Electronically Submitted
January 28, 2021

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

RE: CCN: 245203
Cycle Start Date: January 7, 2021

Dear Administrator:

On January 7, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 6, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 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:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 12, 2021, (42 CFR 488.417 (b)).

This Department is also recommending that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 12, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 12, 2021, (42 CFR 488.417 (b)).

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 $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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 7, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Villa At Bryn Mawr is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 7, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 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 July 7, 2021 (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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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

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

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 01/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/4/21, 1/5/21, 1/6/21, and 1/7/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5203148C at F689 and F609 H203146C at F600 The following complaints were fount to be unsubstantiated: H5203145C H5203147C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to provide the supervision and interventions necessary to prevent elopement for 1 of 3 residents (R1) reviewed for elopements, who subsequently eloped from the facility. R1 eloped from the	F 000	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 which are in violation of the state statute after the statement, "This Rule 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/04/2021

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F 000	Continued From page 1 facility on 1/1/21, from 12:54 p.m. to 6:00 p.m., traveling approximately seven miles in a busy urban area, with winter temperatures that ranged from 12 Fahrenheit (F) to 23 F without proper winter attire or mask to prevent Covid 19 infection. The survey resulted in an IJ to resident health and safety. The facility failed to ensure a functional wander alarm system and an immediate staff response upon the identification of a resident in the community and identification of a breach in the secured doors. The IJ began on 1/1/21, and the immediacy was removed on 1/6/21. The above findings constituted substandard quality of care, and an extended survey was conducted from 1/6/21 to 1/7/21.	F 000		
F 600 SS=D	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 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 600	F600: Free from abuse and neglect	2/9/21

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F 600	Continued From page 2 facility failed to prevent an incident of resident to resident abuse for 2 of 3 residents (R1, R3) reviewed for abuse. Findings include: R1's admission Minimum Data Set (MDS), dated 11/19/20, indicated R1 was admitted from a psychiatric hospital. R1 had severe cognitive impairment. R1 walked independently in corridor and room, and was independent in locomotion on unit and off unit. R1 had a diagnosis of non-traumatic brain dysfunction. R3's quarterly MDS, dated 12/31/20, indicated R3 was cognitively intact. R3 walked independently in corridor and room. R3 was independent in locomotion on unit and off unit. An incident report from the facility, dated 12/28/20, indicated R3 was sitting by the nursing station and asked for a cigarette. The trained medication assistant (TMA)-A informed R3 it was not smoking time yet. R1 and R3 became engaged in a verbal altercation. R1 placed his hands around R3's neck. Staff separated R1 and R3. R1 was placed on checks every 15 minutes. A skin assessment revealed R3 had a quarter size redness to wrist and superficial skin tear to left hand, requiring first aid. R3's skin observation, dated 12/28/20, indicated quarter size bruising noted to left side of Adams apple and left superficial skin tear to ring finger. On 1/4/21, at 12:50 p.m. R1 reported he could not recall any altercations with other residents. On 1/4/21, at 1:40 p.m. R3 reported, "He tried to	F 600	Corrective Action: R1 has been discharged, no further action can be taken R3 was monitored by nursing for any adverse effect and was offered to been seen by in house psychology All staff were educated on reviewing the residents care plan (Kardex) for behaviors and non-pharmacological interventions regarding residents individualized care plan to identify possible behavioral triggers before they occur Identification of other residents: All residents living in a skilled facility are at risk for abuse and neglect Nursing and social service staff were re-educated on Abuse, and Neglect policy/procedures. Abuse care plans on identified residents have been reviewed and updated to include behaviors that put the resident at risk. New patients will be reviewed/ evaluated upon admission for individuals risk factors for abuse, followed by the implementation of abuse prevention plans, and interventions. Monitoring Mechanism: Residents with identified behaviors will be monitored daily by all staff members using identified target behaviors. Target behavioral charting, and the effectiveness of behavioral interventions will be reviewed monthly by clinical team. IDT team will review, and update each residents care plan based upon resident□s clinical diagnosis, target behaviors, behavioral charting, interventions, medication management,	

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F 600	Continued From page 3 choke me right out of the clear blue. I was sitting down out by the front desk." R3 reported he had a bruise on his neck from the incident but thought it had resolved. On 1/4/21, at 3:47 p.m. TMA-B reported she observed R3 approaching her to get a cigarette. TMA-B was working on passing medication. TMA-B looked up and saw R1 standing over R3. R3 asked R1 to step back and R1 refused. R1 put his hands around R3's neck, stating "I am sick and tired of your attitude." TMA-B separated R3 and R1 and sought out a nurse and the administrator. R3 had a bruise and a little cut and blood on his neck. The facility policy on abuse, neglect, exploitation, mistreatment, and misappropriation of resident property, dated 11/28/17, directed staff that it was the policy of the facility that each resident will be free from "abuse". Abuse could include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. The resident would also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Additionally, residents would be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type would be tolerated, and residents and staff would be monitored for protection. The facility would strive to educate staff and other applicable individuals in techniques to protect all parties.	F 600	and clinical recommendations for residents with identified behaviors monthly, quarterly, and as needed A random group of 10 % of residents will be interviewed monthly to ensure residents feel safe, and free from abuse and neglect, results will be reviewed at QAPI to determine the need to continued monitoring for compliance.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		2/9/21

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F 609	Continued From page 4 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report neglect of a resident to the state agency (SA) within 24 hours for a resident with severe cognitive impairment who eloped from the facility for 1 of 4 residents (R1) reviewed for abuse and neglect. Findings include: R1's admission minimum data set (MDS), dated	F 609	F609: Reporting alleged violation Corrective Action: Elopement of R1 was reported to MDH on 1/5/21 NHA was educated on reporting obligations by region director of clinical operations Identification of other Resident: All residents are at risk for abuse Monitoring Mechanism	

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F 609	Continued From page 5 11/19/20, revealed R1 had severe cognitive impairment. R1 walked independently in corridor and room. R1 was independent in locomotion on unit and off unit. R1 had a diagnosis of non-traumatic brain dysfunction. R1 used a wander/elopement alarm daily. R1's Wander/Elopement Risk Evaluation, dated 11/19/21, indicated, R1 was at risk of wandering, elopement with risks factors including independent mobility, a history of leaving the building unsupervised, exit seeking and wandering the building, and early evening confusion. R1's care plan, dated 11/20/20, indicated R1 was at risk of elopement related to disorientation. The care plan goal was to keep R1 safe. R1's interventions included a photo on the list of wandering residents, distractions and diversions, staff assessment of wandering behavior motivation and triggers, offering to call family and a wander alert personal safety device on the left ankle. R1's nurse note, dated 1/1/21, at 3:06 p.m. indicated R1 was out of the building without staff knowledge. A code white, emergency code for missing resident, was called. R1's family, police and nurse practitioner were notified. On 1/4/21, at 3:09 p.m., the administrator reported she did not report to the SA that R1 left the building unsupervised as it was not considered an elopement by the facility. The administrator added the facility had identified R1 was missing within 3 minutes of leaving and the family found him unharmed in an old residence.	F 609	All wander events will be monitored, for reporting obligations, by RDCO for the next 90 days	

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F 609	Continued From page 6	F 609		

On 1/5/21, at 12:56 p.m., the administrator reported R1 left the building unsupervised on 1/1/21. The administrator reported facility staff notified her at 1:20 p.m. they could not find R1, had called a code white. The administrator reported she received a call at 4:45 p.m. from R1's family member (FM)-B to notify her R1 was found at an apartment complex he had previously resided at with his mother. The administrator reported the family returned R1 to the facility at 6:00 p.m. R1 was at a previous residence, approximately 7.5 miles from facility. It was unclear how R1 traveled to the residence.

