

Protecting, Maintaining and Improving the Health of All Minnesotans

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. 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.

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

Minnesota Department of Health

Kumalu Fiske Downing

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

PRINTED: 02/11/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 000	abbreviated survey to conduct a comple was found not to be Part 483, Requirem Facilities. The following compusubstantiated: H5203148C at F680 H203146C at F600 The following compunsubstantiated: H5203145C H5203147C The facility's plan or as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated. Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. The survey resulted (IJ) at F689 when the supervision and integree the lopement reviewed for eloper	1/6/21, and 1/7/21, an was completed at your facility aint investigation. Your facility in compliance with 42 CFR tents for Long Term Care plaints were found to be and F609 Idaints were found to be and F609 Idaints were fount to be all aints were fount to be a forestion (POC) will serve a forestion (POC) will serve a forestion and the polymer of the compliance upon the polymer of the CMS-2567 are submission of the POC will ain an of compliance. In acceptable electronic POC, and are facility may be conducted to notial compliance with the en attained in accordance with the en attained in seesary to for 1 of 3 residents (R1) ments, who subsequently	F 00	Minnesota Department of H documenting the State Licer Correction Orders using fed Tag numbers have been ass Minnesota state statutes/rull Homes. The assigned tag number af far left column entitled "ID F The state statute/rule number corresponding text of the state out of compliance is listed in "Summary Statement of Def column and replaces the "To portion of the correction ord column also includes the fif are in violation of the state of the statement, "This Rule is evidenced by." Following the findings are the Suggested of Correction and the Time Per Correction. PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PL CORRECTION." THIS APPL FEDERAL DEFICIENCIES OF WILL APPEAR ON EACH P THERE IS NO REQUIREME SUBMIT A PLAN OF CORR VIOLATIONS OF MINNESO STATUTES/RULES.	nsing deral software. signed to es for Nursing ppears in the Prefix Tag." er and the ate statute/rule the ficiencies" Comply" er. This ndings which statute after not met as ne surveyors Method of riod For HEADING N WHICH AN OF LIES TO ONLY. THIS PAGE. ENT TO EECTION FOR	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

02/04/2021

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

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F 600 SS=D	facility on 1/1/21, frotraveling approximal urban area, with win from 12 Fahrenheit winter attire or mas infection. The surve health and safety. If functional wander a immediate staff res of a resident in the of a breach in the son 1/1/21, and the in 1/6/21. The above findings quality of care, and conducted from 1/6 Free from Abuse ar CFR(s): 483.12(a)(§483.12 Freedom f Exploitation The resident has the neglect, misappropand exploitation as includes but is not 1 corporal punishmer any physical or cheet treat the resident's §483.12(a) The face §483.12(a)(1) Not uphysical abuse, corinvoluntary seclusion This REQUIREMENTS	om 12:54 p.m. to 6:00 p.m., ately seven miles in a busy inter temperatures that ranged (F) to 23 F without proper k to prevent Covid 19 by resulted in an IJ to resident he facility failed to ensure a plarm system and an ponse upon the identification community and identification ecured doors. The IJ began mmediacy was removed on constituted substandard an extended survey was in item (21 to 1/7/21). The constituted substandard an extended survey was in item (21 to 1/7/21). The constituted substandard an extended survey was in item (22 to 1/7/21). The constituted substandard an extended survey was in item (23 to 1/7/21). The constituted is substandard an extended survey was in item (24 to 1/7/21). The constituted is substandard an extended survey was in item (25 to 1/7/21). The constituted is substandard an extended survey was in item (25 to 1/7/21). The constituted is substandard an extended survey was in item (25 to 1/7/21). The constituted is substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was in item (25 to 1/7/21). The constituted substandard an extended survey was item (25 to 1/7/21). The constituted substandard an extended survey was item (25 to 1/7/21). The constituted substandard an extended survey was item (25 to 1/7/21). The constituted substandard an extended survey was item (25 to 1/7/21). The constituted substandard an extended survey was item (25 to 1/7/	F 60	00	ot.	2/9/21
	Based on interview	and document review, the		F600: Free from abuse and negle	ct	

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F 600	Continued From pa	age 2	F 6	000			
	facility failed to pre-	vent an incident of resident to			Corrective Action:		
		2 of 3 residents (R1, R3)			R1 has been discharged, no further	action	
	reviewed for abuse).			can be taken		
					R3 was monitored by nursing for an		
	Findings include:				adverse effect and was offered to be	een	
	D1's admission Mir	nimum Data Set (MDS), dated			seen by in house psychology All staff were educated on reviewing	n tho	
		R1 was admitted from a			residents care plan (Kardex) for beh	,	
		I. R1 had severe cognitive			and non-pharmacological intervention		
		lked independently in corridor			regarding residents individualized ca		
		s independent in locomotion on			plan to identify possible behavioral		
		1 had a diagnosis of			triggers before they occur		
	non-traumatic brain	n dysfunction.			Identification of other residents:		
					All residents living in a skilled facility	/ are	
		S, dated 12/31/20, indicated R3			at risk for abuse and neglect		
		act. R3 walked independently in			Nursing and social service staff wer		
	locomotion on unit	R3 was independent in			re-educated on Abuse, and Neglect policy/procedures.		
	locomotion on unit	and on unit.			Abuse care plans on identified resid	lents	
	An incident report f	rom the facility, dated			have been reviewed and updated to		
		R3 was sitting by the nursing			include behaviors that put the reside		
		for a cigarette. The trained			risk.		
	medication assista	nt (TMA)-A informed R3 it was			New patients will be reviewed/ evalu	uated	
		et. R1 and R3 became			upon admission for individuals risk f		
		al altercation. R1 placed his			for abuse, followed by the implemen	ntation	
		neck. Staff separated R1 and			of abuse prevention plans, and		
		on checks every 15 minutes.			interventions.		
		revealed R3 had a quarter st and superficial skin tear to			Monitoring Mechanism: Residents with identified behaviors v	will bo	
	left hand, requiring				monitored daily by all staff members		
	leit flaffd, requiring	ilist alu.			identified target behaviors.	s using	
	R3's skin observati	on, dated 12/28/20, indicated			Target behavioral charting, and the		
		ig noted to left side of Adams			effectiveness of behavioral intervent	tions	
		erficial skin tear to ring finger.			will be reviewed monthly by clinical t		
					IDT team will review, and update ea	ıch	
		p.m. R1 reported he could not			residents care plan based upon		
	recall any altercation	ons with other residents.			resident⊡s clinical diagnosis, target		
	0 4/4/04 4 4 4 5	D0			behaviors, behavioral charting,		
	∪n 1/4/21, at 1:40	p.m. R3 reported, "He tried to			interventions, medication managem	ent,	

