



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 20, 2024

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

RE: CCN: 245203
Cycle Start Date: February 26, 2024

Dear Administrator:

On March 14, 2024, the Minnesota Department 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,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 20, 2024

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

Re: Reinspection Results
Event ID: STCF12

Dear Administrator:

On March 14, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 26, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 1, 2024

Administrator
The Villas at Bryn Mawr, LLC
275 Penn Avenue North
Minneapolis, MN 55405

RE: CCN: 245203
Cycle Start Date: February 26, 2024

Dear Administrator:

On February 26, 2024, a 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 Villas at Bryn Mawr, LLC

March 1, 2024

Page 2

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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

The Villas at Bryn Mawr, LLC

March 1, 2024

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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 May 26, 2024 (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 August 26, 2024 (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/lrc_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

The Villas at Bryn Mawr, LLC


March 1, 2024

Page 4

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "H. Zahler". The signature is written in a cursive, slightly slanted style.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 1, 2024

Administrator
The Villas at Bryn Mawr, LLC
275 Penn Avenue North
Minneapolis, MN 55405

Re: State Nursing Home Licensing Orders
Event ID: STCF11

Dear Administrator:

The above facility was surveyed on February 21, 2024 through February 26, 2024, 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.

The Villas at Bryn Mawr, LLC

March 1, 2024

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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:

Annette Winters, Rapid Response Unit Supervisor

Metro 1, Golden Rule Office

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: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155

Office: 651-201-4384

Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BRYN MAWR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405
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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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F 000	<p>INITIAL COMMENTS</p> <p>On 2/21/24 through 2/26/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed. H52031014C(MN100876), H52031013C(MN100910), H52031040C(MN10032 and MN100031). Deficient practice was identified related to incidental finding at tag F686.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 686 SS=D	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p>	F 686		3/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/01/2024

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 686	<p>Continued From page 1</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to document their weekly skin assessments for 2 of 4 residents (R1 and R3) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R1's care plan dated 11/15/23, indicated he had a risk for developing skin breakdown related to bowel and bladder incontinence, and impaired mobility.</p> <p>R1's last weekly skin inspection dated 12/15/23, indicated he did not have any skin impairment.</p> <p>R1's treatment administration record (TAR) dated 2/1/24 through 2/23/24, indicated a nurse would complete a weekly skin assessment on the resident's bath day. They would then document their findings on a weekly skin inspection note located in the electronic medical record. On 2/2/24 the staff documented he was in the hospital when the skin evaluation was due. On 2/9/24 and 2/16/24, the nursing staff documented a check mark and their initials that the skin assessment was complete. The documentation did not indicate what their findings were.</p> <p>R1's significant change Minimum Data Set (MDS) dated 2/15/24, indicated he had severe cognitive impairment, mild depression, and no behaviors. He required extensive assistance from staff for all</p>	F 686	<p>For resident identified: R1 discharged from facility. R3 had a skin assessment completed.</p> <p>For all other residents: Full house audit was completed to ensure they had a skin check in the past week. Weekly skin check orders were updated in PCC for whole house.</p> <p>Education began with all licensed nurses on 2/23 regarding skin assessments and what to do if new wound is identified. Weekly skin check audit for whole house to be completed by DON or designee weekly x4 weeks- and then reviewed by QAPI</p>	

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F 686	<p>Continued From page 2</p> <p>activities of daily living (ADLS). He had a risk for developing skin injuries, but at the time of assessment his skin was intact.</p> <p>R3's last weekly skin assessment dated 12/20/23, indicated no skin impairment.</p> <p>R3's MDS dated 1/18/24, indicated he had normal cognition, was independent with all ADLs, and no identified wounds.</p> <p>During interview on 2/22/24 at 11:45 a.m., license practical nurse (LPN)-A stated all residents receive a head-to-toe skin assessment once a week on their bath day. Once the nurse completes the skin assessment, they document their findings in a weekly skin assessment note. If the resident refused the bath or the skin assessment the nurse would then document the refusal on a progress note. He added most nursing agency staff do not document their findings on the weekly assessment note.</p> <p>During interview on 2/22/24 at 11:55 a.m. clinical manager (CM)-A conducted a record review for R1 and stated he was unable to find a weekly skin assessment note since 12/20/2023. He stated the TAR order served as remind the nursing staff to complete a skin evaluation on their bath day. Once the assessment was completed the staff would document their findings on the weekly skin assessment note. He added documenting in the TAR would not be a substitute for completing the progress note because it did not document findings. He would expect his staff to follow the facility policy even if there were no skin issues.</p> <p>During interview on 2/22/24 at 2:30 p.m., the</p>	F 686		