On 1/5/21, at 3:19 p.m. security footage for 1/1/21, at 12:54 p.m. was observed with the administrator and director of nursing. Administrator reported there was no audio available on the security footage. At 12:54 p.m., R2 was observed walking into the lobby and sitting down in a chair near the front door. About 20 seconds later, R1 was observed approaching the front door, paused and then turned towards R2. R1 turned back to the door, pushed at and held the door. The door opened. R1 walked out of the building wearing a red sweatshirt, gray pants, athletic shoes and green undershirt. R1 was not wearing a a coat, hat, gloves, mittens or a mask. The door remained open. LPN-C approached the open door at 12:58 p.m., went through the open door outside and then returned inside at 12:59 p.m. and was pulling at the door. At 1:00 p.m. NA-A walked to the lobby and stood near LPN-C.

The facility abuse, neglect, exploitation, mistreatment and misappropriation of resident property, dated 11/28/17, directed staff, "Neglect is the failure of the facility, its employees or service providers to provide goods and services

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 01/07/2021

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 609	Continued From page 7 to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." and "It is the policy of this facility that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures."	F 609		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to keep the resident safe	F 689	F689: Free from Accidents Hazards/Supervision	2/9/21

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 01/07/2021

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 689	Continued From page 8 for 1 of 3 residents (R1) whom was identified at risk for elopement that resulted in an immediate jeopardy (IJ). The facility failed to prevent the elopement of R1, who had severe cognitive impairments, for approximately four hours in below freezing winter temperatures without appropriate winter attire resulting in risk of potential serious harm, injury, impairment, or death for 1 out of 3 residents (R1) reviewed for risk of elopement. The immediate jeopardy began on 1/1/21 at 12:48 p.m. when R1 whom had a security alert alarm on his ankle, breached the secured doors at front entrance without any alarms sounding to alert staff. Staff were not aware R1 was gone until 1:06 p.m. and police were notified. R1 was found approximately 7.6 miles from the facility later that evening. The administrator and director of nursing (DON) were notified of the immediate jeopardy at on 1/5/21, at 5:50 p.m. The immediate jeopardy was removed on 1/6/21, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission Minimum Data Set (MDS) dated 11/19/20, indicated R1 had severe cognitively impairment, and was able to ambulate independently. The MDS indicated R1 had a diagnosis of non-traumatic brain dysfunction, and used a wander/elopement alarm daily. R1's Wander/Elopement Risk Evaluation dated 11/19/20, indicated R1 was at risk of wandering and elopement, with risks factors including	F 689	Corrective Action: Identified resident, R1, has returned to the facility and been re-evaluated. Currently plan of care includes a wanderguard that has been placed on R1. Care plan has been reviewed and is appropriate. The resident received an assessment upon return and was found to be free of injury. Both provider and family have been updated. Facility working with resident□s provider to ensure resident safety. Points of exit and entrance have been checked to ensure door alarms are functioning appropriately. Wanderguard alarms have received sensor checks to ensure wander guard alarm system alert. An additional alarm has been added to the front door when the emergency lock is released to alert staff that door has been opened. Dietary, housekeeping, nursing, therapy, and administration staff have been educated, prior to next shift, on ensuring that doors are secured, responding to door alarms, and following resident plans of care related to safety checks and plans of care. Code drills for a potential breach in the elopement system have been completed for all 3 shifts. Identification of other Residents: Residents that reside at Bryn Mawr a Villa center have been assessed for elopement risk. Residents who are at risk for elopement have received care plan updates to ensure resident safety. Care plan updates include resident photo added to wander list, staff aware of wander risk, wander guard added.	

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 01/07/2021

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 689	Continued From page 9 independent mobility, a history of leaving the building unsupervised, exit seeking and wandering the building, and early evening confusion. A progress note dated 11/20/20, at 8:36 a.m. indicated, "Wander guard [wander alarm] placed on L [left] ankle based on residents wander assessment and resident being observed outside of the facility." R1's care plan dated 11/20/20, indicated R1 was at risk of elopement related to disorientation. The care plan goal was to keep R1 safe. R1's interventions included a photo on the list of wandering residents, distractions and diversions, staff assessment of wandering behavior motivation and triggers, offering to call family and a wander alert personal safety device on the left ankle. Review of R1's December 2020 medication and treatment administration record [MAR/TAR] included an order to check functioning and placement of wander device every shift. On the night shift 12/29/20, 12/30/20, 12/31/20 this was marked by a licensed practical nurse (LPN)-B as not completed for R1. TMA-B marked this task as not completed on 12/30/20 evening shift and 12/31/20 day shift. On the day shift for 1/1/21, this order was marked by (LPN)-C as not completed with a note to see nurses notes. There was no indication if R1's alarm was functioning properly during these time frames. R1's nurse note dated 1/1/21, at 3:06 p.m. indicated R1 was out of the building without staff knowledge. A Code White (the emergency code for a missing resident) was called. Family, police	F 689	Residents that are currently not on the locked unit but have been assessed as an elopement risk have received checks to ensure wanderguards are functioning appropriately. Nursing staff have also been educated on checking placement of wanderguards every shift and checking wanderguard functioning once daily. Monitoring Mechanism: Daily audits will be conducted by NHA/designee to ensure door alarms are functioning properly for 30 days and then weekly after 30 days. Nursing staff will be checking placement of wanderguards every shift and checking wanderguard functioning once daily. Nursing leadership will randomly audit Wandgergaurd checks for 30 days to ensure placement and function. After 30 days will continue with weekly audits. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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 01/07/2021

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 689	Continued From page 10	F 689		

and the nurse practitioner were notified.

The facility investigation of R1 elopement identified the following:

Licensed practical nurse (LPN)-D's interview/statement record form dated 1/1/21, indicated LPN-C notified LPN-D that the front doors were left open. Housekeeper (H)-A notified LPN-D that he observed R1 heading towards a nearby store. H-A and LPN-D checked the store and did not find R1. LPN-D then notified the facility administration of R1's elopement, and began searching for R1 in her vehicle. This statement was part of a facility investigation.

Nursing assistant (NA)-A's interview/statement record form undated, indicated the wander alarm did not sound. NA-A accounted for all of her residents after the code white was initiated, and noted R1 was missing.

LPN-C's interview/statement record form dated 1/1/21, indicated LPN-C was serving lunch when she noticed the sliding doors were out of their tracks. This resulted in the doors being open. LPN-C tried to fix the doors. H-A notified her that he observed R1 at the nearby store. LPN-C stated the wander alarm system did not sound. LPN-C did not check R1's wander alarm placement that day, noting she did not have a chance. A Code White was initiated. This statement was part of a facility investigation.