Facility ID: 00175

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COM	E SURVEY IPLETED
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F 600	down out by the frobruise on his neck thad resolved. On 1/4/21, at 3:47 pobserved R3 appro TMA-B was working TMA-B looked up a R3 asked R1 to steput his hands arour sick and tired of you R3 and R1 and sou administrator. R3 h blood on his neck. The facility policy of mistreatment, and property, dated 11/2 the policy of the factive from "abuse". If mental, sexual, or punishment or invowould also be free restraints imposed convenience and the service of the service of the factive from the sexual of the service o	ge 3 of the clear blue. I was sitting int desk." R3 reported he had a from the incident but thought it o.m. TMA-B reported she aching her to get a cigarette. If on passing medication, and saw R1 standing over R3. If the R3's neck, stating "I amour attitude." TMA-B separated in ght out a nurse and the ad a bruise and a little cut and a bruise and a little cut and in abuse, neglect, exploitation, misappropriation of resident exploration abuse could include verbal, ohysical abuse, corporal for purposes of discipline or lat are not required to treat the symptoms. Additionally,	F 600	and clinical recommendations for residents with identified behaviors monthly, quarterly, and as needed A random group of 10 % of reside be interviewed monthly to ensure residents feel safe, and free from and neglect, results will be review QAPI to determine the need to comonitoring for compliance.	s d ents will abuse red at	
	neglect, and harm of facility. No abuse of tolerated, and reside monitored for protesto educate staff and techniques to proteste Reporting of Allege CFR(s): 483.12(c)(d Violations	F 609			2/9/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 609	neglect, exploitation must: §483.12(c)(1) Ensurinvolving abuse, nemistreatment, inclusiource and misappare reported immed hours after the allegath that cause the allegations bodily injuring the events that cause and do not rethe administrator of officials (including the accordance with St.) §483.12(c)(4) Reposition to the state of include the administrator of officials (including the administrator of of	ire that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if see the allegation do not involve esult in serious bodily injury, to fee the facility and to other the facility and to other to the State Survey Agency and vices where state law provides and the results of all the administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified in action must be taken. Note that it is not met as evidenced the agency (SA) within 24 hours severe cognitive impairment e facility for 1 of 4 residents	F 6	F609: Reporting alleged viola Corrective Action: Elopement of R1 was reported 1/5/21 NHA was educated on reporting obligations by region director operations Identification of other Resident All residents are at risk for about Monitoring Mechanism	d to MDH on ng of clinical it:		

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	PROVIDER OR SUPPLIER A AT BRYN MAWR		2	STREET ADDRESS, CITY, STATE, ZIP C 175 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
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F 609	impairment. R1 wa and room. R1 was unit and off unit. R2 non-traumatic brair wander/elopement R1's Wander/Elope 11/19/21, indicated elopement with risk independent mobili building unsupervis wandering the build confusion. R1's care plan, data trisk of elopement care plan goal was interventions including wandering resident staff assessment of motivation and trigg a wander alert persankle. R1's nurse note, daindicated R1 was of the same care plan goal was interventions included wandering resident staff assessment of motivation and trigg a wander alert persankle.	R1 had severe cognitive lked independently in corridor independent in locomotion on a had a diagnosis of a dysfunction. R1 used a alarm daily. The ment Risk Evaluation, dated a R1 was at risk of wandering, as factors including ty, a history of leaving the red, exit seeking and ling, and early evening The ded 11/20/20, indicated R1 was at related to disorientation. The to keep R1 safe. R1's led a photo on the list of s, distractions and diversions, of wandering behavior gers, offering to call family and conal safety device on the left ated 1/1/21, at 3:06 p.m. ut of the building without staff	F 609	All wander events will be more reporting obligations, by RI next 90 days		
	missing resident, wand nurse practition On 1/4/21, at 3:09 preported she did not the building unsuper considered an elop administrator addedwas missing within	white, emergency code for ras called. R1's family, police her were notified. c.m., the administrator of report to the SA that R1 left ervised as it was not ement by the facility. The d the facility had identified R1 3 minutes of leaving and the pharmed in an old residence.				

Event ID: 18J411

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245203	B. WING _		01	C / 07/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	On 1/5/21, at 12:56 reported R1 left the 1/1/21. The administ notified her at 1:20 had called a code were ported she receive R1's family member found at an apartmere sided at with his reported the family 6:00 p.m. R1 was a approximately 7.5 runclear how R1 traunclear how R2 was observed we sitting down in a chapter s	is p.m., the administrator is building unsupervised on strator reported facility staff p.m. they could not find R1, white. The administrator ared a call at 4:45 p.m. from str (FM)-B to notify her R1 was ent complex he had previously mother. The administrator returned R1 to the facility at at a previous residence, miles from facility. It was weled to the residence.	F 60	9			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245203	B. WING			C 07/2021	
	PROVIDER OR SUPPLIER LA AT BRYN MAWR			STREET ADDRESS, CITY, STATE, ZIP COE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	•	0112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
	harm, pain, mental distress." and "It is "abuse" allegations or mistreatment, in source and misapp are reported per Fe facility will ensure the involving abuse, nemistreatment, inclusiource and misapp are reported immed hours after the allegath that cause the allegath that cause the allegath that cause the allegath in serious bodily injif the events that cainvolve abuse and injury, to the admin other officials (incluaded Agency and adult plaw provides for jur facilities) in accordate stablished proced Free of Accident Harder (Section 1988). 25(d) (Accident The facility must en §483.25(d)(1) The as free of accident \$483.25(d)(2) Each	re necessary to avoid physical anguish, or emotional the policy of this facility that (abuse, neglect, exploitation cluding injuries of unknown ropriation of resident property) ederal and State Law. The nat all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result ury, or not later than 24 hours ause the allegation do not do not result in serious bodily istrator of the facility and to ading to the State Survey rotective services where state is diction in long-term care ance with State law through ures." azards/Supervision/Devices 1)(2)	F 6			2/9/21	
	accidents. This REQUIREMED by: Based on observa	NT is not met as evidenced tion, interview, and document ailed to keep the resident safe		F689: Free from Accidents Hazards/Supervision			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		SURVEY PLETED
			20.22				
		245203	B. WING			01/0	7/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT BRYN MAWR				5 PENN AVENUE NORTH INNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	risk for elopement to jeopardy (IJ). The fivelopement of R1, wimpairments, for appeal below freezing wint appropriate winter a potential serious hadeath for 1 out of 3 risk of elopement. The immediate jeop 12:48 p.m. when R alarm on his ankle, at front entrance wind alert staff. Staff wer 1:06 p.m. and polic approximately 7.6 revening. The admin nursing (DON) were jeopardy at on 1/5/2 immediate jeopardy noncompliance rem severity level of D, harm with potential that is not immediate. R1's admission Min 11/19/20, indicated impairment, and was independently. The diagnosis of non-traused a wander/elope 11/19/20, indicated impairment, and was independently. The diagnosis of non-traused a wander/elope 11/19/20, indicated impairment, and was independently. The diagnosis of non-traused a wander/elope 11/19/20, indicated impairment, and was independently. The diagnosis of non-traused a wander/elope 11/19/20, indicated impairment, and was independently. The diagnosis of non-traused a wander/elope 11/19/20, indicated impairment, and was independently. The diagnosis of non-traused a wander/elope 11/19/20, indicated impairment, and was independently. The diagnosis of non-traused a wander/elope 11/19/20, indicated impairment, and was independently.	(R1) whom was identified at hat resulted in an immediate acility failed to prevent the rho had severe cognitive proximately four hours in er temperatures without attire resulting in risk of arm, injury, impairment, or residents (R1) reviewed for pardy began on 1/1/21 at 1 whom had a security alert breached the secured doors thout any alarms sounding to be not aware R1 was gone until er were notified. R1 was found an iles from the facility later that histrator and director of the immediate part of the	F 6	689	Corrective Action: Identified resident, R1, has returned facility and been re-evaluated. Curplan of care includes a wanderguar has been placed on R1. Care plan been reviewed and is appropriate. resident received an assessment ure turn and was found to be free of it Both provider and family have been updated. Facility working with resid provider to ensure resident safety. Points of exit and entrance have be checked to ensure door alarms are functioning appropriately. Wandergalarms have received sensor checkensure wander guard alarm system. An additional alarm has been adde front door when the emergency locineleased to alert staff that door has opened. Dietary, housekeeping, nursing, the and administration staff have been educated, prior to next shift, on ensurated doors are secured, responding door alarms, and following resident of care related to safety checks and for care. Code drills for a potential breach in elopement system have been complied for all 3 shifts. Identification of other Residents: Residents that reside at Bryn Mawr center have been assessed for eloprisk. Residents who are at risk for elopement have received care plant updates include resident photo added to wander list, staff aware of wander risk, wander guard added.	rently d that has The pon njury. It is een uard as to a alert. It d to the k is been erapy, suring to plans the pleted a Villa pement.	

