

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: <a href="mailto:susan.frericks@state.mn.us">susan.frericks@state.mn.us</a>

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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc">https://mdhprovidercontent.web.health.state.mn.us/ltc</a> 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 AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		\ ,	E SURVEY PLETED	
		245203	B. WING _		<b>I</b>	C <b>07/2021</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		0112021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	abbreviated survey to conduct a complewas found not to be Part 483, Requirem Facilities.  The following composition of the following composition of the following composition of the following composition of the facility's plan of as your allegation of the form. Your electron of the form. Your electron of the form of the form. Your electron of the form of the form of the form. The survey resulted your verification.  The survey resulted (IJ) at F689 when the prevent elopement.	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  In an Immediate Jeopardy the facility may be conducted to in an Immediate Jeopardy the facility failed to provide the erventions necessary to for 1 of 3 residents (R1)	F 00	Minnesota Department of It documenting the State Lice Correction Orders using fe Tag numbers have been as Minnesota state statutes/ru Homes.  The assigned tag number a far left column entitled "ID The state statute/rule number corresponding text of the stout of compliance is listed in "Summary Statement of Decolumn and replaces the "Temportion of the correction or column also includes the fare in violation of the state statement, "This Rule is evidenced by." Following the findings are the Suggested Correction and the Time Percorrection.  PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE FOURTH COLUMN STATES, "PROVIDER'S PLEASE DISREGARD THE OF THE STATES THE THE STATES THE STATE	ensing deral software. signed to les for Nursing appears in the Prefix Tag." ber and the atte statute/rule in the efficiencies" to Comply" der. This findings which statute after anot met as the surveyors Method of the eriod For EHEADING N WHICH LAN OF PLIES TO ONLY. THIS PAGE.  ENT TO RECTION FOR	
•	eloped from the fac	nents, who subsequently illity. R1 eloped from the DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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.

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245203	B. WING _		1	C <b>07/2021</b>
NAME OF PROVID	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  275 PENN AVENUE NORTH  MINNEAPOLIS, MN 55405	1 0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
facil trave urba from wint infect heal functimm of a of a on 1 1/6/2  The qual cond Free SS=D CFF  §483  Exp The negl and inclucorp any trea  §483  §483  physinvo This by:	eling approximation area, with wind 12 Fahrenheit er attire or massiction. The surveilth and safety. The stional wander at resident in the breach in the breach in the breach in the stident of the from Abuse and ducted from 1/6 or from Abuse and (s): 483.12(a)(3.12 Freedom for the sident has the lect, misappropexploitation resident has the boral punishment physical or chest the resident's (3.12(a)(1) Not usical abuse, confluentary seclusion as a second and the sident's (s): 483.12(a)(1) Not usical abuse, confluentary seclusion as a second and the second an	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 The facility failed to ensure a plarm system and an ponse upon the identification community and identification ecured doors. The IJ began immediacy was removed on constituted substandard an extended survey was sized to 1/7/21. Ind Neglect 1) from Abuse, Neglect, and the right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from the interest in the required to medical symptoms.	F 00		ct	2/9/21

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			01/0	) 7/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	75 PENN AVENUE NORTH		
THE VILI	A AT BRYN MAWR			N	MINNEAPOLIS, MN 55405		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 600	Continued From pa	age 2	F 6	00			
		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	ıy	
	Findings include:				adverse effect and was offered to be seen by in house psychology	een	
	R1's admission Mir	nimum Data Set (MDS), dated			All staff were educated on reviewing	the t	
	11/19/20, indicated	R1 was admitted from a			residents care plan (Kardex) for ber	naviors	
		l. R1 had severe cognitive			and non-pharmacological intervention		
		lked independently in corridor			regarding residents individualized ca	are	
		independent in locomotion on			plan to identify possible behavioral		
		1 had a diagnosis of			triggers before they occur		
	non-traumatic brair	n dystunction.			Identification of other residents:		
	D2's guerterly MDC	C dated 12/21/20 indicated D2			All residents living in a skilled facility	/ are	
		S, dated 12/31/20, indicated R3 act. R3 walked independently in			at risk for abuse and neglect Nursing and social service staff wer		
		R3 was independent in			re-educated on Abuse, and Neglect		
	locomotion on unit				policy/procedures.		
	iocomotion on anic	and on ann.			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			Monitoring Mechanism:		
		st and superficial skin tear to			Residents with identified behaviors		
	left hand, requiring	iirst aid.			monitored daily by all staff members	s using	
	D3's skip observati	on, dated 12/28/20, indicated			identified target behaviors.  Target behavioral charting, and the		
		ig noted to left side of Adams			effectiveness of behavioral interven	tione	
		erficial skin tear to ring finger.			will be reviewed monthly by clinical		
	The and lost oabo				IDT team will review, and update ea		
	On 1/4/21. at 12:50	p.m. R1 reported he could not			residents care plan based upon		
		ons with other residents.			resident⊡s clinical diagnosis, target		
					behaviors, behavioral charting,		l
	On 1/4/21 at 1:40	n m R3 reported "He tried to			interventions medication managem	ent	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		245203	B. WING		1	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 DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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) COMPLETION DATE
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 nt 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 p back and R1 refused. R1 and R3's neck, stating "I am aur attitude." TMA-B separated and a bruise and a little cut and a bruise and a little cut and a bruise and a little cut and a bruise and resident will be Abuse could include verbal, ohysical abuse, corporal luntary seclusion. The resident from physical or chemical for purposes of discipline or that 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 ved at	
	residents would be 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)(	protected from abuse, while they are residing at the r harm of any type would be ents and staff would be ction. The facility would strive dother applicable individuals in ct all parties.	F 609			2/9/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245203			l ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245203	B. WING		1	C 01/07/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		0112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 609	neglect, exploitation must:  §483.12(c)(1) Ensuinvolving abuse, nemistreatment, inclusiource and misappare reported immechours after the allegations after the allegations bodily injuritie events that cause the administrator of officials (including the accordance with St.)  §483.12(c)(4) Repositions to the designated representations to the designated representations to the appropriate correct. This REQUIREMED by:  Based on observation resident with some officials include:  Findings include:	in, or mistreatment, the facility are that all alleged violations in its exploitation or ding injuries of unknown repriation 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 fit the facility and to other the facility and to other of the State Survey Agency and vices where state law provides ingeterm care facilities) in ate law through established on 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. NT is not met as evidenced the tion, interview and document ailed to report neglect of a severe cognitive impairment are facility for 1 of 4 residents	F 60	F609: Reporting alleged viola Corrective Action: Elopement of R1 was reporte 1/5/21 NHA was educated on reporti obligations by region director operations Identification of other Resider All residents are at risk for ab Monitoring Mechanism	d to MDH on ng of clinical nt:		