An email from the front desk receptionist (FDR) dated 1/4/21, indicated FDR came in to the facility to give a vendor cash, and restock candy store at around noon. The vendor was already in the building. FDR left around 12:20 p.m., let the

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 01/07/2021

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 689	Continued From page 11	F 689		

vendor out the front doors, and locked both outside and inside doors securely.

H-A's interview/statement record undated, indicated H-A was on a break outside, walking to the local store and engaged in a phone conversation. H-A observed R1 near the store. H-A returned to the facility and notified LPN-D he observed R1 at the store. H-A could not recall R1's behavior or what he was wearing, noting he was preoccupied with a phone call.

R2's interview/statement record dated 1/5/21, indicated R2 stated, "I told [R1] how to get outside. I thought he was coming right back." This statement was part of a facility investigation.

On 1/4/21, at 1:26 p.m. the DON was interviewed and stated R1 walked and paced hallways in the facility, and at times appeared tense. The DON stated R1 could be kind and sweet one moment, and explosive the next. During the interview, R1 approached the DON, and stated his head felt "clogged" and "overbearing." The DON took a set of vitals, and encouraged R1 to sit down, and ask for help when he felt dizzy.

On 1/4/21, at 3:09 p.m., the administrator reported she did not report to the SA that R1 left the building unsupervised as it was not considered an elopement by the facility. The administrator added the facility had identified R1 was missing within 3 minutes of leaving and the family found him unharmed in an old residence. The administrator reported she would provide all follow up related to this incident.

On 1/5/21, at 10:19 a.m. LPN-A was interviewed

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 01/07/2021

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 689	Continued From page 12	F 689		

and stated she was unsure if R1 had a wander alarm. LPN-A pulled up R1's sweat pants, and a wander alarm bracelet was present on R1's left ankle. LPN-A demonstrated how she checked functioning by putting a portable sensor near R1's wander alarm, and R1's sensor beeped. R1 twice walked up to within a few feet of the exit doors for the unit and turned around, without pushing on the door.

On 1/5/21, at 10:26 a.m. trained medication aide (TMA)-A stated she checked R1's wander alarm to ensure it was present on his ankle. TMA-A stated she was not aware of a method to ensure it was functioning. TMA-A stated R1 was not allowed to go on outings on his own. The nurse or the TMA working the cart was responsible for checking the wander alarm system.

On 1/5/20, at 11:34 a.m. R1's follow up from the incident was provided by administrator. The follow up included interviews with staff about the incident, but no prevention plan or education.

On 1/5/21, at 11:46 a.m. R1 stated he did not recall leaving the building, "I don't remember. It might come back to me."

On 1/5/21, at 12:04 p.m. TMA-B was interviewed and stated R1 had a wander alarm on his leg. TMA-B stated she checked to see if it was functioning with a portable sensor in the medication cart. TMA-B stated R1 wandered, and needed direction to locate his room.

On 1/5/21 at 12:22 p.m. LPN-B was interviewed and stated R1 had a wander alarm. LPN-B stated he worked with R1 on night shifts, including night of 12/31/21. LPN-B stated he did not check to

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 01/07/2021

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 689	Continued From page 13	F 689		

verify presence and function of R1's wander alarm if R1 was in bed during his shift. LPN-B stated R1 was normally in bed during his shift.

On 1/5/21, at 11:06 a.m. LPN-C was interviewed and stated R1 walked around the building a lot. LPN-C stated she was serving lunch on the day R1 left, when she noted the door was open. LPN-C stated she looked around, and called a Code White to alert staff of a missing resident. R1 did not tell LPN-C he was leaving. R1 did not sign out. LPN-C stated, "He escaped." LPN-C stated a vendor and the receptionist had been at the desk earlier in the day. LPN-C stated R1 rarely wore shoes so he must have seen an opportunity to leave and put his shoes on. LPN-C stated a staff member told her R1 had left the building. LPN-C stated the wander alarm system did not sound and she was concerned because of the opened front door. LPN-C stated R1 had been wearing gray or khaki pants and a sweater that day, and was not sure if he had a coat on when he left. LPN-C explained R1 was not supposed to leave the building without supervision. LPN-C stated she had not had time to check R1's wanderguard functioning that day, but saw it on his left leg. LPN-C noted it was a busy day, she was the only nurse on the unit where R1 resided and she had too much work to do.

R2's quarterly MDS dated 10/9/20, indicated no assessment of R2's cognition. R2 was able to ambulate independently, and had diagnoses that included bipolar disorder, and schizophrenia. R2 was not noted as using a wander/elopement alarm. R2's admission MDS, dated 7/10/20, revealed R2 was cognitively intact and had

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 01/07/2021

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 689	Continued From page 14	F 689		

delusions.

On 1/5/21, at 12:50 p.m. R2 was interviewed and stated he instructed R1 how to leave the building by pushing and holding the front door, facing Penn Avenue. R2 reported no alarm went off. R2 reported he witnessed R1 leave the building. R2 did not recall what R1 was wearing, but reported, "He wasn't wearing much" and noted R1 was not wearing a coat when he left.

During an observation on 1/5/21, at 12:56 p.m. R2, with a wander guard on his ankle showed administrator and director of maintenance how he could walk through the door without triggering the alarm. Even though R2 wore a wander guard on the ankle, similar to R1, the door did not alarm. During interview at this time, the director of maintenance and administrator explained when the door is pushed and held, it released and opens due to fire safety. They explained the wander guard sensor was separate and attached to the side of the door frame, approximately 2 feet off the ground. The alarm should have sounded when the door was opened if the resident had an wander guard on.

On 1/5/21, at 2:08 p.m. the front desk receptionist (FDR) was interviewed and stated she came in to the facility at noon on 1/1/21, for approximately 15 minutes to assist a vendor. The FDR stated she did not see R1 leave the building. The FDR stated she did ensure the door was locked prior to leaving. The FDR stated she worked at the front desk and had seen R1 walk towards the door. The FDR stated she redirected R1 when he approached the front door. The FDR stated she could not recall if R1 had ever pushed at the door before. The FDR stated she worked the day shift

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 01/07/2021

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 689	Continued From page 15	F 689		

and there was not another receptionist that replaced her when she left. FDR stated she was aware R1 was not to leave the building because of her familiarity with the residents, and because of a book at the front desk with pictures that had residents at risk for elopement in it.

On 1/5/21, at 12:56 p.m. the administrator was interviewed and stated the facility completed wander and elopement assessments at admission, quarterly, and as needed. The administrator stated R1 left the building unsupervised on 1/1/21. The administrator stated facility staff notified her at 1:20 p.m. they could not find R1, had called a Code White, and a staff person had seen R1 at the corner store nearby the facility. The administrator stated she arrived at facility at 1:45 p.m. and the police were already onsite. The administrator stated she finished speaking with police at 2:15 p.m., and left a message for R1's family to notify them R1 had left the building. The administrator stated she sent nursing staff to look for R1 with their cars, and also went looking for R1 in her vehicle. The administrator stated family member (FM)-B informed her of the location R1 had previously worked, so she went to look for him at that location. The administrator stated she received a call at 4:45 p.m. from FM-B to notify her they found R1 at an apartment complex he had previously resided with his mother. The administrator stated the family returned R1 to the facility at 6:00 p.m. The administrator stated R1 was allowed to leave the building on his own, however, R1 used a wander alarm due to his cognition. The administrator stated she viewed the video, of R1 leaving the facility, R1 pushed the front door and it did not do anything. Then R1 turned towards R2, who was sitting nearby,

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 01/07/2021

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 689	Continued From page 16	F 689		

pushed on the door and proceeded out of the building.