Facility ID: 00175

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245203	B. WING			C 07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	independent mobilibuilding unsupervis wandering the build confusion. A progress note daindicated, "Wander on L [left] ankle bas assessment and reof the facility." R1's care plan date at risk of elopement care plan goal was interventions include wandering resident staff assessment of motivation and trigg a wander alert persankle. Review of R1's Dectreatment administriculded an order to placement of wand night shift 12/29/20 marked by a licens not completed for Four tompleted on 1 12/31/20 day shift. This order was marked completed with a not the completed with a	ty, a history of leaving the ed, exit seeking and ling, and early evening ted 11/20/20, at 8:36 a.m. guard [wander alarm] placed sed on residents wander sident being observed outside at 11/20/20, indicated R1 was trelated to disorientation. The to keep R1 safe. R1's led a photo on the list of s, distractions and diversions, f wandering behavior gers, offering to call family and conal safety device on the left of the check functioning and ler device every shift. On the position of the day shift for 1/1/21, and the condition of the day shift for 1/1/21, and the condition of the day shift for 1/1/21, and the condition of the day shift for 1/1/21, and the condition of the day shift for 1/1/21, and the condition of the day shift for 1/1/21, and the condition of the building without staff and the condition of the	F 689	Residents that are currently locked unit but have been as elopement risk have receive ensure wanderguards are furth appropriately. Nursing staff have also been checking placement of wandevery shift and checking war functioning once daily. Monitoring Mechanism: Daily audits will be conducte NHA/designee to ensure doc functioning properly for 30 days. Nursing staff will be checking of wanderguards every shift wanderguard functioning one Nursing leadership will randow Wandgergaurd checks for 30 ensure placement and functioning will continue with week Audit results will be reviewed determine the need to continue monitoring and compliance.	sessed as an d checks to nctioning a educated on lerguards anderguard d by or alarms are ays and then g placement and checking ce daily. Omly audit 0 days to ion. After 30 ly audits. d at QAPI to	
	knowledge. A Code	with the building without starr with the white (the emergency code ent) was called. Family, police				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245203	B. WING		01	/07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	and the nurse practical interview/statemen indicated LPN-C not doors were left ope LPN-D that he observed R1 at stated the wander a LPN-C indicated LPN-C in the indicated LPN-C in the indicated LPN-C indicated LPN-C in the indicated LPN-C in the indicated indicated indicated indicated indicated indicated indicated indicated LPN-C indicated LI indicated LI indicated LI indicated LI indicated LI indicated LPN-C indicated LI indicated LPN-C indicated LI indicated LPN-C indicat	titioner were notified. gation of R1 elopement ving: nurse (LPN)-D's t record form dated 1/1/21, butified LPN-D that the front en. Housekeeper (H)-A notified erved R1 heading towards a and LPN-D checked the store . LPN-D then notified the on of R1's elopement, and or R1 in her vehicle. This t of a facility investigation. NA)-A's interview/statement ed, indicated the wander alarm A accounted for all of her code white was initiated, and	F 6	39		
	dated 1/4/21, indicato give a vendor caround noon. The	rront desk receptionist (FDR) ated FDR came in to the facility ash, and restock candy store at vendor was already in the around 12:20 p.m., let the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245203	B. WING		01	C / 07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	· · · · · · · · · · · · · · · · · · ·	70172021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	vendor out the from outside and inside of H-A's interview/statindicated H-A was of the local store and conversation. H-A of H-A returned to the observed R1 at the R1's behavior or whomas preoccupied where the the state outside. I thought he statement was part outside. I thought he stated R1 could be and explosive the mapproached the D0 "clogged" and "over of vitals, and encour for help when he feed on 1/4/21, at 3:09 preported she did not the building unsuper considered an elop administrator added was missing within family found him under the did not the did not the did not the did not the properties of the did not the building unsuper considered an elop administrator added was missing within family found him under the did not the building unsuper considered an elop administrator added was missing within family found him under the did not the did	t doors, and locked both doors securely. ement record undated, on a break outside, walking to engaged in a phone observed R1 near the store. facility and notified LPN-D he store. H-A could not recall nat he was wearing, noting he ith a phone call. ement record dated 1/5/21, I, I'l told [R1] how to get e was coming right back." This of a facility investigation. D.m. the DON was interviewed ed and paced hallways in the sappeared tense. The DON kind and sweet one moment, ext. During the interview, R1 DN, and stated his head felt reparing." The DON took a set traged R1 to sit down, and ask It dizzy. D.m., the administrator of report to the SA that R1 left ervised as it was not ement by the facility. The did the facility had identified R1 minutes of leaving and the charmed in an old residence. eported she would provide all	F 6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245203	B. WING		01	C / 07/2021
NAME OF PROVIDE				STREET ADDRESS, CITY, STATE, Z 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		70772021
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
and s alarm wands ankle function wands walke the urthe do on 1/ (TMA to ensistated it was allowed the TI check on 1/ incide up incided up incided incided on 1/ recall might on 1/ and s TMA-function medical on 1/ and s	LPN-A pulle er alarm brace. LPN-A demoning by puttier alarm, and dup to within hit and turned for. 5/21, at 10:26)-A stated she sure it was professed to go on or functioning. End to go on or MA working the wand for the was provided interview the best of the was provided to go on or MA working the wand for the was provided to go on or MA working the wand for the was provided to go on or MA working the was provided interview the was provided to go on or was provided	s unsure if R1 had a wander and up R1's sweat pants, and a selet was present on R1's left constrated how she checked ing a portable sensor near R1's R1's sensor beeped. R1 twice in a few feet of the exit doors for around, without pushing on a sent on his ankle. TMA-A traware of a method to ensure TMA-A stated R1 was not sutings on his own. The nurse or the cart was responsible for the alarm system. If a.m. R1's follow up from the ded by administrator. The follow the evention plan or education. If a.m. R1 stated he did not building, "I don't remember. It		689		

