Electronically delivered
December 10, 2020

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

RE: CCN: 245203
Cycle Start Date: December 2, 2020

Dear Administrator:

On December 2, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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 January 09, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 9, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 9, 2021.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

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 $11,160; 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 January 9, 2021 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 January 9, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. 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 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
Metro C District 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: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division 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 June 2, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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: 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,

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

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of appropriate use of face masks.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

SOCIAL DISTANCING CONCERNS

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

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Develop and implement procedures and policies to provide for, and enforce social distancing among residents/staff.
- Develop and implement procedures and policies to provide for social distancing during dining and/or activities.
- Assess each individual resident's ability to understand or willingness to comply with social distancing and care plan interventions to promote compliance.
- Develop and implement procedures to educate and remind residents to practice social distancing.
- Follow current CDC and MDH guidance on communal dining. (i.e. clothe masks/6 feet apart)
- Follow current CDC and MDH guidance on communal activities. (i.e. clothe masks/6 feet apart)

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist, the Director of Nursing, all staff in the facility whether it be dietary, housekeeping staff, or activity staff. The training must cover the importance of social distancing of residents/staff/discontinuation of communal dining and activities. Online infection prevention training courses may be utilized. The Center for Disease Control (CDC) has specific COVID-19 training videos which cover social distancing and discontinuation of communal dining/activities.
https://www.cdc.gov/coronavirus/2019-ncov/communication/videos.html?Sort=Date%3A%3Adesc&Search=nursing%20home

Additional information may be used from the MDH COVID-19 Toolkit :
(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)

- Include documentation of the training completed with a timeline for completion.
- Include documentation of the training completed with a timeline for completion

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct rounds throughout the facility on each shift to ensure social distancing is being maintained by all staff and residents during various times of day and during various activities. The rounds will be conducted every day for four weeks, or until 100% compliance is obtained. Then the audits/monitoring may be decreased in frequency.

The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC

for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

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 12/02/2020

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 on 12/1/20 and 12/2/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §492.62. The facility was in full compliance.	E 000		
F 000	INITIAL COMMENTS On 12/1/20 and 12/2/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5203139C, with a deficiency cited at F880. The following complaints were found to be UNSUBSTANTIATED: H5203138C H5203140C Additionally, A COVID-19 Focused Infection Control survey was conducted on 12/1/20 and 12/2/20, at your facility by the Minnesota Department of 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 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 880 SS=F	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 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	F 880		12/29/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 2 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 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	F 880	F880: Infection Prevention and Control	

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F 880	Continued From page 3 review, the facility failed to follow the current CDC (Center for Disease Control) guidance for preventing the spread of COVID-19 in long term care facilities for 5 of 10 staff members (NA-A, H-A, LPN-A, RMM-A and H-B) who were observed to be wearing face masks inappropriately. This practice had the potential to affect 85 residents who were currently COVID-19 negative in the facility. In addition, the facility failed to implement to social distancing requirements to prevent the spread of Coronavirus Disease (COVID-19) during a facility led activity, which had the potential to affect 3 of 3 residents (R1, R2 and R3) engaged in the activity and the staff member leading the activity. Finding include: The CDC guidance entitled, People with Certain Medical Conditions, revised November 2, 2020, identified adults with certain underlying medical conditions such as kidney disease, diabetes, or lung disease, are at increased risk from the virus that causes COVID-19. The greatest risk is with advanced age and living in a congregate care setting. Severe illness from COVID-19 is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death. During interview and observation on 12/1/20, at 9:15 a.m. nursing assistant (NA)-A wore a face mask covering her mouth with nares (nostrils) exposed. NA-A was at the first floor nursing station standing less that 5 feet from the medication cart for 3 minutes while talking to another staff member who was less than 3 feet from NA-A. NA-A stated she had received education on how to prevent the transmission of COVID-19 and on how to appropriately wear a	F 880	Corrective Action: PPE Check in and screening area was moved to the back door on 12.1.2020. R1, R2, R3, R4, R5 and R6 were monitored daily for signs and symptoms for COVID-19. They are also tested weekly for COVID-19 and offered masks. All staff were educated on standard infection control practices, including transmission-based precautions, appropriate PPE use, and donning and doffing of PPE and completed a competency Activity staff were educated on maintaining social distance at all times during an activity Signs reading please keep your distance, one resident per table were placed on all tables in the dining/activity room to remind and enforce social distancing between staff/residents. The DON Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care. Infection preventionist and DON completed a root cause analysis to identify the problems that resulted in this deficiency and developed interventions and was reviewed by IDT. Identification of other residents: All residents are at risk for COVID-19 Monitoring Mechanism: The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts for appropriate use of face masks daily for four weeks, then twice weekly for one	