Facility ID: 00175

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		245203	B. WING			/07/2021
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CO 75 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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	impairment. R1 wa and room. R1 was unit and off unit. R1 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 includ 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 liked independently in corridor independent in locomotion on had a diagnosis of dysfunction. R1 used a alarm daily.  Ement Risk Evaluation, dated R1 was at risk of wandering,	F 609	All wander events will be mo reporting obligations, by RD 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 added was missing within	as called. R1's family, police				

Event ID: 18J411

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245203	B. WING _		01	C / <b>07/2021</b>
	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		

STATEMENT OF DEFI AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	COM	E SURVEY IPLETED
		245203	B. WING			C <b>07/2021</b>
NAME OF PROVIDE				STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
to a re harm, distres "abuse or mis source are re facility involvi mistre source are re hours that ca in seri if the e involve injury, other Agence law prescribed as free \$483.2 The fa §483.3 as free \$483.2 super accide This F by: Base	pain, mental ss." and "It is e" allegations treatment, in e and misapp ported per Fe will ensure to me abuse, ne atment, inclue and misapp ported imme after the alleguse the alleguse that called a buse and to the admir officials (inclue) and adult povides for jures) in accordished proced of Accident H (a): 483.25(d)(25(d)) Accident H (a): 483.25(d)(1) The electron of accident to the admir officials (inclue) and adult povides for jures) in accordished procedof Accident H (a): 483.25(d)(1) The electron of accident to the a	re necessary to avoid physical anguish, or emotional the policy of this facility that (abuse, neglect, exploitation cluding injuries of unknown propriation of resident property) ederal and State Law. The hat all alleged violations eglect, exploitation or uding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result jury, or not later than 24 hours ause the allegation do not do not result in serious bodily distrator of the facility and to uding to the State Survey protective services where state risdiction in long-term care ance with State law through lures."  azards/Supervision/Devices (1)(2)	F 609			2/9/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l ` ′	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG	С		
		245203	B. WING_		1	07/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				275 PENN AVENUE NORTH			
THE VILI	A AT BRYN MAWR			MINNEAPOLIS, MN 55405			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE ROPRIATE	COMPLETION DATE	
F 689	Continued From pa	ige 8	F 68	39			
	for 1 of 3 residents	(R1) whom was identified at		Corrective Action:			
		that resulted in an immediate		Identified resident, R1, has retu	irned to the		
	jeopardy (IJ). The f	acility failed to prevent the		facility and been re-evaluated.	Currently		
		ho had severe cognitive		plan of care includes a wander			
		proximately four hours in		has been placed on R1. Care p			
		er temperatures without		been reviewed and is appropria			
		attire resulting in risk of		resident received an assessme	•		
		arm, injury, impairment, or		return and was found to be free			
	risk of elopement.	residents (R1) reviewed for		Both provider and family have updated. Facility working with r			
	risk of eloperficit.			provider to ensure resident saf			
	The immediate ieo	pardy began on 1/1/21 at		Points of exit and entrance have			
		1 whom had a security alert		checked to ensure door alarms			
		breached the secured doors		functioning appropriately. Wan			
		ithout any alarms sounding to		alarms have received sensor c			
	alert staff. Staff we	re not aware R1 was gone until		ensure wander guard alarm sy			
		e were notified. R1 was found		An additional alarm has been a			
		miles from the facility later that		front door when the emergency			
		nistrator and director of		released to alert staff that door	has been		
		e notified of the immediate		opened.			
		21, at 5:50 p.m. The y was removed on 1/6/21, but		Dietary, housekeeping, nursing and administration staff have b			
		nained at the lower scope and		educated, prior to next shift, or			
		which indicated no actual		that doors are secured, respon			
		for more than minimal harm		door alarms, and following resi			
	that is not immedia			of care related to safety checks	•		
		, ,		of care.	·		
	Findings include:			Code drills for a potential bread	h in the		
				elopement system have been o	ompleted		
		nimum Data Set (MDS) dated		for all 3 shifts.			
		R1 had severe cognitively		Identification of other Resident			
		as able to ambulate		Residents that reside at Bryn N			
		MDS indicated R1 had a		center have been assessed for risk. Residents who are at risk			
		aumatic brain dysfunction, and pement alarm daily.		elopement have received care			
	useu a wanuci/ciu	Sometic alaitii dally.		updates to ensure resident safe			
	R1's Wander/Flone	ement Risk Evaluation dated		plan updates include resident p			
		R1 was at risk of wandering		added to wander list, staff awa			
		h risks factors including		wander risk, wander guard add			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245203	B. WING			C 07/2021
PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	•	7172021
A AT DOWN MAND			275 PENN AVENUE NORTH		
AAI BRYN MAWR			MINNEAPOLIS, MN 55405		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
Continued From pa	age 9	F 689			
building unsupervis wandering the build confusion.	sed, exit seeking and ding, and early evening		locked unit but have been a elopement risk have receive ensure wanderguards are fu appropriately.	ssessed as an ed checks to unctioning	
indicated, "Wander on L [left] ankle bas assessment and re of the facility."	guard [wander alarm] placed sed on residents wander ssident being observed outside		checking placement of wand every shift and checking wa functioning once daily. Monitoring Mechanism: Daily audits will be conducted	derguards nderguard ed by	
at risk of elopemen care plan goal was interventions includ wandering resident staff assessment o motivation and trigg	t related 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		functioning properly for 30 d weekly after 30 days. Nursing staff will be checkin of wanderguards every shift wanderguard functioning on Nursing leadership will rand Wandgergaurd checks for 3	lays and then ag placement and checking ce daily. omly audit d days to	
treatment administriculded an order to placement of wand night shift 12/29/20 marked by a licens not completed for Fnot completed on 1 12/31/20 day shift. this order was mark completed with a not there was no indictional functioning properly R1's nurse note day indicated R1 was order to was not the completed with a new properly shift.	ration record [MAR/TAR] to check functioning and er device every shift. On the 1, 12/30/20, 12/31/20 this was ed practical nurse (LPN)-B as R1. TMA-B marked this task as 2/30/20 evening shift and On the day shift for 1/1/21, ked by (LPN)-C as not ote to see nurses notes. ation if R1's alarm was y during these time frames.		days will continue with week Audit results will be reviewe	dy audits. d at QAPI to nued	
	Continued From paindependent mobilibuilding unsuperviswandering the build confusion.  A progress note daindicated, "Wander on L [left] ankle basassessment and reof the facility."  R1's care plan date at risk of elopement care plan goal was interventions include wandering resident staff assessment on motivation and trigg a wander alert persankle.  Review of R1's Dectreatment administrincluded an order to placement of wand night shift 12/29/20 marked by a licens not completed on 1 12/31/20 day shift. this order was marked by a licens not completed with a not completed wit	PROVIDER OR SUPPLIER  LA AT BRYN MAWR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9 independent mobility, a history of leaving the building unsupervised, exit seeking and wandering the building, and early evening confusion.  A progress note dated 11/20/20, at 8:36 a.m. indicated, "Wander guard [wander alarm] placed on L [left] ankle based on residents wander assessment and resident being observed outside of the facility."  R1's care plan dated 11/20/20, indicated R1 was at risk of elopement related to disorientation. The care plan goal was to keep R1 safe. R1's interventions included a photo on the list of wandering residents, distractions and diversions, staff assessment of wandering behavior motivation and triggers, offering to call family and a wander alert personal safety device on the left	PROVIDER OR SUPPLIER  AAT BRYN MAWR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9  independent mobility, a history of leaving the building unsupervised, exit seeking and wandering the building, and early evening confusion.  A progress note dated 11/20/20, at 8:36 a.m. indicated, "Wander guard [wander alarm] placed on L [left] ankle based on residents wander assessment and resident being observed outside of the facility."  R1's care plan dated 11/20/20, indicated R1 was at risk of elopement related to disorientation. The care plan goal was to keep R1 safe. R1's interventions included a photo on the list of wandering residents, distractions and diversions, staff assessment of wandering behavior motivation and triggers, offering to call family and a wander alert personal safety device on the left ankle.  Review of R1's December 2020 medication and treatment administration record [MAR/TAR] included an order to check functioning and placement of wander device every shift. On the night shift 12/29/20, 12/30/20, 12/31/20 this was marked by a licensed practical nurse (LPN)-B as not completed on 12/30/20 evening shift and 12/31/20 day shift. On the day shift for 11/1/21, this order was marked by (LPN)-C as not completed with a note to see nurses notes. There was no indication if R1's alarm was functioning properly during these time frames.  R1's nurse note dated 1/1/21, at 3:06 p.m. indicated R1 was out of the building without staff knowledge. A Code White (the emergency code	PROVIDER OR SUPPLIER  AAT BRYN MAWR  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9 independent mobility, a history of leaving the building unsupervised, exit seeking and wandering the building, and early evening confusion.  A progress note dated 11/20/20, at 8:36 a.m. indicated, "Wander guard [wander alarm] placed on L [left] ankle based on residents wander assessment and resident being observed outside of the facility."  R1's care plan dated 11/20/20, indicated R1 was at risk of elopement related to disorientation. The care plan goal was to keep R1 safe. R1's interventions included a photo on the list of wandering residents, distractions and diversions, staff assessment of 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 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 indicated If was a functioning properly during these time frames.  R1's nurse note dated 11/12, at 3:06 p.m. indicated R1 was out of the building without staff knowledge. A Code White (the emergency code	AT BRYN MAWR  SITERET ADDRESS, CITY, STATE, ZIP CODE  275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9 independent mobility, a history of leaving the building unsupervised, exit seeking and wandering the building, and early evening confusion.  A progress note dated 11/20/20, at 8:36 a.m. indicated, "Wander guard [wander alarm] placed 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 eight shift 12/29/20, 12/31/20, 12/31/20 this was marked by a licensed practical nurse (LPN)-B as not completed of R1. TMA-B marked this task as not completed on 12/30/20 evening shift and 12/23/120 day shift. On the day shift for 11/121, this order was marked by (LPN)-C as not completed with a note to see nurses notes. There was no indication fR R1's alarm was functioning properly during these time frames.  R1's nurse note dated 11/1/21, at 3:06 p.m. indicated R1 was out of the building without staff knowledge. A Code White (the emergency code