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245203	B. WING _			C / 07/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		0110112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	alarm if R1 was in stated R1 was norm. On 1/5/21, at 11:06 and stated R1 walk LPN-C stated she in R1 left, when she in LPN-C stated she in Code White to aler R1 did not tell LPN sign out. LPN-C stated a vendor and the desk earlier in the rarely wore shoes sopportunity to leave stated a staff mem building. LPN-C stated a vendor and stated a staff mem building. LPN-C stated a vendor and stated a staff mem building. LPN-C stated a vendor and stated a vendor an	age 13 If function of R1's wander bed during his shift. LPN-B mally in bed during his shift. If a.m. LPN-C was interviewed ted around the building a lot. was serving lunch on the day noted the door was open. ooked around, and called a t staff of a missing resident. If a che was leaving. R1 did not ated, "He escaped." LPN-C did the receptionist had been at the day. LPN-C stated R1 so he must have seen an e and put his shoes on. LPN-C ber told her R1 had left the ated the wander alarm system she was concerned because of for. LPN-C stated R1 had or khaki pants and a sweater not sure if he had a coat on C explained R1 was not the building without c stated she had not had time derguard functioning that day, if leg. LPN-C noted it was a the only nurse on the unit and she had too much work to	F 68	9			
	assessment of R2's ambulate independincluded bipolar dis was not noted as u alarm. R2's admiss	s dated 10/9/20, indicated no s cognition. R2 was able to lently, and had diagnoses that sorder, and schizophrenia. R2 sing a wander/elopement sion MDS, dated 7/10/20,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245203	B. WING			//2021
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	stated he instructed by pushing and ho Penn Avenue. R2 reported he witness did not recall what "He wasn't wearing wearing a coat who During an observa R2, with a wander administrator and could walk through alarm. Even though the ankle, similar the door is pushed opens due to fire swander guard sens to the side of the ground sounded when the resident had an way on 1/5/21, at 2:08 (FDR) was intervied the facility at noon minutes to assist a did not see R1 lear stated she did ensity to leaving. The FD front desk and had door. The FDR state approached the frocould not recall if Formal could not recall if Formal	D p.m. R2 was interviewed and d R1 how to leave the building Iding the front door, facing reported no alarm went off. R2 sed R1 leave the building. R2 R1 was wearing, but reported, g much" and noted R1 was not en he left. Ition on 1/5/21, at 12:56 p.m. guard on his ankle showed director of maintenance how he in the door without triggering the h R2 wore a wander guard on the R3 wore a wander guard on the R4 was separate and attached or frame, approximately 2 the alarm should have door was opened if the				

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_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245203	B. WING		0	C 1/07/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	•	170772021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	and there was not a replaced her when aware R1 was not to fher familiarity wit of a book at the from residents at risk for On 1/5/21, at 12:56 interviewed and state wander and elopem admission, quarterly administrator stated unsupervised on 1/facility staff notified not find R1, had calperson had seen R the facility. The administrator stated at facility at 1:45 p.r. onsite. The administrator staff to look also went looking for administrator stated informed her of the worked, so she wer location. The administrator stated informed R1 at an apa previously resided wadministrator stated facility at 6:00 p.m. was allowed to leave however, R1 used a cognition. The admithe video, of R1 leathe front door and it	inother receptionist that she left. FDR stated she was o leave the building because h the residents, and because at desk with pictures that had	F 6	89			

Event ID: 18J411

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245203	B. WING		01	C / 07/2021
	PROVIDER OR SUPPLIER _A AT BRYN MAWR			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	building. A Microsoft electron indicated a distance location of the facility was found by family. Review of the Nation weather data for 1/ was 23 degrees Fahrenheir on 1/5/21, at 1:00 penvironmental direct functioning of the firsystem with the sunthe door frame appfrom the ground as The door was a slice stayed open after beforce due to fire convalked through the alarm on his ankle. resident sitting in the alarm on his wrist was system. The admin positioning of the walarm not to activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident's "slipped by." The activate she instructed nursualarms to resident she instructed nursualarms to resident she instructed nursualarms to resident she ins	r and proceeded out of the rich map of Minneapolis e of 7.6 miles between the ity and the location where R1 y. In all Weather Service historical 1/21, indicated the weather threnheit for a high and 12 t for a low that day. In the administrator and coor (ED) observed the ront door and wander alarm reveyor. A sensor was placed on roximately 18 to 24 inches well as about shoulder height. ding door, but opened and being pushed and held with de. R2, sitting in the lobby, front door with a wander No alarm sounded. R8, a ne lobby nearby, had a wander which triggered the alarm histrator stated it may be the rander alarm that caused the real calarm that caused the real calarm that caused the real alarm that real alarm that real alarm that real ala	F 6	89		
	1/1/21, at 12:54 p.r administrator and [n. was observed with the DON. The administrator stated available on the security				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245203	B. WING		01	C / /07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		70772021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 689	footage. At 12:54 p into the lobby and s front door. About 20 observed approach then turned towards the door, pushed as opened. R1 walked red sweatshirt, gray green undershirt. Rhat, gloves, mittens remained open. LP door at 12:58 p.m., outside, and then reand was pulling at twalked to the lobby. During interview on administrator states leave the facility" at them in." The DON asked to sign a formagainst medical adfacility without discleaving, wanting to location and was for administrator states facility "if he knows administrator report wander alarm place and short term mer administrator report manufacture recommerce able to wear to ankle. The administrator the manufacture recommerce and the property of the	in. R2 was observed walking sitting down in a chair near the 0 seconds later, R1 was sing the front door, paused and is R2. R1 then turned back to that and held the door. The door if out of the building wearing a grants, athletic shoes and it was not wearing a a coat, is or a mask. The door in N-C approached the open went through the open door eturned inside at 12:59 p.m. Ithe door. At 1:00 p.m. NA-A and stood near LPN-C. 1/5/21, at 3:19 p.m. the direction of explained, "We can't lock stated residents would be im saying they were leaving vise if they wanted to leave the	F6	889		