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	245203	A. BUILDING _____ B. WING _____	C 12/02/2020

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

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F 880	Continued From page 4 surgical face mask covering nose and mouth. During observation on 12/1/20, at 10:05 a.m. housekeeper (HK)-A wore a surgical face mask covering her mouth, with nares exposed. HK-A entered R4's room while R4 was seated in a chair, less than 3 feet from HK-A. HK-A cleaned the room for 5 minutes. R4's admission Minimum Data Set (MDS) dated 9/21/20, identified him as 71 years old with a diagnosis of hypertension (HTN). These comorbidities placed him at high risk for severe illness should he contract COVID-19, according to the CDC. When interviewed on 12/1/20, HK-A stated she was aware she should wear the mask covering her nose and mouth to prevent the spread of COVID-19 and did not explain why she was not. During observation on 12/1/20, at 10:24 a.m. HK-A entered R5's room with the surgical face mask only covering her mouth and not her nares again. HK-A cleaned there room for 10 minutes while R5 was in bed watching television. HK-A was often within 2-3 feet of R5. R5's quarterly MDS dated 10/8/20, identified him as 64 years old with diagnoses including HTN and diabetes. These comorbidities placed him at high risk for severe illness should he contract COVID-19. During observation on 12/1/20, at 11:45 a.m. HK-A entered R6's room continuing to wear the surgical face mask over her mouth, but not nose. HK-A cleaned the room for 11 minutes while R6 was in bed, often being within 2-3 feet of R6. R6's annual MDS dated 11/6/20, identified him as 74 years old with a diagnosis of liver disease, which placed him at risk for severe illness should he contract COVID-19.	F 880	week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents. The Director of Nursing, the Infection Preventionist, NHA and other facility leadership will conduct rounds throughout the facility on each shift to ensure social distancing is being maintained by all staff and residents during various times of day and during various activities. The rounds will be conducted every day for four weeks, or until 100% compliance is obtained. The Director of Nursing, Infection Preventionist, NHA or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.	

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F 880	Continued From page 5	F 880		

During observation on 12/1/20, at 11:47 a.m. licensed practical nurse (LPN)-A entered the facility without a face mask and stood at the COVID-19 screening area located at the first floor nursing desk inside a resident care area. LPN-A, without a facemask, proceeded to be screened by nursing assistant (NA)-B. After the two minute screening process NA-B gave LPN-A a surgical face mask which she then put on from a box of face masks located next to the screening thermometer on at the nursing desk. While not wearing a face mask LPN-A was in a resident care area within one foot of a medication cart with plastic drinking cups and medication cups and also standing within one foot of a wheeled portable vital signs monitor.

During interview on 12/1/20, at 12:04 a.m. NA-B stated she gave LPN-A a face mask after screening LPN-A and stated the expectation for staff entering the facility without a face mask is to put on a surgical face mask from the nursing desk immediately after entering.

During interview on 12/1/20, at 12:06 p.m. registered nurse (RN)-A stated not all staff entering the facility wear a face mask, and those staff get a face mask from the first floor nursing desk after getting screened in.

During observation on 12/1/20, at 1:15 p.m. regional maintenance manager (RMM)-A entered the facility without a face mask and was COVID screened at the screening area at the first floor nurses desk by NA-B. After the screening process was completed RMM-A was given a surgical facemask by NA-B and put the face mask on. While not wearing a face mask RMM-A was within one foot of a medication cart with

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F 880	Continued From page 6	F 880		

plastic drinking cups and medication cups and also standing within one foot of a wheeled portable vital signs monitor.