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		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 end LPN-D checked the store. LPN-D then notified the en of R1's elopement, and er R1 in her vehicle. This et 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, indicate to 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:		` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245203	B. WING		01	C / <b>07/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	vendor out the front 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 who was preoccupied who was preoccupied who have the local stated R2 stated outside. I thought his statement was part on 1/4/21, at 1:26 pand stated R1 walk facility, and at times stated R1 could be and explosive the mapproached the DC "clogged" and "over of vitals, and encour for help when he feron sidered an elop administrator added was missing within family found him un The administrator refollow up related to	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.  The ment record dated 1/5/21, "I told [R1] how to get e was coming right back." This of a facility investigation.  The DON was interviewed ed and paced hallways in the sappeared tense. The DON kind and sweet one moment, ext. During the interview, R1 on, and stated his head felt rearing." The DON took a set traged R1 to sit down, and ask lt dizzy.  The administrator of the same and the same to the facility had identified R1 minutes of leaving and the charmed in an old residence. eported she would provide all	F 63	39		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245203	B. WING		01	C / <b>07/2021</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 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		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	alarm. LPN-A pulled wander alarm brace ankle. LPN-A demo functioning by puttir wander alarm, and walked up to within the unit and turned the door.  On 1/5/21, at 10:26 (TMA)-A stated she to ensure it was prestated she was not it was functioning. I allowed to go on out the TMA working the checking the wander on 1/5/20, at 11:34 incident was providup included intervie incident, but no precon 1/5/21, at 11:46 recall leaving the burnight come back to On 1/5/21, at 12:04 and stated R1 had a TMA-B stated she of functioning with a predication cart. The needed direction to On 1/5/21 at 12:22 and stated R1 had a stated R1 h	d unsure if R1 had a wander d up R1's sweat pants, and a elet was present on R1's left instrated how she checked ng a portable sensor near R1's R1's sensor beeped. R1 twice a few feet of the exit doors for around, without pushing on a.m. trained medication aide e checked R1's wander alarm esent on his ankle. TMA-A aware of a method to ensure TMA-A stated R1 was not stings on his own. The nurse or e cart was responsible for er alarm system.  a.m. R1's follow up from the ed by administrator. The follow was with staff about the vention plan or education.  a.m. R1 stated he did not uilding, "I don't remember. It o me."  p.m. TMA-B was interviewed a wander alarm on his leg. checked to see if it was ortable sensor in the MA-B stated R1 wandered, and		689		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245203	B. WING _			C / <b>07/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  275 PENN AVENUE NORTH  MINNEAPOLIS, MN 55405		V	
(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,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	Y
		245203	B. WING		01/07/2021	1
	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉ	TION
F 689	delusions.  On 1/5/21, at 12:50 stated he instructe by pushing and ho Penn Avenue. R2 reported he witnes 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 to During interview at maintenance and a the door is pushed opens due to fire swander guard sens to the side of the deet off 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 leas stated she did ensito leaving. The FD front desk and had door. The FDR state approached the frocould not recall if Forcould not recall if Forc	D p.m. R2 was interviewed and d R1 how to leave the building lding the front door, facing reported no alarm went off. R2 sed R1 leave the building. R2 R1 was wearing, but reported, gmuch" 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 the door without triggering the h R2 wore a wander guard on this time, the director of administrator explained when and held, it released and afety. They explained the sor was separate and attached oor frame, approximately 2. The alarm should have door was opened if the	F 689			

