 1st floor dining room baseboards, walls and windowsills were soiled with spills and/or food debris.

The director of maintenance (DOM) was interviewed on 2/13/19, at 2:00 p.m. and verified cleaning of the stairwells was on an as needed basis. DOM indicated the mopping was to be completed twice a day, but was not on a schedule. Additionally, the DOM indicated the movable side tables were to be cleaned by the nursing assistants or the housekeeping staff. The DOM verified the facility was in process of acquiring additional housekeeping staff.

A policy for housekeeping services was requested but not provided.

Electronically delivered
March 8, 2019

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

Re: State Nursing Home Licensing Orders - Project Number H5203072C

Dear Administrator:

The above facility was surveyed on February 13, 2019 through February 14, 2019 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00175	A. BUILDING: _____ B. WING _____	C 02/14/2019

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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 2/13/19-2/14/19, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. The following complaint(s) was/were found to be	2 000		

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2 000	Continued From page 1 substantiated: H5203075C substantiated: State Licensing Order 1665 The following were found not to be substantiated: H5203072C, H5203076C, H5203074C, H5203073C, H5203071C, and H5203068.	2 000		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, and interview the facility failed to maintain a safe, sanitary and comfortable environment, affecting all 118 residents in the facility. Findings include: An environmental tour was conducted with the administrator on 2/13/19, at 11:00 a.m. The following items were observed and verified: - The door to unit 3 was heavily gouged and appeared very old and soiled. The window in the door had peeling paint around the trim. - Unit 3 hallway floor appeared un-mopped with a brown smear along the floor and liquid spills. - The bathroom in Unit 3 felt cold. The window was found to be un-latched. The windowsill and window track was soiled with dust and debris. - Unit 3 dining room had two movable tray tables with build up of soil on the framing. - The bathroom on unit 2 had dusty vents and	21665	Corrected	4/1/19

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21665	Continued From page 2 there was a mess of miscellaneous items on the floor. A shower stall area had wall covering removed exposing the interior. The administrator stated work had been done on frozen pipes. - The door frame to the bathroom on unit 2 was loose from deterioration in the wall. - Unit 4 dining room had a heavily smudged wall around the wall-mounted telephone. - The front stairwell used by staff and residents, appeared un-swept or cleaned with loose debris and soil. - First floor baseboards in the hallway at the entrance to the kitchen and the kitchen door, were soiled. - The 1st floor dining room baseboards, walls and windowsills were soiled with spills and/or food debris. The director of maintenance (DOM) was interviewed on 2/13/19, at 2:00 p.m. and verified cleaning of the stairwells was on an as needed basis. DOM indicated the mopping was to be completed twice a day, but was not on a schedule. Additionally, the DOM indicated the movable side tables were to be cleaned by the nursing assistants or the housekeeping staff. The DOM verified the facility was in process of acquiring additional housekeeping staff. A policy for housekeeping services was requested but not provided. Suggested Method of Correction: The administrator and director of housekeeping could review cleaning schedules to ensure all areas of the facility are maintained to acceptable standards. The administrator could inventory all broken and or significantly worn resident furniture for replacement. The administrator or designee could inventory facility environmental needs for	21665		

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21665	Continued From page 3 repair. Time period for completion: 30 days.	21665		