During observation on 12/1/20, at 1:20 p.m. signage located before entering the door to the first floor care area for screening read the following; "*Check in station #1 [first floor nurses desk]; *Fever check; *Receive mask."

During continuous observation on 12/1/20, at from 10:06 a.m. to 10: 52 a.m. HK-B wore a cloth face mask while restocking each of the 3 linen closets on each of the 3 wings on both first and second floor of the two floor facility. When interviewed on 12/1/20, at 10:52 a.m. HK-B stated she prefers the cloth face masks and wears a cloth face mask that she obtains from a supply at home while working in the facility. She could get a surgical mask from the facility, but chooses not to. She has been doing this for months. No one has told her she must wear a surgical mask.

During observation on 12/1/20, at 12:11 p.m. recreational services assistant (RCA)-A led a game of Farkle (dice game) with R1, R2 and R3 seated all in contact with a 30 inch by 48 inch table on the second floor dining room. Signage on the wall in the second floor dining room read, "Thanks for keeping your distance. 1 person per table." During the observed portion of the game which lasted greater than 15 minutes, R1, R2 and R3 passed a single set of dice and a dice shaking cup around the table without sanitization occurring between passes. During the game R1 was not wearing a face mask and no attempt was mad by RCA-A to
encourage R1 to wear a face mask. RCA-A

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F 880	Continued From page 7	F 880		

stated she was educated on keeping residents greater than 6 feet apart and she was aware that residents are required to be greater than 6 feet apart in the dining room and during activities. RCA-A stated usually their is another staff member that can assist, but due to the limited help available, she made the decision to use one table.

R1's quarterly MDS dated 11/16/20, identities him as 62 years old with a diagnosis of HTN. R2's admission MDS dated 11/2/20, identified him as 58 years old with a diagnosis of HTN. R3's quarterly MDS dated 10/15/20, identified her as 58 years old with diagnoses including a stroke, diabetes and lung disease. R1, R2, and R3 were at risk of severe illness should they contract COVID-19 due to their comorbidities, age and congregate living situation.

When interviewed on 12/2/20, at 8:41 a.m. housekeeping director (HD)-B stated, housekeeping staff should wear surgical masks covering their mouth and nose at all times while in the resident care areas to prevent the spread of COVID-19. Clothe face coverings were not allowed. He had educated the staff on this recently.

When interviewed on 12/2/20, at 9:00 a.m. recreational services director (RSD)-C stated activities staff are expected to enforce social distancing guidelines of a minimum of 6 feet between residents during activities and residents should use individual game equipment that is not shared and if it is shared it needed to be sanitized appropriately between individual usage. Staff had been educated on this to help prevent the spread of COVID-19 in the facility.

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F 880	Continued From page 8 When interviewed on 12/1/20, at 1:22 p.m. the director of nursing (DON) stated staff are to wear a surgical face mask at all times while in the resident care area, the mask needs to cover both the mouth and nose. Activities should ensure residents are maintaining social distance of at least 6 feet apart and should not be sharing equipment. When interviewed on 12/2/20, at 10:42 a.m. the administrator stated the facility does not have policy specific to COVID-19 precautions during activities and the facility practice is to follow the Centers for Medicare and Medicaid Services (CMS) guidelines. Which included, "Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering." Facility policy titled, Infection Prevention and Control Guideline dated 11/28/17, indicated, "1. Written standards, practices, and procedures for Infection Prevention and Control Program, include: c) Standard and transmission-based precautions to be followed to prevent the spread of infections, b) Selection and use of PPE [personal protective equipment]."	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2020

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

Re: Event ID: 9RY811

Dear Administrator:

The above facility survey was completed on December 2, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

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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 12/1/20 through 12/2/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaints were found to be UNSUBSTANTIATED: H5203138C and	2 000		

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2 000	Continued From page 1 H5203140C. NO licensing orders were issued. The following complaint was found to be substantiated, however no licensing orders were issued: H5203139C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		