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG	, ,	ATE SURVEY DMPLETED
		245203	B. WING			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

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

[`` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	(X3) DATE SURVEY COMPLETED			
		245203	B. WING				C <b>07/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 689	pushed on the door building.  A Microsoft electror indicated a distance location of the facili was found by family.  Review of the Nation weather data for 1/2 was 23 degrees Fadegrees Fahrenheir.  On 1/5/21, at 1:00 penvironmental direct functioning of the frage system with the surthe door frame app from the ground as The door was a slice stayed open after beforce due to fire conwalked 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 nursularms to resident's "slipped by." The activate she instructed nursularms to resident's "slipped by." The activate she instructed nursularms to resident's "slipped by." The activate she instructed nursularms to resident's "slipped by." The activate she instructed nursularms to resident's "slipped by." The activate she instructed nursularms to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instructed nursular to resident's "slipped by." The activate she instruc	r and proceeded out of the nic map of Minneapolis of 7.6 miles between the ty and the location where R1 //.  In all Weather Service historical 1/21, indicated the weather hrenheit for a high and 12	F 6	89			

Facility ID: 00175

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245203	B. WING		01	C / <b>/07/2021</b>
	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 reterm mer administrator repormanufacture recommerce able to wear to ankle. The administrator the administrator repormanufacture.	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:			l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	
		245203	B. WING _		1	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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 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 store on his left at the exit doors of t	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 with the red and did not want R1 to leave vised again. NP-A stated R1	F 68	9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245203	B. WING _		01	C / <b>07/2021</b>
	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 f stated it was fortun memory, and his fa metro he resided to stated it would not would learn and restated R1 had a sh built 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 an leaving the facility of a phone call from the p.m., as well as ph. FM-A stated several searching for R1 in worked, visited, an found R1 at 4:55 plobby where he had FM-A then met R1 FM-A stated R1 had months and had signed FM-C, was at the facility for past coulonger lived at the astated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants, a long sleever and stated R1 was weat pants.	A worried R1 was at risk of acility unsupervised. NP-A ate R1 worked off long term amiliarity with the area of the offind a familiar location. NP-A be reasonable to expect R1 train new information. NP-A ort attention span, and anxiety a day. R1 was always needing his surroundings, which were R1 exhibited aggression on he misinterpreted their and she was the on call provider pement, and was not notified NP-A stated the facility elopement on 1/5/21, at 6:30 or the event occurred. NP-A expect 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. In the apartment building. In the apartment building direviously resided at the ple months. FM-D also no apartment complex. FM-A aring summer weight sweat e shirt, possibly an undershirt hoes. FM-A stated R1 was not	F 68	9		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245203	B. WING			1	C 07/2024
	PROVIDER OR SUPPLIER	240200		ST 27	REET ADDRESS, CITY, STATE, ZIP CODE  5 PENN AVENUE NORTH INNEAPOLIS, MN 55405	1 01/	07/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	wearing a mask, condespite traveling application facility to apartment FM-A reported R1 of coughing and apperfurrowed 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 substarintervention from the family escort to retustated he was disaptrack of the wherea as they were in character open. LPN-D unidentified nurse the determine if any resistated staff searched building on foot as LPN-D stated R1 si	pat, hat or mittens/gloves, proximately seven miles from a 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 g and eating a little. FM-A y resided with FM-A and FM-C talized, and transferred to the R1 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			

to be on the streets alone. LPN-D stated there

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245203	B. WING_		01	C / <b>07/2021</b>
	NAME OF PROVIDER OR SUPPLIER  THE VILLA AT BRYN MAWR   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 21 was no alarm sounding when she approached to front door.  On 1/7/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release hanger, which meant he exploded and had been physically and verbally aggressive towards othe when he was frustrated. R1 had a variable attention span. At times R1 could be preoccupied for an hour with an activity and at times, only 5 minutes. LPN-D stated R1 was not allowed to leave the building unsupervised. LPN-D explain R1 was not safe to leave on his own due to			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	,	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD 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 coordin.	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,	F 68	39		
		igh quarterly review and residents would be evaluated				

· /		` IDENTIFICATION NUMBER.   ` `		PLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		245203	B. WING			C / <b>07/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405	Y, STATE, ZIP CODE ORTH		
(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 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 are nurse or director of nursing	F 689				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED  C
		245203	B. WING		01	/ <b>07/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	person (the charge Administrator, Dire Upon return of the Director of Nursing Examine the resid attending physicial condition of the research Representative.  The Touchpad Exi Guide, dated 7/20 generated alarms-resident generated safety. The alarm possession of resiperiodically and re	is found, notify the charge experson will notify the extor of Nursing and police). It resident to the facility, the gor Charge nurse should: ent for injuries. Consult with the n and report findings and sident. Notify the Resident of Controller Administration 18, directed users, "Resident Do no rely exclusively on a alarms for resident care and function of equipment in the dents must be verified gular resident surveillance is	F 68			
	"Resident Monitoring resident monitoring surveillance with continuous equipment. It is the periodically check RF Technologies I pull cords, control inappropriate use and stumbling haz	he guide further directed users, ing-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."				
	was removed on 1 educated all staff of audited functioning ensured each residuant ensured each residuant ensured ensured ensured ensured monitor presence alarms for each replace, but the none	/6/21, when the facility on elopement procedures, g of wander alarm system, dent with a wander alarm had a t assessment and care plan in d treatment orders in place to 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		I	C <b>/07/2021</b>	
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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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