A Microsoft electronic map of Minneapolis indicated a distance of 7.6 miles between the location of the facility and the location where R1 was found by family.

Review of the National Weather Service historical weather data for 1/1/21, indicated the weather was 23 degrees Fahrenheit for a high and 12 degrees Fahrenheit for a low that day.

On 1/5/21, at 1:00 p.m. the administrator and environmental director (ED) observed the functioning of the front door and wander alarm system with the surveyor. A sensor was placed on the door frame approximately 18 to 24 inches from the ground as well as about shoulder height. The door was a sliding door, but opened and stayed open after being pushed and held with force due to fire code. R2, sitting in the lobby, walked through the front door with a wander alarm on his ankle. No alarm sounded. R8, a resident sitting in the lobby nearby, had a wander alarm on his wrist which triggered the alarm system. The administrator stated it may be the positioning of the wander alarm that caused the alarm not to activate. The administrator stated she instructed nursing staff to move wander alarms to resident's wrists, but R2 must have "slipped by." The administrator stated there was frequently a receptionist at the door during the day shift, but not during night or evening shifts.

On 1/5/21, at 3:19 p.m. security footage for 1/1/21, at 12:54 p.m. was observed with the administrator and DON. The administrator stated there was no audio available on the security

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 01/07/2021

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 689	Continued From page 17	F 689		

footage. At 12:54 p.m. R2 was observed walking into the lobby and sitting down in a chair near the front door. About 20 seconds later, R1 was observed approaching the front door, paused and then turned towards R2. R1 then turned back to the door, pushed at and held the door. The door opened. R1 walked out of the building wearing a red sweatshirt, gray pants, athletic shoes and green undershirt. R1 was not wearing a a coat, hat, gloves, mittens or a mask. The door remained open. LPN-C approached the open door at 12:58 p.m., went through the open door outside, and then returned inside at 12:59 p.m. and was pulling at the door. At 1:00 p.m. NA-A walked to the lobby and stood near LPN-C.

During interview on 1/5/21, at 3:19 p.m. the administrator stated residents had a "right to leave the facility" and explained, "We can't lock them in." The DON stated residents would be asked to sign a form saying they were leaving against medical advise if they wanted to leave the facility without discharge orders. The administrator stated R1 had a purpose to his leaving, wanting to go home, made his way to a location and was found in a safe location. The administrator stated R1 was safe to leave the facility "if he knows where he is going." The administrator stated R1 had short term memory impairments, but good long term memory. R1's wander and elopement risk assessment was completed in November 2020, and he had a wander alarm placed on him due to confusion and short term memory impairments. The administrator reported she reviewed the manufacture recommendations and residents were able to wear the wander alarm on the wrist or ankle. The administrator reported an additional alarm had been purchased to sound when the

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 01/07/2021

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 689	Continued From page 18	F 689		

door was open. This had not been installed. A receptionist was present at the front door only during business hours. There were no additional prevention measures were in place, such as education of staff or reassessment of R1 and other residents with wanderguard. Also, there was no indication residents whom had wanderguards located on their ankles had these checked to ensure they were functioning properly at the exit doors with the current alarm system.

Review of R1's Wander/Elopement Risk Evaluation, updated on 1/5/21, at 7:28 p.m., revealed R1 was assessed as having a history of wandering and elopement, cognitively impaired, ambulatory, independently mobile, physically able to leave the building on his own and had a history of elopement attempts. R1 was assessed as appropriate for a wander alert personal safety device on his left ankle.

On 1/6/21, at 10:01 a.m. housekeeper (H)-A was interviewed and stated he was outside smoking a cigarette on break on 1/1/21, at 1:00 p.m. about a half a block from the facility. H-A stated he was engaged in a conversation on his cell phone and then entered a nearby store and observed R1 in the same location. H-A stated he returned to the facility and notified LPN-D that he had seen R1 at the store. H-A stated he was not paying attention to R1's behaviors or clothing. H-A estimated he saw R1 at the store at approximately 1:06 p.m.

On 1/6/21, at 10:34 a.m. R1's primary care nurse practitioner (NP)-A was interviewed and stated R1 had amnesia. NP-A stated she was concerned about R1 leaving, and did not want R1 to leave the facility unsupervised again. NP-A stated R1 was not safe to be outside the facility

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 01/07/2021

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F 689	Continued From page 19	F 689		

unsupervised. NP-A worried R1 was at risk of harm if he left the facility unsupervised. NP-A stated it was fortunate R1 worked off long term memory, and his familiarity with the area of the metro he resided to find a familiar location. NP-A stated it would not be reasonable to expect R1 would learn and retain new information. NP-A stated R1 had a short attention span, and anxiety built throughout the day. R1 was always needing reassurance about his surroundings, which were unfamiliar to him. R1 exhibited aggression towards others when he misinterpreted their actions. NP-A stated she was the on call provider the day of R1's elopement, and was not notified of R1's elopement. NP-A stated the facility notified her of the elopement on 1/5/21, at 6:30 p.m., four days after the event occurred. NP-A stated she would expect to be notified of R1's elopement on the same day it occurred.

On 1/7/21, at 9:21 a.m. family member (FM)-A was interviewed and stated he was aware of R1's leaving the facility without supervision because of a phone call from the facility on 1/1/21 at 2:52 p.m., as well as phone calls to FM-B at 3:32 p.m. FM-A stated several family members started searching for R1 in areas R1 had previously worked, visited, and resided. FM-A reported FM-B found R1 at 4:55 p.m. at an apartment building lobby where he had previously resided with FM-D. FM-A then met R1 at the apartment building. FM-A stated R1 had not lived there in several months and had since traveled, lived with FM-A and FM-C, was at the hospital, and resided at the facility for past couple months. FM-D also no longer lived at the apartment complex. FM-A stated R1 was wearing summer weight sweat pants, a long sleeve shirt, possibly an undershirt and mesh slip on shoes. FM-A stated R1 was not

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	245203	A. BUILDING _____ B. WING _____	C 01/07/2021

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F 689	Continued From page 20	F 689		

wearing a mask, coat, hat or mittens/gloves, despite traveling approximately seven miles from facility to apartment complex in winter weather. FM-A reported R1 did not appear injured, but was coughing and appeared "fuzzy" with a troubled, furrowed brow. FM-A thought R1 might be thirsty, so FM-A purchased R1 an electrolyte beverage and a bag of chips. FM-A stated R1 was less "hazy" after drinking and eating a little. FM-A stated R1 previously resided with FM-A and FM-C prior to being hospitalized, and transferred to the facility. FM-A stated R1 could not safely travel on his own. FM-A and FM-C had previously provided supervision for walks and travel in the community when R1 resided with them due to concerns with R1's cognition FM-A stated, "We knew if he was away from us that he would probably be lost." FM-A stated R1 had become lost for approximately one month, 3/26/20, to 4/26/20, while traveling internationally during the past year, related to impaired cognition and use of intoxicating substances. FM-A stated this required intervention from the United States Embassy and family escort to return R1 safely home. FM-A stated he was disappointed the facility had lost track of the whereabouts of R1 for several hours, as they were in charge of keeping him safe.