Facility ID: 00175

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245203	B. WING _			07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	1	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	receptionist was produring business had prevention measure education of staff of other residents with was no indication rowanderguards local checked to ensure at the exit doors with the exit doors of the ex	is had not been installed. A resent at the front door only burs. There were no additional res were in place, such as or reassessment of R1 and in wanderguard. Also, there residents whom had red on their ankles had these they were functioning properly the current alarm system. Inder/Elopement Risk don 1/5/21, at 7:28 p.m., assessed as having a history of prement, cognitively impaired, rendently mobile, physically able gon his own and had a history of prement, ander personal safety risk. If a.m. housekeeper (H)-A was read he was outside smoking a non 1/1/21, at 1:00 p.m. about a ne facility. H-A stated he was rersation on his cell phone and on the LPN-D that he had seen R1 at red he was not paying attention or clothing. H-A estimated he at approximately 1:06 p.m. If a.m. R1's primary care nurse was interviewed and stated R1 a stated she was concerned and did not want R1 to leave vised again. NP-A stated R1 and the vised again.	F 68	9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245203	B. WING _		01	C / 07/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	harm if he left the fistated it was fortun memory, and his fametro he resided to stated it would not would learn and restated R1 had a shbuilt throughout the reassurance about unfamiliar to him. It towards others who actions. NP-A stated the day of R1's elopement. notified her of the ep.m., four days after stated she would elopement on the stated she would elopement on the stated she would elopement on the stated she would an leaving the facility of a phone call from the p.m., as well as phemore sarching for R1 in worked, visited, an found R1 at 4:55 plobby where he had find find the facility for past coulonger lived at the stated R1 was weapants, a long sleever and found sleever and found sleever and found stated R1 was weapants, a long sleever and found sleever and found sleever and found sleever and found find for past coulonger lived at the stated R1 was weapants, a long sleever and found sleever and found find for past coulonger lived at the stated R1 was weapants, a long sleever and found find for past coulonger lived at the stated R1 was weapants, a long sleever and found find find for past coulonger lived at the stated R1 was weapants, a long sleever and for found find find find find find find find fi	A worried R1 was at risk of facility unsupervised. NP-A tate R1 worked off long term amiliarity with the area of the offind a familiar location. NP-A be reasonable to expect R1 etain new information. NP-A tort attention span, and anxiety etay. R1 was always needing this surroundings, which were R1 exhibited aggression en he misinterpreted their eta she was the on call provider pement, and was not notified NP-A stated the facility elopement on 1/5/21, at 6:30 er the event occurred. NP-A xpect to be notified of R1's same day it occurred. a.m. family member (FM)-A and stated he was aware of R1's without supervision because of he facility on 1/1/21 at 2:52 one calls to FM-B at 3:32 p.m. all family members started areas R1 had previously diresided. FM-A reported FM-B at an apartment building direviously resided with FM-D at the apartment building. Ince traveled, lived with FM-A the hospital, and resided at the ple months. FM-D also no apartment complex. FM-A aring summer weight sweat the shirt, possibly an undershirt thoes. FM-A stated R1 was not the second of the second of the stated R1 was not the second of t	F 68	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				· · · · · · · · · · · · · · · · · · ·		С	
		245203	B. WING			/07/2021	
	THE VILLA AT BRYN MAWR			STREET ADDRESS, CITY, STATE, ZIP CO 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE	
F 689	despite traveling apperson facility to apartment FM-A reported R1 coughing and apperson furrowed brow. FM-so FM-A purchased and a bag of chips. "hazy" after drinking stated R1 previous prior to being hospifacility. FM-A stated his own. FM-A and supervision for wall when R1 resided w R1's cognition FM-away from us that he FM-A stated R1 has approximately one while traveling interrelated to impaired intoxicating substantintervention from the family escort to retustated he was disaptrack of the wherea as they were in characteristical nurse to determine if any resistated staff searched building on foot as LPN-D stated R1 seave the building of search and stated staff searched building on foot as LPN-D stated R1 seave the building of search and stated staff searched building on foot as LPN-D stated R1 seave the building of search and stated staff searched building on foot as LPN-D stated R1 seave the building of search and stated staff searched building on foot as LPN-D stated R1 seave the building of search and stated staff searched building on foot as LPN-D stated R1 seave the building of search and search an	pat, hat or mittens/gloves, oproximately seven miles from to complex in winter weather. did not appear injured, but was ared "fuzzy" with a troubled, -A thought R1 might be thirsty, R1 an electrolyte beverage FM-A stated R1 was less grand eating a little. FM-A yresided with FM-A and FM-C talized, and transferred to the R1 could not safely travel on FM-C had previously provided as and travel in the community ith them due to concerns with A stated, "We knew if he was ne would probably be lost."	F	689			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245203	B. WING		01	C / 07/2021
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOOT CORRECT TO THE APPOPT (DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	was no alarm soun front door. On 1/7/21, at 10:51 manager, was interget frustrated and canger, which mean physically and verb when he was frustrattention span. At t for an hour with an minutes. LPN-D staleave the building to R1 was not safe to cognition. On 1/7/21, at 11:33 under his covers or had moved rooms on the 1st floor. R1 where he was but rhe was employed at On 1/12/21, at 3:32 manager (CM) was was not safe in the appropriate suppor memory, and orien informed R1 was for previous residence elopement by famil by the facility. CM r facility to notify him appropriate coordinates.	ding when she approached the a.m. LPN-D, R1's nurse rviewed and stated R1 would did not know how to release his t he exploded and had been ally aggressive towards others ated. R1 had a variable imes R1 could be preoccupied activity and at times, only 5 ated R1 was not allowed to insupervised. LPN-D explained leave on his own due to a.m. R1 was observed resting his bed in a private room. R1 and was in an unsecured unit reported he was not sure hamed a rural town. R1 noted and lived with FM-A and FM-C. p.m. R1's mental health case interviewed and stated R1 community without ts due to cognition, short term tation. CM noted he had been bund without a coat on and in a . CM was notified of R1's y, and then several days later reported he would expect the in a timely fashion for nation of care. d Elopement Guideline dated taff upon admission,	F6	89		
	re-admission, throu	igh quarterly review and residents would be evaluated				

AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245203	B. WING			C 01/07/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405			01/01/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	for potential eloper appropriate placem Residents identified elopement risk brata a wander alarm. Broof functioning and Bracelets would be functioning every swould be checked every shift. Each facommunicate the aresident at risk for Representatives wadmission, regardias applicable. The facility Observ Facility procedure attempt to prevent diversional techniques resident specific in plan of care. The pobtain assistance fimmediate vicinity. to inform the chargues assistance is required to provide the facility Missing 3/16/17, directed search immediately of a suspected month of the chargues and the facility Missing 3/16/17, directed search immediately of a suspected month of the chargues and the facility Missing 3/16/17, directed search immediately of a suspected month of the chargues and the facility Missing 3/16/17, directed search immediately of a suspected month of the chargues and the facility Missing 3/16/17, directed search immediately of a suspected month of the chargues and the facility Missing 3/16/17, directed search immediately of the facility Missing 3/16/17, directed search immediately of a suspected month of the facility Missing 3/16/17, directed search immediately of the facility Missing 3/16/17, directed search immedia	ment risk to determine nent within the facility. d at risk would have an celet placed on them, such as racelets would have validation expiration prior to placement. It checked for placement and hift. Expiration of the bracelet for functioning and placement acility would have a process to admission or re-admission of a elopement across all units. Ould receive education, uponing memory care unit security, ation of a Resident Exiting the dated 3/16/17, directed staff to the departure- provide ues, re-direction and apply tervention as directed by the procedure also directed staff to from staff members in the Instruct another staff member in the urse or director of nursing	F 689				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245203	B. WING		1	07/2021
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	,	
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F 689	person (the charge Administrator, Dire Upon return of the Director of Nursing Examine the residuatending physicial condition of the research attending and seriodical alarms-resident generated safety. The alarms-resident generated safety. The alarms-resident Monitori resident monitoring surveillance with a cequipment. It is the periodically check RF Technologies in pull cords, control inappropriate used and stumbling haz. The immediate jed was removed on 1 educated all staff of audited functioning ensured each residuander/elopement	age 23 s found, notify the charge e person will notify the ector of Nursing and police). resident to the facility, the g or Charge nurse should: ent for injuries. Consult with the n and report findings and sident. Notify the Resident Controller Administration 18, directed users, "Resident Do no rely exclusively on I alarms for resident care and function of equipment in the dents must be verified gular resident surveillance is ne guide further directed users, ng-The most reliable method of g combines close personal orrect operation of monitoring e responsibility of the facility to on residents in possession of nc.'s equipment (i.e. pendants, units) to mitigate risks of of equipment or strangulation ards from cables and cords." pardy that began on 1/1/21, /6/21, when the facility on elopement procedures, g of wander alarm system, dent with a wander alarm had a cassessment and care plan in d treatment orders in place to	F 689	,		
	alarms for each re place, but the none	and functioning of wander sident with a wander alarm in compliance remained at the everity level of a D, isolated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245203			B. WING			C 01/07/2021	
NAME OF PROVIDER OR SUPPLIER THE VILLA AT BRYN MAWR				STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 689	scope and severity	level, which is no actual harm, ore than minimal harm that is	F 6				



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		00475	B. WING								
		00175	D. WING		01/0	7/2021					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH											
THE VILLA AT BRYN MAWR 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE						
2 000 Initial Comments			2 000								
	*****ATTENTION*****										
	NH LICENSING CORRECTION ORDER										
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been									
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.									
	abbreviated survey compliance with Sta	TS: 1/6/21 and 1/7/21, an was conducted to determine ate Licensure. Your facility was a in compliance with the MN									
	The following comp	laints were found to be									