(X6) DATE

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. WINO		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)	TION SHOULD BE COM THE APPROPRIATE DA						
2 000 Initial Comments			2 000								
	****ATTENTION*****										
	NH LICENSING CORRECTION ORDER										
	144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of tack of compliance. re-inspection with a result in the assess	nether a violation has been									
	You may request a that may result from orders provided tha the Department with	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 e 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

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00475		B. WING		C 01/07/2021	
NAME OF I	PROVIDER OR SUPPLIER	00175		STATE, ZIP CODE	01/0	7/2021	
			AVENUE NO				
I HE VILI	_A AT BRYN MAWR		OLIS, MN 5	5405			
(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 APPROF	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 1	2 000				
	UNSUBSTANTIATE H5203147C H203145C	ED:					
	The following complaints were found to be SUBSTANTIATED: H5203146C H5203148C						
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.  Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.						
21995	MN St. Statute 626 Maltreatment of Vul	.557 Subd. 4a Reporting - Inerable Adults	21995			2/9/21	
	Subd. 4a. Internal reporting of maltreatment.  (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.						
	by: Based on observati review, the facility fa for 1 of 3 residents risk for elopement t jeopardy (IJ). The fa	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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.		C	
		00175	B. WING		_	7/2021
NAME OF PROVIDER	OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE VILLA AT BI	RYN MAWR		AVENUE NO OLIS, MN 5			
	CH DEFICIENC	ATEMENT 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
impairibelow approproprotenti death in risk of The im 12:48 palarm of at from alert standard immediate and a severit that is Finding R1's and a severit that is R1's was a severit that is Finding and a severit that is Finding impairing the period and a severit that is Finding R1's was a severit that is Finding R1's and a severit that is Finding and a severit that is Finding was a severit that is Finding and a severit that is Finding a severit that	freezing winter al serious has or 1 out of 3 elopement.  Imediate jeo o.m. when Ron his ankle, the entrance when and police imately 7.6 rug. The adming (DON) were dy at on 1/5/2 iate jeopard pliance renty level of D, with potential not immediately The sis of non-trawander/elopement, with nodently. The sis of non-trawander/elopement, with nodently indicated opement, with nodent mobiling unsupervising the build	oproximately four hours in the temperatures without attire resulting in risk of farm, injury, impairment, or a residents (R1) reviewed for a pardy began on 1/1/21 at 1 whom had a security alert 1 breached the secured doors at a part and a par	21995			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00175	B. WING			C <b>07/2021</b>
	PROVIDER OR SUPPLIER	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21995	A progress note data indicated, "Wander on L [left] ankle bas assessment and resof the facility."  R1's care plan date at risk of elopement care plan goal was interventions includ wandering residents staff assessment of motivation and trigg a wander alert persankle.  Review of R1's Dectreatment administrincluded an order to placement of wander included for some completed on 1. 12/31/20 day shift. This order was mark completed with a not the complete with a not the	ted 11/20/20, at 8:36 a.m. guard [wander alarm] placed and on residents wander sident being observed outside ded on residents wander sident being observed outside ded 11/20/20, indicated R1 was threlated to disorientation. The to keep R1 safe. R1's ed a photo on the list of standard districtions and diversions, of wandering behavior gers, offering to call family and onal safety device on the left dember 2020 medication and action record [MAR/TAR] of check functioning and for device every shift. On the process of practical nurse (LPN)-B as action 12/30/20, 12/31/20 this was ed practical nurse (LPN)-B as action the day shift for 1/1/21, and On the day shift for 1/1/21, and on the day shift for 1/1/21, and on the day shift for 1/1/21, and of the building without staff white (the emergency code ent) was called. Family, police ditioner were notified.	21995			
	Licensed practical r	_				

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 4 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00175	B. WING		01/0	C <b>)7/2021</b>
	PROVIDER OR SUPPLIER	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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21995	indicated LPN-C not doors were left ope LPN-D that he observed R1 and did not find R1. facility administration began searching for statement was part.  Nursing assistant (Note of the content of the con	record form dated 1/1/21, tified LPN-D that the front in. Housekeeper (H)-A notified erved R1 heading towards a ind LPN-D checked the store LPN-D then notified the on of R1's elopement, and in R1 in her vehicle. This is of a facility investigation.  NA)-A's interview/statement indicated the wander alarm in accounted for all of her code white was initiated, and ing.  Interview of their din the doors were out of their indicated the wander alarm in the doors being open. The doors was elided in the value alarm in the nearby store. LPN-C alarm system did not sound. The was initiated. This in of a facility investigation.  The continuation of the facility investigation in the facility investigation.  The continuation of the facility is and restock candy store at rendor was already in the food of the facility investigation. It is and restock candy store at rendor was already in the food of the facility investigation. It is and restock candy store at rendor was already in the food of the facility investigation. It is and restock candy store at rendor was already in the food of the facility investigation.	21995			
	the local store and					

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 5 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00175	B. WING			C <b>07/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21995	Continued From particles of the observed R1 at the R1's behavior or whom was preoccupied who R2's interview/state indicated R2 stated outside. I thought his statement was part.  On 1/4/21, at 1:26 pand stated R1 walk facility, and at times stated R1 could be and explosive the napproached the DC "clogged" and "over of vitals, and encour for help when he feron sidered an elopy administrator added was missing within family found him unter the desired of the control of t	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 lt dizzy.  o.m., the administrator t report 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	21995			
	wander alarm brace ankle. LPN-A demo functioning by puttir wander alarm, and walked up to within	d up R1's sweat pants, and a elet was present on R1's left nstrated how she checked ng a portable sensor near R1's R1's sensor beeped. R1 twice a few feet of the exit doors for around, without pushing on				

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 6 of 18

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
			B. WING				
		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	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(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 6	21995				
	the door.						
	(TMA)-A stated she to ensure it was prestated she was not it was functioning. I allowed to go on outhe TMA working the checking the wands On 1/5/20, at 11:34 incident was provid up included intervieincident, but no pre	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					
	On 1/5/21, at 12:04 p.m. TMA-B was interviewed and stated R1 had a wander alarm on his leg. TMA-B stated she checked to see if it was functioning with a portable sensor in the medication cart. TMA-B stated R1 wandered, and needed direction to locate his room.						
	and stated R1 had a 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 I 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 v R1 left, when she n	a.m. LPN-C was interviewed ed around the building a lot. was serving lunch on the day oted the door was open. boked around, and called a					

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 7 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		00175	B. WING		01/0	7/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE VIL	THE VILLA AT BRYN MAWR					
(V4) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	OLIS, MN 5	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID 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	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				
	R2's quarterly MDS dated 10/9/20, indicated no assessment of R2's cognition. R2 was able to ambulate independently, and had diagnoses that included bipolar disorder, and schizophrenia. R2 was not noted as using a wander/elopement alarm. R2's admission MDS, dated 7/10/20, revealed R2 was cognitively intact and had delusions.  On 1/5/21, at 12:50 p.m. R2 was interviewed and stated he instructed R1 how to leave the building by pushing and holding the front door, facing Penn Avenue. R2 reported no alarm went off. R2 reported he witnessed R1 leave the building. R2 did not recall what R1 was wearing, but reported, "He wasn't wearing much" and noted R1 was not wearing a coat when he left.					