On 1/7/21, at 10:34 a.m. LPN-D was interviewed and stated she was working on station two, and an unidentified nurse notified her the front doors were open. LPN-D stated she directed the unidentified nurse to call a Code White, and determine if any residents were missing. LPN-D stated staff searched the building and nearby building on foot as well as farther out, in vehicles. LPN-D stated R1 should not have been able to leave the building on his own as he was not safe to be on the streets alone. LPN-D stated there

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	245203	A. BUILDING _____ B. WING _____	C 01/07/2021

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F 689	Continued From page 21	F 689		

was no alarm sounding when she approached the front door.

On 1/7/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release his anger, which meant he exploded and had been physically and verbally aggressive towards others when he was frustrated. R1 had a variable attention span. At times R1 could be preoccupied for an hour with an activity and at times, only 5 minutes. LPN-D stated R1 was not allowed to leave the building unsupervised. LPN-D explained R1 was not safe to leave on his own due to cognition.

On 1/7/21, at 11:33 a.m. R1 was observed resting under his covers on his bed in a private room. R1 had moved rooms and was in an unsecured unit on the 1st floor. R1 reported he was not sure where he was but named a rural town. R1 noted he was employed and lived with FM-A and FM-C.

On 1/12/21, at 3:32 p.m. R1's mental health case manager (CM) was interviewed and stated R1 was not safe in the community without appropriate supports due to cognition, short term memory, and orientation. CM noted he had been informed R1 was found without a coat on and in a previous residence. CM was notified of R1's elopement by family, and then several days later by the facility. CM reported he would expect the facility to notify him in a timely fashion for appropriate coordination of care.

The Wandering and Elopement Guideline dated 3/16/17, directed staff upon admission, re-admission, through quarterly review and change in condition residents would be evaluated

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 01/07/2021

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F 689	Continued From page 22	F 689		

for potential elopement risk to determine appropriate placement within the facility. Residents identified at risk would have an elopement risk bracelet placed on them, such as a wander alarm. Bracelets would have validation of functioning and expiration prior to placement. Bracelets would be checked for placement and functioning every shift. Expiration of the bracelet would be checked for functioning and placement every shift. Each facility would have a process to communicate the admission or re-admission of a resident at risk for elopement across all units. Representatives would receive education, upon admission, regarding memory care unit security, as applicable.

The facility Observation of a Resident Exiting the Facility procedure dated 3/16/17, directed staff to attempt to prevent the departure- provide diversional techniques, re-direction and apply resident specific intervention as directed by the plan of care. The procedure also directed staff to obtain assistance from staff members in the immediate vicinity. Instruct another staff member to inform the charge nurse or director of nursing assistance is required."

The facility Missing Resident procedure dated 3/16/17, directed staff to conduct an organized search immediately when a resident was determined missing. Staff were also directed to report immediately to the Charge Nurse missing, OR a suspected missing resident. The Charge Nurse should immediately determine if resident was on an authorized leave, pass or medical appointment; announce on the overhead paging system for "CODE WHITE" followed by the resident room number. Code White was a code to notify the staff that a resident was missing.

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F 689	Continued From page 23	F 689		

After the resident is found, notify the charge person (the charge person will notify the Administrator, Director of Nursing and police). Upon return of the resident to the facility, the Director of Nursing or Charge nurse should: Examine the resident for injuries. Consult with the attending physician and report findings and condition of the resident. Notify the Resident Representative.

The Touchpad Exit Controller Administration Guide, dated 7/2018, directed users, "Resident generated alarms-Do no rely exclusively on resident generated alarms for resident care and safety. The alarm function of equipment in the possession of residents must be verified periodically and regular resident surveillance is recommended." The guide further directed users, "Resident Monitoring-The most reliable method of resident monitoring combines close personal surveillance with correct operation of monitoring equipment. It is the responsibility of the facility to periodically check on residents in possession of RF Technologies Inc.'s equipment (i.e. pendants, pull cords, control units) to mitigate risks of inappropriate use of equipment or strangulation and stumbling hazards from cables and cords."

The immediate jeopardy that began on 1/1/21, was removed on 1/6/21, when the facility educated all staff on elopement procedures, audited functioning of wander alarm system, ensured each resident with a wander alarm had a wander/elopement assessment and care plan in place, and ensured treatment orders in place to monitor presence and functioning of wander alarms for each resident with a wander alarm in place, but the noncompliance remained at the lower scope and severity level of a D, isolated

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F 689	Continued From page 24 scope and severity level, which is no actual harm, with potential for more than minimal harm that is not immediate jeopardy.	F 689		

Electronically delivered
January 28, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 18J411

Dear Administrator:

The above facility was surveyed on January 4, 2021 through January 7, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

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

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

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

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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,

Kamala Fiske-Downing

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

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 01/07/2021

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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 1/4/21, 1/5/21, 1/6/21 and 1/7/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT be in compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H5203147C H203145C The following complaints were found to be SUBSTANTIATED: H5203146C H5203148C 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		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to keep the resident safe for 1 of 3 residents (R1) whom was identified at risk for elopement that resulted in an immediate jeopardy (IJ). The facility failed to prevent the elopement of R1, who had severe cognitive	21995	na	2/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21995	Continued From page 2	21995		

impairments, for approximately four hours in below freezing winter temperatures without appropriate winter attire resulting in risk of potential serious harm, injury, impairment, or death for 1 out of 3 residents (R1) reviewed for risk of elopement.

The immediate jeopardy began on 1/1/21 at 12:48 p.m. when R1 whom had a security alert alarm on his ankle, breached the secured doors at front entrance without any alarms sounding to alert staff. Staff were not aware R1 was gone until 1:06 p.m. and police were notified. R1 was found approximately 7.6 miles from the facility later that evening. The administrator and director of nursing (DON) were notified of the immediate jeopardy at on 1/5/21, at 5:50 p.m. The immediate jeopardy was removed on 1/6/21, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include:

R1's admission Minimum Data Set (MDS) dated 11/19/20, indicated R1 had severe cognitively impairment, and was able to ambulate independently. The MDS indicated R1 had a diagnosis of non-traumatic brain dysfunction, and used a wander/elopement alarm daily.

R1's Wander/Elopement Risk Evaluation dated 11/19/20, indicated R1 was at risk of wandering and elopement, with risks factors including independent mobility, a history of leaving the building unsupervised, exit seeking and wandering the building, and early evening confusion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21995	Continued From page 3	21995		

A progress note dated 11/20/20, at 8:36 a.m. indicated, "Wander guard [wander alarm] placed on L [left] ankle based on residents wander assessment and resident being observed outside of the facility."