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 02/04/21

STATE FORM 6899 If continuation sheet 1 of 18 18J411

TITLE

(X6) DATE

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00175	B. WING			C 0 7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 5	******		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	UNSUBSTANTIATE H5203147C H203145C The following comp SUBSTANTIATED: H5203146C H5203148C	ED: laints were found to be				
	signature is not req page of state form. Although no plan of	ed in ePOC and therefore a uired at the bottom of the first correction is required, it is cility acknowledge receipt of ments.				
21995	MN St. Statute 626. Maltreatment of Vul	.557 Subd. 4a Reporting - nerable Adults	21995			2/9/21
	(a) Each facility shat ongoing written pro- applicable licensing of suspected maltre- facility has an interr mandated reporter requirements of this internally. However	reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting the facility remains applying with the immediate ents of this section.				
	by: Based on observati review, the facility fa for 1 of 3 residents risk for elopement t jeopardy (IJ). The fa	ent is not met as evidenced on, interview, and document ailed to keep the resident safe (R1) whom was identified at hat resulted in an immediate acility failed to prevent the tho had severe cognitive		na		

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 2 of 18

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00175	B. WING		01/0	; 7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	L	STATE, ZIP CODE	1 01.10	
THE VIL	LA AT BRYN MAWR		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	impairments, for ap below freezing winter appropriate winter a potential serious had death for 1 out of 3 risk of elopement. The immediate jeop 12:48 p.m. when Realarm on his ankle, at front entrance wire alert staff. Staff wer 1:06 p.m. and police approximately 7.6 mevening. The admin nursing (DON) were jeopardy at on 1/5/2 immediate jeopardy noncompliance rem severity level of D, wharm with potential that is not immediate. R1's admission Min 11/19/20, indicated impairment, and waindependently. The diagnosis of non-traused a wander/elope 11/19/20, indicated and elopement, with independent mobility building unsupervis	proximately four hours in er temperatures without attire resulting in risk of arm, injury, impairment, or residents (R1) reviewed for bardy began on 1/1/21 at 1 whom had a security alert breached the secured doors thout any alarms sounding to be not aware R1 was gone until e were notified. R1 was found aniles from the facility later that histrator and director of e notified of the immediate 21, at 5:50 p.m. The compared which indicated no actual for more than minimal harm the jeopardy. Immum Data Set (MDS) dated R1 had severe cognitively as able to ambulate MDS indicated R1 had a numatic brain dysfunction, and	21995			

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 3 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	TION (X3) DATE SURVEY COMPLETED
00175 B. WING	C 01/07/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD	DE
THE VILLA AT BRYN MAWR 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
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:	

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 4 of 18

NAME OF PROVIDER OR SUPPLIER THE VILLA AT BRYN MAWR STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405 DEPROVIDERS PLAN OF CORRECTION PREFIX FAG. CALLA AT BRYN MAWR SUMMARY STATEMENT OF DEFICIENCIES PREFIX FAG. CALLA AT BRYN MAWR PREFIX FAG. COMPLETE FAG. CONTINUED FOR LISC IDENTIFYING INFORMATION) PREFIX FAG. CONTINUED FOR DEFICIENCY FAG. CONTINUED FOR DEFICIENCY FAG. CONTINUED FOR DEFICIENCY FAG. COMPLETE FAG. CROSS-REPERCECTO THE ACTIONS HOULD BE CROSS-REPERCED TO THE ACTION HOULD B		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE VILLA AT BRYN MAWR SUMMARY STATEMENT OF DEFICIENCES SUMMER SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES TAG PROVIDERS ANA OF CORRECTION [EXCIT OFFRECTIVE AT THE STATE OF THE APPROPRIATE DATE PROVIDERS ANA OF CORRECTION [EXCIT OFFRECTIVE AT THE STATE OF THE APPROPRIATE CROSS-REFERENCES AND OF THE APPROPRIATE CROSS-REFERENCES AND OF THE APPROPRIATE DATE 21995 21				A. BOILDING.			;
Act ID SUMMARY STATEMENT OF DEFICIENCIES CRACH DEFICIENCY MINNEAPOLIS, MN 55405			00175	B. WING			
CALL AT BRYN MAWR SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 to beserved R1 he 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,	THE VIL	LA AT BRYN MAWR					
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.	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
indicated H-A was on a break outside, walking to the local store and engaged in a phone	21995	interview/statement indicated LPN-C not doors were left ope LPN-D that he obsenearby store. H-A a and did not find R1 facility administration began searching for statement was part. Nursing assistant (I record form undated did not sound. NA-residents after the conted R1 was miss. LPN-C's interview/s1/1/21, indicated LF she noticed the slid tracks. This resulte LPN-C tried to fix the observed R1 at stated the wander at LPN-C did not checoplacement that day chance. A Code WI statement was part. An email from the findated 1/4/21, indicated to give a vendor ca around noon. The woulding. FDR left at vendor out the from outside and inside of H-A's interview/statindicated H-A was content in the state of the state o	a record form dated 1/1/21, biffied LPN-D that the front in. Housekeeper (H)-A notified erved R1 heading towards a and LPN-D checked the store. LPN-D then notified the on of R1's elopement, and it R1 in her vehicle. This of a facility investigation. NA)-A's interview/statement indicated the wander alarm indicated the wander alarm indicated the wander alarm indicated the was initiated, and ing. Statement record form dated endors were out of their indicated in the doors being open. The doors H-A notified her that the nearby store. LPN-C alarm system did not sound. Sk R1's wander alarm, noting she did not have a nite was initiated. This in a facility investigation. Tront desk receptionist (FDR) ated FDR came in to the facility is, and restock candy store at wendor was already in the round 12:20 p.m., let the todors, and locked both doors securely.	21995			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E SURVEY PLETED	
		00175	B. WING			C 07/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		N AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21995	Continued From particles of the observed R1 at the R1's behavior or whomas preoccupied with R2's interview/state indicated R2 stated outside. I thought he statement was particles of the particl	ge 5 facility and notified LPN-D he store. H-A could not recall nat he was wearing, noting he ith a phone call. ment record dated 1/5/21, , "I told [R1] how to get e was coming right back." This of a facility investigation. o.m. the DON was interviewed ed and paced hallways in the appeared tense. The DON kind and sweet one moment, ext. During the interview, R1 on, and stated his head felt bearing." The DON took a set raged R1 to sit down, and ask a didzzy. o.m., the administrator treport to the SA that R1 left rivised as it was not ement by the facility. The did the facility had identified R1 minutes of leaving and the charmed in an old residence. Exported she would provide all this incident. a.m. LPN-A was interviewed unsure if R1 had a wander dup R1's sweat pants, and a	21995			
	alarm. LPN-A pulled wander alarm brace ankle. LPN-A demo functioning by puttir wander alarm, and walked up to within					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			, DOILDII40.			,	
		00175	B. WING			7/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE VIL	LA AT BRYN MAWR		OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21995	Continued From pa	ige 6	21995				
	the door.						
	(TMA)-A stated she to ensure it was pre stated she was not it was functioning. allowed to go on ou	is a.m. trained medication aide to checked R1's wander alarm esent on his ankle. TMA-A aware of a method to ensure TMA-A stated R1 was not utings on his own. The nurse or the cart was responsible for er alarm system.					
l	incident was provid up included intervie	a.m. R1's follow up from the ed by administrator. The follow ws with staff about the vention plan or education.					
		a.m. R1 stated he did not uilding, "I don't remember. It o me."					
	and stated R1 had TMA-B stated she of functioning with a p	p.m. TMA-B was interviewed a wander alarm on his leg. checked to see if it was cortable sensor in the MA-B stated R1 wandered, and locate his room.					
	and stated R1 had he worked with R1 of 12/31/21. LPN-B verify presence and alarm if R1 was in b	p.m. LPN-B was interviewed a wander alarm. LPN-B stated on night shifts, including night stated he did not check to d function of R1's wander ped during his shift. LPN-B nally in bed during his shift.					
	and stated R1 walk LPN-C stated she w R1 left, when she n	a.m. LPN-C was interviewed ed around the building a lot. was serving lunch on the day loted the door was open. ooked around, and called a					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					0	
		00175	B. WING		01/0	7/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		OLIS, MN 5			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 7	21995			
	Code White to alert R1 did not tell LPN-sign out. LPN-C sta stated a vendor and the desk earlier in the rarely wore shoes sopportunity to leave stated a staff member building. LPN-C standid not sound and state opened front do been wearing gray that day, and was nowhen he left. LPN-C supposed to leave the supervision. LPN-C to check R1's wand but saw it on his left busy day, she was stated a vendor to the supposed to leave the supervision. LPN-C to check R1's wand but saw it on his left busy day, she was stated a vendor to the supposed to leave the supervision.	a staff of a missing resident. C he was leaving. R1 did not ated, "He escaped." LPN-C of the receptionist had been at the day. LPN-C stated R1 for he must have seen an and put his shoes on. LPN-C oper told her R1 had left the ted the wander alarm system the was concerned because of for. LPN-C stated R1 had for khaki pants and a sweater of sure if he had a coat on C explained R1 was not				
	assessment of R2's ambulate independ included bipolar dis was not noted as us alarm. R2's admiss revealed R2 was codelusions. On 1/5/21, at 12:50 stated he instructed by pushing and hold Penn Avenue. R2 reported he witness did not recall what I	dated 10/9/20, indicated no s cognition. R2 was able to ently, and had diagnoses that order, and schizophrenia. R2 sing a wander/elopement ion MDS, dated 7/10/20, ognitively intact and had p.m. R2 was interviewed and I R1 how to leave the building ding the front door, facing eported no alarm went off. R2 sed R1 leave the building. R2 R1 was wearing, but reported, much" and noted R1 was not n he left.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CONNECTION	IDENTIFICATION NOINBER.	A. BUILDING:			
		00175	B. WING		01/0	; 7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		AVENUE NO			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	OLIS, MN 5	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21995	Continued From pa	ge 8	21995			
	R2, with a wander of administrator and doculd walk through alarm. Even though the ankle, similar to During interview at maintenance and a the door is pushed opens due to fire sawander guard sensito the side of the dofeet off the ground. sounded when the cresident had an war On 1/5/21, at 2:08 p	o.m. the front desk receptionist				
	the facility at noon of minutes to assist a did not see R1 leav stated she did ensut to leaving. The FDF front desk and had door. The FDR stat approached the from could not recall if R before. The FDR stand there was not a replaced her when aware R1 was not to fher familiarity wit	wed and stated she came in to on 1/1/21, for approximately 15 vendor. The FDR stated she et he building. The FDR tree the door was locked prior R stated she worked at the seen R1 walk towards the ed she redirected R1 when he ht door. The FDR stated she 1 had ever pushed at the door ated she worked the day shift another receptionist that she left. FDR stated she was o leave the building because ht the residents, and because ht desk with pictures that had elopement in it.				
	interviewed and sta wander and elopem	p.m. the administrator was ted the facility completed nent assessments at y, and as needed. The				