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 8 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			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 DEFICIENC)	ATEMENT 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)	LD BE	(X5) COMPLETE DATE
21995	Continued From pa	ige 8	21995			
	R2, with a wander of administrator and of could walk through alarm. Even though the ankle, similar to During interview at maintenance and a the door is pushed opens due to fire so wander guard sense to the side of the dofeet off the ground. sounded when the resident had an war	_				
	resident had an wander guard on.  On 1/5/21, at 2:08 p.m. the front desk receptionist (FDR) was interviewed and stated she came in to the facility at noon on 1/1/21, for approximately 15 minutes to assist a vendor. The FDR stated she did not see R1 leave the building. The FDR stated she did ensure the door was locked prior to leaving. The FDR stated she worked at the front desk and had seen R1 walk towards the door. The FDR stated she redirected R1 when he approached the front door. The FDR stated she could not recall if R1 had ever pushed at the door before. The FDR stated she worked the day shift and there was not another receptionist that replaced her when she left. FDR stated she was aware R1 was not to leave the building because of her familiarity with the residents, and because of a book at the front desk with pictures that had residents at risk for elopement in it.  On 1/5/21, at 12:56 p.m. the administrator was interviewed and stated the facility completed wander and elopement assessments at					

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 9 of 18

PRINTED: 02/11/2021 FORM APPROVED

Minneso	Minnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00175	B. WING		01/0	; 7/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE VII I	LA AT BRYN MAWR	275 PENN	AVENUE N	ORTH			
111E VIE	LAAI BITTI WAWI	MINNEAP	OLIS, MN 5	5405			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21995	Continued From pa	ge 9	21995				
	administrator stated unsupervised on 1/ facility staff notified not find R1, had cal person had seen R the facility. The admat facility at 1:45 p.r onsite. 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 administrator stated administrator stated facility at 6:00 p.m. was allowed to leave however, R1 used a cognition. The admitter the video, of R1 least the front door and if 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 National Pacing Pacing National Pa	d R1 left the building 1/21. The administrator stated her at 1:20 p.m. they could lled a Code White, and a staff 1 at the corner store nearby ninistrator stated she arrived m. and the police were already strator stated she finished e at 2:15 p.m., and left a amily to notify them R1 had left dministrator stated she sent a for R1 with their cars, and or R1 in her vehicle. The d family member (FM)-B location R1 had previously nt to look for him at that nistrator stated she received a m FM-B to notify her they rtment complex he had with his mother. The d the family returned R1 to the The administrator stated R1 re the building on his own, a wander alarm due to his inistrator stated she viewed ving the facility, R1 pushed t did not do anything. Then R1 who was sitting nearby, r and proceeded out of the  nic map of Minneapolis e of 7.6 miles between the ty and the location where R1	21000				
	Review of the Natio	onal Weather Service historical 1/21, indicated the weather hrenheit for a high and 12					

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 10 of 18 18J411

PRINTED: 02/11/2021 FORM APPROVED

Minneso	<u>ota Department of He</u>	<u>ealth</u>				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					l c	
		00175	B. WING		01/07/2021	
					0	1/202.
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE VILI	LA AT BRYN MAWR		I AVENUE NO			
		MINNEAP	OLIS, MN 5	5405		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG		30 BE,	IAG	DEFICIENCY)	1 1 1 2	
04005	0 C		04005			
21995	Continued From pa	ige 10	21995			
		p.m. the administrator and				
		ctor (ED) observed the				
		ront door and wander alarm				
		rveyor. A sensor was placed on				
		proximately 18 to 24 inches				
		well as about shoulder height.				
		ding door, but opened and				
		peing pushed and held with				
		de. R2, sitting in the lobby, front door with a wander				
		No alarm sounded. R8, a				
	ll control of the con	ne lobby nearby, had a wander				
		which triggered the alarm				
		istrator stated it may be the				
		ander alarm that caused the				
	, .	te. The administrator stated				
		ing staff to move wander				
		s wrists, but R2 must have				
		dministrator stated there was				
		ionist at the door during the				
	day shift, but not dι	uring night or evening shifts.				
		p.m. security footage for				
		n. was observed with the				
		OON. The administrator stated				
	ll control of the con	available on the security				
		.m. R2 was observed walking sitting down in a chair near the				
		0 seconds later, R1 was				
		ning the front door, paused and				
		s R2. R1 then turned back to				
		t and held the door. The door				
		I out of the building wearing a				
		y pants, athletic shoes and				
		R1 was not wearing a a coat,				
		s or a mask. The door				
		N-C approached the open				
	door at 12:58 p.m.,	went through the open door				
	outside, and then re	eturned inside at 12:59 p.m.				