R1's care plan dated 11/20/20, indicated R1 was at risk of elopement related to disorientation. The care plan goal was to keep R1 safe. R1's interventions included a photo on the list of wandering residents, distractions and diversions, staff assessment of wandering behavior motivation and triggers, offering to call family and a wander alert personal safety device on the left ankle.

Review of R1's December 2020 medication and treatment administration record [MAR/TAR] included an order to check functioning and placement of wander device every shift. On the night shift 12/29/20, 12/30/20, 12/31/20 this was marked by a licensed practical nurse (LPN)-B as not completed for R1. TMA-B marked this task as not completed on 12/30/20 evening shift and 12/31/20 day shift. On the day shift for 1/1/21, this order was marked by (LPN)-C as not completed with a note to see nurses notes. There was no indication if R1's alarm was functioning properly during these time frame.

R1's nurse note dated 1/1/21, at 3:06 p.m. indicated R1 was out of the building without staff knowledge. A Code White (the emergency code for a missing resident) was called. Family, police and the nurse practitioner were notified.

The facility investigation of R1 elopement identified the following:

Licensed practical nurse (LPN)-D's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 4 interview/statement record form dated 1/1/21, indicated LPN-C notified LPN-D that the front doors were left open. Housekeeper (H)-A notified LPN-D that he observed R1 heading towards a nearby store. H-A and LPN-D checked the store and did not find R1. LPN-D then notified the facility administration of R1's elopement, and began searching for R1 in her vehicle. This statement was part of a facility investigation. Nursing assistant (NA)-A's interview/statement record form undated, indicated the wander alarm did not sound. NA-A accounted for all of her residents after the code white was initiated, and noted R1 was missing. LPN-C's interview/statement record form dated 1/1/21, indicated LPN-C was serving lunch when she noticed the sliding doors were out of their tracks. This resulted in the doors being open. LPN-C tried to fix the doors. H-A notified her that he observed R1 at the nearby store. LPN-C stated the wander alarm system did not sound. LPN-C did not check R1's wander alarm placement that day, noting she did not have a chance. A Code White was initiated. This statement was part of a facility investigation. An email from the front desk receptionist (FDR) dated 1/4/21, indicated FDR came in to the facility to give a vendor cash, and restock candy store at around noon. The vendor was already in the building. FDR left around 12:20 p.m., let the vendor out the front doors, and locked both outside and inside doors securely. H-A's interview/statement record undated, indicated H-A was on a break outside, walking to the local store and engaged in a phone conversation. H-A observed R1 near the store.	21995		

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 01/07/2021

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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21995	Continued From page 5	21995		

H-A returned to the facility and notified LPN-D he observed R1 at the store. H-A could not recall R1's behavior or what he was wearing, noting he was preoccupied with a phone call.

R2's interview/statement record dated 1/5/21, indicated R2 stated, "I told [R1] how to get outside. I thought he was coming right back." This statement was part of a facility investigation.

On 1/4/21, at 1:26 p.m. the DON was interviewed and stated R1 walked and paced hallways in the facility, and at times appeared tense. The DON stated R1 could be kind and sweet one moment, and explosive the next. During the interview, R1 approached the DON, and stated his head felt "clogged" and "overbearing." The DON took a set of vitals, and encouraged R1 to sit down, and ask for help when he felt dizzy.

On 1/4/21, at 3:09 p.m., the administrator reported she did not report to the SA that R1 left the building unsupervised as it was not considered an elopement by the facility. The administrator added the facility had identified R1 was missing within 3 minutes of leaving and the family found him unharmed in an old residence. The administrator reported she would provide all follow up related to this incident.

On 1/5/21, at 10:19 a.m. LPN-A was interviewed and stated she was unsure if R1 had a wander alarm. LPN-A pulled up R1's sweat pants, and a wander alarm bracelet was present on R1's left ankle. LPN-A demonstrated how she checked functioning by putting a portable sensor near R1's wander alarm, and R1's sensor beeped. R1 twice walked up to within a few feet of the exit doors for the unit and turned around, without pushing on

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 01/07/2021

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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21995	Continued From page 6 the door. On 1/5/21, at 10:26 a.m. trained medication aide (TMA)-A stated she checked R1's wander alarm to ensure it was present on his ankle. TMA-A stated she was not aware of a method to ensure it was functioning. TMA-A stated R1 was not allowed to go on outings on his own. The nurse or the TMA working the cart was responsible for checking the wander alarm system. On 1/5/20, at 11:34 a.m. R1's follow up from the incident was provided by administrator. The follow up included interviews with staff about the incident, but no prevention plan or education. On 1/5/21, at 11:46 a.m. R1 stated he did not recall leaving the building, "I don't remember. It might come back to me." On 1/5/21, at 12:04 p.m. TMA-B was interviewed and stated R1 had a wander alarm on his leg. TMA-B stated she checked to see if it was functioning with a portable sensor in the medication cart. TMA-B stated R1 wandered, and needed direction to locate his room. On 1/5/21 at 12:22 p.m. LPN-B was interviewed and stated R1 had a wander alarm. LPN-B stated he worked with R1 on night shifts, including night of 12/31/21. LPN-B stated he did not check to verify presence and function of R1's wander alarm if R1 was in bed during his shift. LPN-B stated R1 was normally in bed during his shift. On 1/5/21, at 11:06 a.m. LPN-C was interviewed and stated R1 walked around the building a lot. LPN-C stated she was serving lunch on the day R1 left, when she noted the door was open. LPN-C stated she looked around, and called a	21995		

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 01/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 7 Code White to alert staff of a missing resident. R1 did not tell LPN-C he was leaving. R1 did not sign out. LPN-C stated, "He escaped." LPN-C stated a vendor and the receptionist had been at the desk earlier in the day. LPN-C stated R1 rarely wore shoes so he must have seen an opportunity to leave and put his shoes on. LPN-C stated a staff member told her R1 had left the building. LPN-C stated the wander alarm system did not sound and she was concerned because of the opened front door. LPN-C stated R1 had been wearing gray or khaki pants and a sweater that day, and was not sure if he had a coat on when he left. LPN-C explained R1 was not supposed to leave the building without supervision. LPN-C stated she had not had time to check R1's wanderguard functioning that day, but saw it on his left leg. LPN-C noted it was a busy day, she was the only nurse on the unit where R1 resided and she had too much work to do. R2's quarterly MDS dated 10/9/20, indicated no assessment of R2's cognition. R2 was able to ambulate independently, and had diagnoses that included bipolar disorder, and schizophrenia. R2 was not noted as using a wander/elopement alarm. R2's admission MDS, dated 7/10/20, revealed R2 was cognitively intact and had delusions. On 1/5/21, at 12:50 p.m. R2 was interviewed and stated he instructed R1 how to leave the building by pushing and holding the front door, facing Penn Avenue. R2 reported no alarm went off. R2 reported he witnessed R1 leave the building. R2 did not recall what R1 was wearing, but reported, "He wasn't wearing much" and noted R1 was not wearing a coat when he left.	21995		