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING.		С	
		00175	B. WING		1	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21995	administrator stated unsupervised on 1/ facility staff notified not find R1, had cal person had seen R the facility. The administrator stated informed her of the worked, so she wer location. The administrator stated informed her of the worked, so she wer location. The administrator stated informed R1 at an apa previously resided administrator stated administrator stated facility at 6:00 p.m. was allowed to leave however, R1 used a cognition. The admit turned towards R2, pushed on the door building. A Microsoft electror indicated a distance location of the facility was found by family Review of the Nation weather data for 1/2 weath	It R1 left the building 1/21. The administrator stated her at 1:20 p.m. they could led a Code White, and a staff 1 at the corner store nearby ininistrator stated she arrived in. and the police were already strator stated she finished in at 2:15 p.m., and left a samily to notify them R1 had left liministrator stated she sent if for R1 with their cars, and in R1 in her vehicle. The identify member (FM)-B location R1 had previously into look for him at that inistrator stated she received a im FM-B to notify her they retirent complex he had with his mother. The identify the family returned R1 to the inistrator stated she viewed wing the facility, R1 pushed it did not do anything. Then R1 who was sitting nearby, and proceeded out of the inic map of Minneapolis in for 7.6 miles between the ty and the location where R1 in map of Minneapolis in the initial was sitting nearby, and proceeded out of the initial was sitting nearby, and proceeded out of the initial was sitting nearby, and proceeded out of the initial was sitting nearby.	21995			

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PRINTED: 02/11/2021 FORM APPROVED

Minnesota Department of Health

Millinesc	ita Department of He	eaim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					ے ا	,
		00475	B. WING		04/0	
		00175	B: Wii(0		01/0	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		275 PENN	AVENUE N	ORTH		
THE VIL	LA AT BRYN MAWR		OLIS, MN 5			
	OUR MAA DV OTA		1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
04005	0	40	04005			
21995	Continued From pa	ge 10	21995			
	On 1/5/21 at 1:00 r	o.m. the administrator and				
		ctor (ED) observed the				
		ont door and wander alarm				
		veyor. A sensor was placed on				
		roximately 18 to 24 inches				
		well as about shoulder height.				
		ling door, but opened and				
		eing pushed and held with				
		de. R2, sitting in the lobby,				
		front door with a wander				
		No alarm sounded. R8, a				
		e lobby nearby, had a wander				
		which triggered the alarm				
		istrator stated it may be the				
		ander alarm that caused the				
		e. The administrator stated				
		ing staff to move wander				
		s wrists, but R2 must have				
		dministrator stated there was				
		onist at the door during the				
		iring night or evening shifts.				
	day Siliit, but not ut	ining hight of evening simils.				
	On 1/5/21 at 3:10 r	o.m. security footage for				
		n. was observed with the				
		OON. The administrator stated				
		available on the security				
		.m. R2 was observed walking				
		sitting down in a chair near the				
		Seconds later, R1 was				
		ing the front door, paused and				
		s R2. R1 then turned back to				
		and held the door. The door				
		out of the building wearing a				
		pants, athletic shoes and				
		1 was not wearing a a coat,				
		or a mask. The door				
		N-C approached the open				
		went through the open door				
	outside, and then re	eturned inside at 12:59 p.m.				

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Minnesota Department of Health STATE FORM