6899

Minnesota Department of Health						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					c	`
		00175	B. WING			7/2021
		00173			01/0	112021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		275 PENN	AVENUE N	ORTH		
THE VILLA AT BRYN MAWR MINNEAR		OLIS, MN 5	5405			
(V4) ID	QUIMMADV QTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
21995	Continued From pa	ge 11	21995			
21333	Continued i Tom pa	ge ii	21333			
	and was pulling at t	he door. At 1:00 p.m. NA-A				
	walked to the lobby	and stood near LPN-C.				
	During interview on	1/5/21, at 3:19 p.m. the				
		d residents had a "right to				
		nd explained, "We can't lock				
	them in." The DON	stated residents would be				
		n saying they were leaving				
		vise if they wanted to leave the				
	facility without disch					
		d R1 had a purpose to his				
		go home, made his way to a				
		und in a safe location. The				
		d R1 was safe to leave the				
		where he is going." The				
		d R1 had short term memory				
		ood long term memory. R1's				
		nent risk assessment was				
		nber 2020, and he had a				
		ed on him due to confusion				
		nory impairments. The				
	•	ted she reviewed the				
		mendations and residents				
		he wander alarm on the wrist				
		nistrator reported an additional				
		chased to sound when the				
		s had not been installed. A				
		esent at the front door only				
		urs. There were no additional				
		es were in place, such as				
		r reassessment of R1 and				
		wanderguard. Also, there				
	was no indication re					
		ted on their ankles had these				
		functioning with the current				
	alarm system.					
		nder/Elopement Risk				
		d on 1/5/21, at 7:28 p.m.,				
	revealed R1 was as	ssessed as having a history of				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED		
ANDFLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP		
		00175	B. WING		01/0	7/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE VII I	LA AT BRYN MAWR	275 PENN	AVENUE N	ORTH			
1112 412		MINNEAP	OLIS, MN 5	5405			
(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	
21995	Continued From pa	ge 12	21995				
	wandering and elop ambulatory, indepe to leave the building of elopement attem appropriate for a wa device on his left ar On 1/6/21, at 10:01 interviewed and sta cigarette on break of	pement, cognitively impaired, ndently mobile, physically able g on his own and had a history pts. R1 was assessed as ander alert personal safety nkle.  a.m. housekeeper (H)-A was ted he was outside smoking a pon 1/1/21, at 1:00 p.m. about a					
	engaged in a converthen entered a near the same location. facility and notified the store. H-A state to R1's behaviors o	e facility. H-A stated he was ersation on his cell phone and rby 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 unsuper was not safe to be unsupervised. NP-A harm if he left the fastated it was fortunamemory, and his fametro he resided to stated it would not learn and restated R1 had a she built throughout the reassurance about unfamiliar to him. R towards others whe actions. NP-A state the day of R1's elop	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 outside the facility A worried R1 was at risk of acility unsupervised. NP-A ate R1 worked off long term miliarity with the area of the ofind a familiar location. NP-A or reasonable to expect R1 tain new information. NP-A ort attention span, and anxiety day. R1 was always needing his surroundings, which were the exhibited aggression on he misinterpreted their dishe was the on call provider bement, and was not notified NP-A stated the facility.					

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 13 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	COMPLETED	
					_ c	
		00175	B. WING		01/0	7/2021
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
THE VII I	LA AT BRYN MAWR	275 PENN	AVENUE NO	ORTH		
· · · · · · · · · · · · · · · · · · ·	LAAI BITTI MATTI	MINNEAP	OLIS, MN 5	5405		
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 13	21995			
21995	notified her of the ep.m., four days afte stated she would exelopement on the selopement of the selope	lopement on 1/5/21, at 6:30 r the event occurred. NP-A spect to be notified of R1's ame day it occurred.  a.m. family member (FM)-A 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. If family members started areas R1 had previously different face and a partment building a previously resided with FM-D, at the apartment building, and the apartment building, and the hospital, and resided at the ole months. FM-D also no apartment complex. FM-A ring summer weight sweat a shirt, possibly an undershirt noes. FM-A stated R1 was not at, hat or mittens/gloves, proximately seven miles from a complex in winter weather. It did not appear injured, but was ared "fuzzy" with a troubled, A thought R1 might be thirsty, IR1 an electrolyte beverage	21995			
	"hazy" after drinking stated R1 previousl prior to being hospi facility. FM-A stated his own. FM-A and supervision for walk when R1 resided w	FM-A stated R1 was less g and eating a little. FM-A y resided with FM-A and FM-C talized, and transferred to the IR1 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				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  THE VILLA AT BRYN MAWR  275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405  [X4], ID  SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21995  Continued From page 14  away from us that he would probably be lost." FIM-A stated R1 had become lost for approximately one month, 3/26/20, to 4/26/20, while traveling internationally during the past year, related to impaired cognition and use of intoxicating substances. FIM-A stated this required intervention from the United States Embassy and family escort to return R1 safely home. FIM-A stated he was disappointed the facility had lost track of the whereabouts of R1 for several hours, as they were in charge of keeping him safe.  On 1/7/21, at 10:34 a.m. LPN-D was interviewed and stated she was working on station two, and an unidentified nurse notified her the front doors were open. LPN-D stated she directed the unidentified nurse to call a Code White, and determine if any residents were missing, LPN-D stated staff searched the building and nearby building on fot as well as farther out, in vehicles. LPN-D stated R1 should not have been able to leave the building on his own as he was not safe to be on the streets alone. LPN-D stated there was no alarm sounding when she approached the front door.  On 1/7/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release his anger, which meant he exploded and had been	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER  THE VILLA AT BRYN MAWR  275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405    CALL   D.   PREPIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPIX TAG   PREPIX TAG   Continued From page 14   21995    away from us that he would probably be lost." FM-A stated R1 had become lost for approximately one month, 3/26/20, to 4/26/20, while traveling internationally during the past year, related to impaired cognition and use of intoxicating substances. FM-A stated this required intervention from the United States Embassy and family escort to return R1 safely home. FM-A stated he was disappointed the facility had lost track of the whereabouts of R1 for several hours, as they were in charge of keeping him safe.  On 1/7/21, at 10:34 a.m. LPN-D was interviewed and stated she was working on station two, and an unidentified nurse notified her the front doors were open. LPN-D stated she directed the unidentified nurse to call a Code White, and determine if any residents were missing. LPN-D stated States and nearly building on his own as he was not safe to be on the streets alone. LPN-D stated there was no alarm sounding when she approached the front door.  On 1/7/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release his anger, which meant he exploded and had been					С		
C(44) D    SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   CROSS-REFERENCE DO THE APROPRIATE   DATE    21995   Continued From page 14   21995   away from us that he would probably be lost."   FM-A stated R1 had become lost for approximately one month, 3/26/20, to 4/26/20, while traveling internationally during the past year, related to impaired cognition and use of intoxicating substances. FM-A stated this required intervention from the United States Embassy and family escort to return R1 safely home. FM-A stated he was disappointed the facility had lost track of the whereabouts of R1 for several hours, as they were in charge of keeping him safe.  On 17/21, at 10:34 a.m. LPN-D was interviewed and stated she was working on station two, and an unidentified nurse notified her the front doors were open. LPN-D stated she directed the unidentified nurse to call a Code White, and determine if any residents were missing. LPN-D stated staff searched the building on his own as he was not safe to be on the streets alone. LPN-D stated there was no alarm sounding when she approached the front door.  On 17/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release his anger, which meant he exploded and had been			00175	B. WING		01/0	7/2021
(X4) D   CALL   DEFICIENCY   CALL   DEFICIENCIES   DEFICIENCY   PREFIX   CALL   DEFICIENCY MUST BE PRECEDED BY FULL   PREGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY    21995   Continued From page 14   21995   Away from us that he would probably be lost."   FM-A stated R1 had become lost for approximately one month, 3/26/20, to 4/26/20, while traveling internationally during the past year, related to impaired cognition and use of intoxicating substances. FM-A stated this required intervention from the United States Embassy and family secont to return R1 safely home. FM-A stated he was disappointed the facility had lost track of the whereabouts of R1 for several hours, as they were in charge of keeping him safe.  On 1/7/21, at 10:34 a.m. LPN-D was interviewed and stated she was working on station two, and an unidentified nurse notified her the front doors were open. LPN-D stated she directed the unidentified nurse to call a Code White, and determine if any residents were missing. LPN-D stated staff searched the building and nearby building on foot as well as farther out, in vehicles. LPN-D stated R1 should not have been able to leave the building on his own as he was not safe to be on the streets alone. LPN-D stated there was no alarm sounding when she approached the front door.  On 1/7/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release his anger, which meant he exploded and had been	NAME OF	PROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES   IRACH DEFICIENCY   NUST BE PRECEDED BY FULL   PREFIX   TAG   EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	THE VIL	LA AT BRYN MAWR					
away from us that he would probably be lost." FM-A stated R1 had become lost for approximately one month, 3/26/20, to 4/26/20, while traveling internationally during the past year, related to impaired cognition and use of intoxicating substances. FM-A stated this required intervention from the United States Embassy and family escort to return R1 safely home. FM-A stated he was disappointed the facility had lost track of the whereabouts of R1 for several hours, as they were in charge of keeping him safe.  On 1/7/21, at 10:34 a.m. LPN-D was interviewed and stated she was working on station two, and an unidentified nurse notified her the front doors were open. LPN-D stated she directed the unidentified nurse to call a Code White, and determine if any residents were missing. LPN-D stated staff searched the building and nearby building on foot as well as farther out, in vehicles. LPN-D stated R1 should not have been able to leave the building on his own as he was not safe to be on the streets alone. LPN-D stated there was no alarm sounding when she approached the front door.  On 1/7/21, at 10:51 a.m. LPN-D, R1's nurse manager, was interviewed and stated R1 would get frustrated and did not know how to release his anger, which meant he exploded and had been	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
when he was frustrated. R1 had a variable attention span. At times R1 could be preoccupied for an hour with an activity and at times, only 5 minutes. LPN-D stated R1 was not allowed to leave the building unsupervised. LPN-D explained R1 was not safe to leave on his own due to cognition.  On 1/7/21, at 11:33 a m. R1 was observed resting.	21995	away from us that it 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 character of the wherea as they were in character of the was an unidentified nurse the determine if any restated staff searched building on foot as LPN-D stated R1 seave the building of to be on the streets 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 frustratention span. At tiff or an hour with an minutes. LPN-D stated R1 was not safe to cognition.	ne would probably be lost." d become lost for month, 3/26/20, to 4/26/20, mationally during the past year, cognition and use of nces. FM-A stated this required the United States Embassy and the United States Embassy and the R1 safely home. FM-A topointed the facility had lost bouts of R1 for several hours, the properties of keeping him safe.  a.m. LPN-D was interviewed to working on station two, and the notified her the front doors the stated she directed the to call a Code White, and the building and nearby well as farther out, in vehicles. Thould not have been able to the his own as he was not safe the alone. LPN-D stated there ding when she approached the  a.m. LPN-D, R1's nurse to the exploded and had been the stated R1 would did not know how to release his the exploded and had been the ally aggressive towards others ated. R1 had a variable times R1 could be preoccupied activity and at times, only 5 the R1 was not allowed to the properties of the p	21995			