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	00175	A. BUILDING: _____ B. WING _____	C 01/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 8 During an observation on 1/5/21, at 12:56 p.m. R2, with a wander guard on his ankle showed administrator and director of maintenance how he could walk through the door without triggering the alarm. Even though R2 wore a wander guard on the ankle, similar to R1, the door did not alarm. During interview at this time, the director of maintenance and administrator explained when the door is pushed and held, it released and opens due to fire safety. They explained the wander guard sensor was separate and attached to the side of the door frame, approximately 2 feet off the ground. The alarm should have sounded when the door was opened if the resident had an wander guard on. On 1/5/21, at 2:08 p.m. the front desk receptionist (FDR) was interviewed and stated she came in to the facility at noon on 1/1/21, for approximately 15 minutes to assist a vendor. The FDR stated she did not see R1 leave the building. The FDR stated she did ensure the door was locked prior to leaving. The FDR stated she worked at the front desk and had seen R1 walk towards the door. The FDR stated she redirected R1 when he approached the front door. The FDR stated she could not recall if R1 had ever pushed at the door before. The FDR stated she worked the day shift and there was not another receptionist that replaced her when she left. FDR stated she was aware R1 was not to leave the building because of her familiarity with the residents, and because of a book at the front desk with pictures that had residents at risk for elopement in it. On 1/5/21, at 12:56 p.m. the administrator was interviewed and stated the facility completed wander and elopement assessments at admission, quarterly, and as needed. The	21995		

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	00175	A. BUILDING: _____ B. WING _____	C 01/07/2021

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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21995	Continued From page 9	21995		

administrator stated R1 left the building unsupervised on 1/1/21. The administrator stated facility staff notified her at 1:20 p.m. they could not find R1, had called a Code White, and a staff person had seen R1 at the corner store nearby the facility. The administrator stated she arrived at facility at 1:45 p.m. and the police were already onsite. The administrator stated she finished speaking with police at 2:15 p.m., and left a message for R1's family to notify them R1 had left the building. The administrator stated she sent nursing staff to look for R1 with their cars, and also went looking for R1 in her vehicle. The administrator stated family member (FM)-B informed her of the location R1 had previously worked, so she went to look for him at that location. The administrator stated she received a call at 4:45 p.m. from FM-B to notify her they found R1 at an apartment complex he had previously resided with his mother. The administrator stated the family returned R1 to the facility at 6:00 p.m. The administrator stated R1 was allowed to leave the building on his own, however, R1 used a wander alarm due to his cognition. The administrator stated she viewed the video, of R1 leaving the facility, R1 pushed the front door and it did not do anything. Then R1 turned towards R2, who was sitting nearby, pushed on the door and proceeded out of the building.

A Microsoft electronic map of Minneapolis indicated a distance of 7.6 miles between the location of the facility and the location where R1 was found by family.

Review of the National Weather Service historical weather data for 1/1/21, indicated the weather was 23 degrees Fahrenheit for a high and 12 degrees Fahrenheit for a low that day.

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	00175	A. BUILDING: _____ B. WING _____	C 01/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 10 On 1/5/21, at 1:00 p.m. the administrator and environmental director (ED) observed the functioning of the front door and wander alarm system with the surveyor. A sensor was placed on the door frame approximately 18 to 24 inches from the ground as well as about shoulder height. The door was a sliding door, but opened and stayed open after being pushed and held with force due to fire code. R2, sitting in the lobby, walked through the front door with a wander alarm on his ankle. No alarm sounded. R8, a resident sitting in the lobby nearby, had a wander alarm on his wrist which triggered the alarm system. The administrator stated it may be the positioning of the wander alarm that caused the alarm not to activate. The administrator stated she instructed nursing staff to move wander alarms to resident's wrists, but R2 must have "slipped by." The administrator stated there was frequently a receptionist at the door during the day shift, but not during night or evening shifts. On 1/5/21, at 3:19 p.m. security footage for 1/1/21, at 12:54 p.m. was observed with the administrator and DON. The administrator stated there was no audio available on the security footage. At 12:54 p.m. R2 was observed walking into the lobby and sitting down in a chair near the front door. About 20 seconds later, R1 was observed approaching the front door, paused and then turned towards R2. R1 then turned back to the door, pushed at and held the door. The door opened. R1 walked out of the building wearing a red sweatshirt, gray pants, athletic shoes and green undershirt. R1 was not wearing a a coat, hat, gloves, mittens or a mask. The door remained open. LPN-C approached the open door at 12:58 p.m., went through the open door outside, and then returned inside at 12:59 p.m.	21995		

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 01/07/2021

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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21995	Continued From page 11	21995		

and was pulling at the door. At 1:00 p.m. NA-A walked to the lobby and stood near LPN-C.

During interview on 1/5/21, at 3:19 p.m. the administrator stated residents had a "right to leave the facility" and explained, "We can't lock them in." The DON stated residents would be asked to sign a form saying they were leaving against medical advise if they wanted to leave the facility without discharge orders. The administrator stated R1 had a purpose to his leaving, wanting to go home, made his way to a location and was found in a safe location. The administrator stated R1 was safe to leave the facility "if he knows where he is going." The administrator stated R1 had short term memory impairments, but good long term memory. R1's wander and elopement risk assessment was completed in November 2020, and he had a wander alarm placed on him due to confusion and short term memory impairments. The administrator reported she reviewed the manufacture recommendations and residents were able to wear the wander alarm on the wrist or ankle. The administrator reported an additional alarm had been purchased to sound when the door was open. This had not been installed. A receptionist was present at the front door only during business hours. There were no additional prevention measures were in place, such as education of staff or reassessment of R1 and other residents with wanderguard. Also, there was no indication residents whom had wanderguards located on their ankles had these checked for proper functioning with the current alarm system.

Review of R1's Wander/Elopement Risk Evaluation, updated on 1/5/21, at 7:28 p.m., revealed R1 was assessed as having a history of

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 01/07/2021

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

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21995	Continued From page 12	21995		

wandering and elopement, cognitively impaired, ambulatory, independently mobile, physically able to leave the building on his own and had a history of elopement attempts. R1 was assessed as appropriate for a wander alert personal safety device on his left ankle.

On 1/6/21, at 10:01 a.m. housekeeper (H)-A was interviewed and stated he was outside smoking a cigarette on break on 1/1/21, at 1:00 p.m. about a half a block from the facility. H-A stated he was engaged in a conversation on his cell phone and then entered a nearby store and observed R1 in the same location. H-A stated he returned to the facility and notified LPN-D that he had seen R1 at the store. H-A stated he was not paying attention to R1's behaviors or clothing. H-A estimated he saw R1 at the store at approximately 1:06 p.m.