Minnesota Department of He	ealth				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00175	B. WING		01/0) 7/2021
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE VILLA AT BRYN MAWR		OLIS, MN 5			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21995 Continued From pa	ige 11	21995			
	the door. At 1:00 p.m. NA-A r and stood near LPN-C.				
administrator state leave the facility" at them in." The DON asked to sign a form against medical ad facility without discipled administrator state leaving, wanting to location and was for administrator state facility "if he knows administrator state impairments, but go wander and elopen completed in Nove wander alarm place and short term men administrator report manufacture recompleted in Nove wander able to wear to or ankle. The administrator report in had been pure door was open. The receptionist was producing business hop revention measured and short term in the same pure door was open. The receptionist was produced in the produced in the same pure during business hop revention measured ucation of staff of the residents with was no indication rewanderguards located the same pure alarm system. Review of R1's Was Evaluation, updates.	d R1 had a purpose to his go home, made his way to a bund in a safe location. The d R1 was safe to leave the where he is going." The d R1 had short term memory bod long term memory. R1's nent risk assessment was mber 2020, and he had a led on him due to confusion mory impairments. The ted she reviewed the mendations and residents he wander alarm on the wrist nistrator reported an additional richased to sound when the is had not been installed. A lesent at the front door only urs. There were no additional les were in place, such as r reassessment of R1 and in wanderguard. Also, there				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			71. DOILDING.			_
		00175	B. WING		01/0)7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			AVENUE NO			
THE VIL	LA AT BRYN MAWR		OLIS, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETE DATE
21995	Continued From pa	ge 12	21995			
	ambulatory, indeperto leave the building of elopement attem	nement, cognitively impaired, ndently mobile, physically able g on his own and had a history pts. R1 was assessed as ander alert personal safety nkle.				
	interviewed and sta cigarette on break of half a block from the engaged in a convection entered a near the same location. I facility and notified the store. H-A state to R1's behaviors of	a.m. housekeeper (H)-A was ted he was outside smoking a on 1/1/21, at 1:00 p.m. about a e facility. H-A stated he was ersation on his cell phone and by store and observed R1 in H-A stated he returned to the LPN-D that he had seen R1 at d he was not paying attention r clothing. H-A estimated he at approximately 1:06 p.m.				
	practitioner (NP)-A had amnesia. NP-A about R1 leaving, a the facility unsupervised of the facility unsupervised. NP-A harm if he left the factated it was fortunamemory, and his fametro he resided to stated it would not a would learn and restated R1 had a should throughout the reassurance about unfamiliar to him. R towards others whe actions. NP-A states	a.m. R1's primary care nurse was interviewed and stated R1 a stated she was concerned and did not want R1 to leave vised again. NP-A stated R1 coutside the facility A worried R1 was at risk of acility unsupervised. NP-A at eR1 worked off long term miliarity with the area of the find a familiar location. NP-A are reasonable to expect R1 tain new information. NP-A are tattention span, and anxiety day. R1 was always needing his surroundings, which were an exhibited aggression on he misinterpreted their d she was the on call provider bement, and was not notified				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` 'c) DATE SURVEY COMPLETED	
7 IND 1 L7 IIV	OF CONTRECTION	BENTI IOMITEN NOMBER.	A. BUILDING:				
		00175	B. WING		01/0	7/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE VILLA AT BRYN MAWR 275 PENN							
	OLIMA AA DV OTA		OLIS, MN 5		ION	0.1-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21995	Continued From pa	ae 13	21995				
	notified her of the ep.m., four days after stated she would exelopement on the s	lopement on 1/5/21, at 6:30 or the event occurred. NP-A expect to be notified of R1's ame day it occurred.					
	was interviewed an leaving the facility was phone call from the p.m., as well as photo FM-A stated several searching for R1 in worked, visited, and found R1 at 4:55 p. lobby where he had FM-A then met R1 FM-A stated R1 had months and had sin and FM-C, was at the facility for past couple.	d stated he was aware of R1's without supervision because of the facility on 1/1/21 at 2:52 one calls to FM-B at 3:32 p.m. all family members started areas R1 had previously diresided. FM-A reported FM-B m. at an apartment building at the apartment building. It is a partment building at the apartment building. It is a partment building at the apartment building. It is a partment building at the apartment building. It is a partment building at the apartment building. It is a partment building at the hospital, and resided at the ble months. FM-D also no					
	stated R1 was weat pants, a long sleever and mesh slip on site wearing a mask, condespite traveling appropriate facility to apartment FM-A reported R1 coughing and apperfurrowed brow. FM-so FM-A purchased and a bag of chips. "hazy" after drinking	apartment complex. FM-A ring summer weight sweat e shirt, possibly an undershirt hoes. FM-A stated R1 was not pat, hat or mittens/gloves, proximately seven miles from a complex in winter weather. Glid not appear injured, but was ared "fuzzy" with a troubled, A thought R1 might be thirsty, I R1 an electrolyte beverage FM-A stated R1 was less g and eating a little. FM-A and FM-C are resided with FM-A and FM-C					
	prior to being hospi facility. FM-A stated his own. FM-A and supervision for wall when R1 resided w	y resided with FM-A and FM-C talized, and transferred to the I R1 could not safely travel on FM-C had previously provided as and travel in the community ith them due to concerns with A stated, "We knew if he was					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00175	B. WING		I	C 07/2021
THE VILLA AT BRYN MAWR 275 PENI			DRESS, CITY, S I AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21995	away from us that he FM-A stated R1 had approximately one while traveling interrelated to impaired intoxicating substar intervention from the family escort to retustated he was disaptrack of the wherea as they were in chandle of the was an unidentified nurse were open. LPN-D sunidentified nurse to determine if any resistated staff searches building on foot as a LPN-D stated R1 stated staff searches building on foot as a LPN-D stated R1 stated the building of to be on the streets was no alarm sound front door. On 1/7/21, at 10:51 manager, was interget frustrated and danger, which means physically and verbawhen he was frustrated and the state of th	ne would probably be lost."	21995			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		00175	B. WING		01/0	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		I AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21995	under his covers or had moved rooms on the 1st floor. R1 where he was but in he was employed at On 1/12/21, at 3:32 manager (CM) was was not safe in the appropriate support memory, and orient informed R1 was for previous residence elopement by famility by the facility. CM in facility to notify him appropriate coordin. The Wandering and 3/16/17, directed stre-admission, through change in condition for potential elopement risk brace a wander alarm. Broof functioning and elopement risk brace a wander alarm. Broof functioning every shift. Each facommunicate the aresident at risk for expresentatives would be checked the elopement appropriate placement. The facility Observation in the facility Observation in the facility Observation in the facility Observation.	n his bed in a private room. R1 and was in an unsecured unit reported he was not sure named a rural town. R1 noted and lived with FM-A and FM-C. It p.m. R1's mental health case interviewed and stated R1 community without as due to cognition, short term tation. CM noted he had been bound without a coat on and in a c. CM was notified of R1's y, and then several days later eported he would expect the in a timely fashion for	21995			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			`
		00175	B. WING		01/0	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		I AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	attempt to prevent diversional techniques resident specific into plan of care. The probation assistance from the charge assistance is required. The facility Missing 3/16/17, directed stocked search immediately determined missing report immediately determined missing report immediately of a suspected minumed was on an authorizal appointment; annot system for "CODE resident room num to notify the staff the After the resident is person (the charge Administrator, Director of Nursing Examine the resident attending physician condition of the resident generated alarms-I resident generated safety. The alarm frossession of resident generated safety. The alarm frossession of resident generated." The recommended." The recommended." The recommended." The recommended."	the departure- provide ues, re-direction and apply ervention as directed by the rocedure also directed staff to rom staff members in the Instruct another staff member e nurse or director of nursing	21995			

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00175	B. WING		01/0	D 17/2021
NAME OF PROVIDER OR SUPPLIER THE VILLA AT BRYN MAWR 275 PENN			DRESS, CITY, S I AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21995	resident monitoring surveillance with coequipment. It is the periodically check of RF Technologies In pull cords, control uninappropriate use of and stumbling haza. The immediate jeopowas removed on 1/1/1/2 educated all staff of audited functioning ensured each resid wander/elopement place, and ensured monitor presence a alarms for each resplace, but the noncolower scope and severity with potential for monot immediate jeoposticies and proced of mistreatment. The administrator of policies and proced of mistreatment. The amonitoring system compliance.	combines close personal prect operation of monitoring responsibility of the facility to an residents in possession of c.'s equipment (i.e. pendants, inits) to mitigate risks of fequipment or strangulation and from cables and cords." Deardy that began on 1/1/21, 6/21, when the facility nelopement procedures, of wander alarm system, ent with a wander alarm had a assessment and care plan in treatment orders in place to not functioning of wander ident with a wander alarm in ompliance remained at the verity level of a D, isolated level, which is no actual harm, ore than minimal harm that is	21995			

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