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

PRINTED: 03/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/26/2024
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F 686	<p>Continued From page 3</p> <p>director of nursing (DON) stated it was her expectation that weekly skin assessments would be accomplished on each residence bath day. If the nurse were unable to do the assessment, she would expect a progress note explaining why it was not accomplished and what interventions they used to encourage the resident.</p> <p>During interview on 2/26/24 at 10:14 a.m., regional nurse coordinator (RNC)-A stated she reviewed R1 and R3's medical records and found the nursing staff were not documenting the weekly skin evaluations per facility protocol. She said the TAR documentation was a reminder for the staff to complete a skin assessment. Once they completed the assessment their findings would be documented on a weekly skin assessment form.</p> <p>The facility policy Skin Assessment & Wound Management dated 2/24, indicated a skin evaluation and risk factors would be completed upon admission, yearly, and when a change of condition occurred. Staff would perform routine skin inspections with their daily care and nurses would be notified of any changes in condition. In addition, a weekly skin inspection would be completed by a licensed nursing staff. New skin problems the nursing staff would notify the medical provider and family member. Education would be provided to the patient and the family to include risk and benefits. Staff would initiate a skin and wound evaluation and notify the nurse manager and wound nurse for follow up care. The facility dietitian would be notified for potential interventions. The residents care plan would be updated with risk for skin breakdown and interventions.</p>	F 686		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BRYN MAWR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/21/24 through 2/26/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

03/01/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BRYN MAWR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405
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2 000	<p>Continued From page 1</p> <p>H52031014C(MN100876), H52031013C(MN100910), H52031040C(MN10032 and MN100031), with an incident finding at tag 900.</p> <p>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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p>	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2024
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2 000	Continued From page 2	2 000		
2 900	<p>MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers</p> <p>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:</p> <p>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and</p> <p>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document their weekly skin assessments for 2 of 4 residents (R1 and R3) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>R1's care plan dated 11/15/23, indicated he had a risk for developing skin breakdown related to</p>	2 900	Corrected	3/8/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT BRYN MAWR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	<p>Continued From page 3</p> <p>bowel and bladder incontinence, and impaired mobility.</p> <p>R1's last weekly skin inspection dated 12/15/23, indicated he did not have any skin impairment.</p> <p>R1's treatment administration record (TAR) dated 2/1/24 through 2/23/24, indicated a nurse would complete a weekly skin assessment on the resident's bath day. They would then document their findings on a weekly skin inspection note located in the electronic medical record. On 2/2/24 the staff documented he was in the hospital when the skin evaluation was due. On 2/9/24 and 2/16/24, the nursing staff documented a check mark and their initials that the skin assessment was complete. The documentation did not indicate what their findings were.</p> <p>R1's significant change Minimum Data Set (MDS) dated 2/15/24, indicated he had severe cognitive impairment, mild depression, and no behaviors. He required extensive assistance from staff for all activities of daily living (ADLS). He had a risk for developing skin injuries, but at the time of assessment his skin was intact.</p> <p>R3's last weekly skin assessment dated 12/20/23, indicated no skin impairment.</p> <p>R3's MDS dated 1/18/24, indicated he had normal cognition, was independent with all ADLs, and no identified wounds.</p> <p>During interview on 2/22/24 at 11:45 a.m., license practical nurse (LPN)-A stated all residents receive a head-to-toe skin assessment once a week on their bath day. Once the nurse completes the skin assessment, they document their findings in a weekly skin assessment note. If</p>	2 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/26/2024
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2 900	<p>Continued From page 4</p> <p>the resident refused the bath or the skin assessment the nurse would then document the refusal on a progress note. He added most nursing agency staff do not document their findings on the weekly assessment note.</p> <p>During interview on 2/22/24 at 11:55 a.m. clinical manager (CM)-A conducted a record review for R1 and stated he was unable to find a weekly skin assessment note since 12/20/2023. He stated the TAR order served as remind the nursing staff to complete a skin evaluation on their bath day. Once the assessment was completed the staff would document their findings on the weekly skin assessment note. He added documenting in the TAR would not be a substitute for completing the progress note because it did not document findings. He would expect his staff to follow the facility policy even if there were no skin issues.</p> <p>During interview on 2/22/24 at 2:30 p.m., the director of nursing (DON) stated it was her expectation that weekly skin assessments would be accomplished on each residence bath day. If the nurse were unable to do the assessment, she would expect a progress note explaining why it was not accomplished and what interventions they used to encourage the resident.</p> <p>During interview on 2/26/24 at 10:14 a.m., regional nurse coordinator (RNC)-A stated she reviewed R1 and R3's medical records and found the nursing staff were not documenting the weekly skin evaluations per facility protocol. She said the TAR documentation was a reminder for the staff to complete a skin assessment. Once they completed the assessment their findings would be documented on a weekly skin assessment form.</p>	2 900		

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2 900	<p>Continued From page 5</p> <p>The facility policy Skin Assessment & Wound Management dated 2/24, indicated a skin evaluation and risk factors would be completed upon admission, yearly, and when a change of condition occurred. Staff would perform routine skin inspections with their daily care and nurses would be notified of any changes in condition. In addition, a weekly skin inspection would be completed by a licensed nursing staff. New skin problems the nursing staff would notify the medical provider and family member. Education would be provided to the patient and the family to include risk and benefits. Staff would initiate a skin and wound evaluation and notify the nurse manager and wound nurse for follow up care. The facility dietitian would be notified for potential interventions. The residents care plan would be updated with risk for skin breakdown and interventions.</p> <p>Based on interview and document review, the facility failed to document their weekly skin assessments for 2 of 4 residents (R1 and R3) when R1 was hospitalized with pressure ulcers.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days.</p>	2 900		