On 1/6/21, at 10:34 a.m. R1's primary care nurse practitioner (NP)-A was interviewed and stated R1 had amnesia. NP-A stated she was concerned about R1 leaving, and did not want R1 to leave the facility unsupervised again. NP-A stated R1 was not safe to be outside the facility unsupervised. NP-A worried R1 was at risk of harm if he left the facility unsupervised. NP-A stated it was fortunate R1 worked off long term memory, and his familiarity with the area of the metro he resided to find a familiar location. NP-A stated it would not be reasonable to expect R1 would learn and retain new information. NP-A stated R1 had a short attention span, and anxiety built throughout the day. R1 was always needing reassurance about his surroundings, which were unfamiliar to him. R1 exhibited aggression towards others when he misinterpreted their actions. NP-A stated she was the on call provider the day of R1's elopement, and was not notified of R1's elopement. NP-A stated the facility

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 01/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 13	21995		

notified her of the elopement on 1/5/21, at 6:30 p.m., four days after the event occurred. NP-A stated she would expect to be notified of R1's elopement on the same day it occurred.

On 1/7/21, at 9:21 a.m. family member (FM)-A was interviewed and stated he was aware of R1's leaving the facility without supervision because of a phone call from the facility on 1/1/21 at 2:52 p.m., as well as phone calls to FM-B at 3:32 p.m. FM-A stated several family members started searching for R1 in areas R1 had previously worked, visited, and resided. FM-A reported FM-B found R1 at 4:55 p.m. at an apartment building lobby where he had previously resided with FM-D. FM-A then met R1 at the apartment building. FM-A stated R1 had not lived there in several months and had since traveled, lived with FM-A and FM-C, was at the hospital, and resided at the facility for past couple months. FM-D also no longer lived at the apartment complex. FM-A stated R1 was wearing summer weight sweat pants, a long sleeve shirt, possibly an undershirt and mesh slip on shoes. FM-A stated R1 was not wearing a mask, coat, hat or mittens/gloves, despite traveling approximately seven miles from facility to apartment complex in winter weather. FM-A reported R1 did not appear injured, but was coughing and appeared "fuzzy" with a troubled, furrowed brow. FM-A thought R1 might be thirsty, so FM-A purchased R1 an electrolyte beverage and a bag of chips. FM-A stated R1 was less "hazy" after drinking and eating a little. FM-A stated R1 previously resided with FM-A and FM-C prior to being hospitalized, and transferred to the facility. FM-A stated R1 could not safely travel on his own. FM-A and FM-C had previously provided supervision for walks and travel in the community when R1 resided with them due to concerns with R1's cognition FM-A stated, "We knew if he was

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 01/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 14	21995		

away from us that he would probably be lost." FM-A stated R1 had become lost for approximately one month, 3/26/20, to 4/26/20, while traveling internationally during the past year, related to impaired cognition and use of intoxicating substances. FM-A stated this required intervention from the United States Embassy and family escort to return R1 safely home. FM-A stated he was disappointed the facility had lost track of the whereabouts of R1 for several hours, as they were in charge of keeping him safe.

On 1/7/21, at 10:34 a.m. LPN-D was interviewed and stated she was working on station two, and an unidentified nurse notified her the front doors were open. LPN-D stated she directed the unidentified nurse to call a Code White, and determine if any residents were missing. LPN-D stated staff searched the building and nearby building on foot as well as farther out, in vehicles. LPN-D stated R1 should not have been able to leave the building on his own as he was not safe to be on the streets alone. LPN-D stated there was no alarm sounding when she approached the front door.

On 1/7/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release his anger, which meant he exploded and had been physically and verbally aggressive towards others when he was frustrated. R1 had a variable attention span. At times R1 could be preoccupied for an hour with an activity and at times, only 5 minutes. LPN-D stated R1 was not allowed to leave the building unsupervised. LPN-D explained R1 was not safe to leave on his own due to cognition.

On 1/7/21, at 11:33 a.m. R1 was observed resting

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 01/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 15	21995		

under his covers on his bed in a private room. R1 had moved rooms and was in an unsecured unit on the 1st floor. R1 reported he was not sure where he was but named a rural town. R1 noted he was employed and lived with FM-A and FM-C.

On 1/12/21, at 3:32 p.m. R1's mental health case manager (CM) was interviewed and stated R1 was not safe in the community without appropriate supports due to cognition, short term memory, and orientation. CM noted he had been informed R1 was found without a coat on and in a previous residence. CM was notified of R1's elopement by family, and then several days later by the facility. CM reported he would expect the facility to notify him in a timely fashion for appropriate coordination of care.

The Wandering and Elopement Guideline dated 3/16/17, directed staff upon admission, re-admission, through quarterly review and change in condition residents would be evaluated for potential elopement risk to determine appropriate placement within the facility. Residents identified at risk would have an elopement risk bracelet placed on them, such as a wander alarm. Bracelets would have validation of functioning and expiration prior to placement. Bracelets would be checked for placement and functioning every shift. Expiration of the bracelet would be checked for functioning and placement every shift. Each facility would have a process to communicate the admission or re-admission of a resident at risk for elopement across all units. Representatives would receive education, upon admission, regarding memory care unit security, as applicable.

The facility Observation of a Resident Exiting the Facility procedure dated 3/16/17, directed staff to

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 01/07/2021

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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
21995	Continued From page 16	21995		

attempt to prevent the departure- provide diversional techniques, re-direction and apply resident specific intervention as directed by the plan of care. The procedure also directed staff to obtain assistance from staff members in the immediate vicinity. Instruct another staff member to inform the charge nurse or director of nursing assistance is required."

The facility Missing Resident procedure dated 3/16/17, directed staff to conduct an organized search immediately when a resident was determined missing. Staff were also directed to report immediately to the Charge Nurse missing, OR a suspected missing resident. The Charge Nurse should immediately determine if resident was on an authorized leave, pass or medical appointment; announce on the overhead paging system for "CODE WHITE" followed by the resident room number. Code White was a code to notify the staff that a resident was missing. After the resident is found, notify the charge person (the charge person will notify the Administrator, Director of Nursing and police). Upon return of the resident to the facility, the Director of Nursing or Charge nurse should: Examine the resident for injuries. Consult with the attending physician and report findings and condition of the resident. Notify the Resident Representative.

The Touchpad Exit Controller Administration Guide, dated 7/2018, directed users, "Resident generated alarms-Do no rely exclusively on resident generated alarms for resident care and safety. The alarm function of equipment in the possession of residents must be verified periodically and regular resident surveillance is recommended." The guide further directed users, "Resident Monitoring-The most reliable method of

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 01/07/2021

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21995	Continued From page 17	21995		

resident monitoring combines close personal surveillance with correct operation of monitoring equipment. It is the responsibility of the facility to periodically check on residents in possession of RF Technologies Inc.'s equipment (i.e. pendants, pull cords, control units) to mitigate risks of inappropriate use of equipment or strangulation and stumbling hazards from cables and cords."

The immediate jeopardy that began on 1/1/21, was removed on 1/6/21, when the facility educated all staff on elopement procedures, audited functioning of wander alarm system, ensured each resident with a wander alarm had a wander/elopement assessment and care plan in place, and ensured treatment orders in place to monitor presence and functioning of wander alarms for each resident with a wander alarm in place, but the noncompliance remained at the lower scope and severity level of a D, isolated scope and severity level, which is no actual harm, with potential for more than minimal harm that is not immediate jeopardy.

SUGGESTED METHOD OF CORRECTION: The administrator could educate all staff on policies and procedures regarding alleged reports of mistreatment. The administrator could develop a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.