Minnesota Department of Health

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	DRESS, CITY, S	STATE, ZIP CODE		
THE VIL	LA AT BRYN MAWR		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)	.D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 15	21995			
	under his covers or had moved rooms a on the 1st floor. R1 where he was but in he was employed a 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 family by the facility. CM residence on the control of the c	n his bed in a private room. R1 and was in an unsecured unit reported he was not sure samed a rural town. R1 noted nd lived with FM-A and FM-C.  p.m. R1's mental health case interviewed and stated R1 community without as due to cognition, short term sation. 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 eported he would expect the in a timely fashion for				
	3/16/17, directed st re-admission, throu change in condition for potential elopem appropriate placem Residents identified elopement risk brade a wander alarm. Bradelets would be functioning and elopement risk brade a wander alarm. Bradelets would be functioning every shift. Each facommunicate the aresident at risk for eleptonic regarding as applicable.	d Elopement Guideline dated aff upon admission, gh quarterly review and residents would be evaluated nent risk to determine ent within the facility. If at risk would have an celet placed on them, such as accelets would have validation expiration prior to placement, checked for placement and nift. Expiration of the bracelet for functioning and placement cility would have a process to dmission or re-admission of a elopement across all units, buld receive education, uponing memory care unit security, ation of a Resident Exiting the lated 3/16/17, directed staff to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00175	B. WING		<b>I</b>	C <b>07/2021</b>
NAME OF PROVIDER OR SUPPLIER  THE VILLA AT BRYN MAWR  STREET ADI  275 PENN		DRESS, CITY, S I AVENUE NO OLIS, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21995	attempt to prevent to diversional techniques resident specific into plan of care. The probation assistance from mediate vicinity. It to inform the charge assistance is required. The facility Missing 3/16/17, directed store search immediately determined missing report immediately of a suspected min Nurse should immediately of the resident form of the resident of the resident generated alarms-from the sident generated safety. The alarm from the sident generated safety. The sident generated safety and regression of resident generated safety.	the departure- provide ues, re-direction and apply ervention as directed by the rocedure also directed staff to rom staff members in the linstruct another staff member enurse or director of nursing	21995			

Minnesota Department of Health

STATE FORM 6899 18J411 If continuation sheet 17 of 18

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
					C <b>07/2021</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21995	resident monitoring surveillance with consequipment. It is the periodically check of RF Technologies In pull cords, control unicontrol in inappropriate use of and stumbling hazar.  The immediate jeopy was removed on 1/1/2 educated all staff of audited functioning ensured each residy wander/elopement place, and ensured monitor presence an alarms for each residy with potential for monot immediate jeopy.  SUGGESTED MET The administrator of policies and proceds 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 ardy.  THOD OF CORRECTION: ould educate all staff on ures regarding alleged reports the administrator could develop	21995			