Electronically delivered
December 14, 2021

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

RE: CCN: 245203
Cycle Start Date: November 18, 2021

Dear Administrator:

On December 9, 2021, we informed you of imposed enforcement remedies.

On December 1, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 18, 2021, will remain in effect.

This Department continues to recommend 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 December 18, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 18, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of December 9, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 18, 2021.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an"E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007

Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 18, 2022 (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

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	C 12/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/30/21, through 12/1/21, a standard abbreviated survey was conducted at your facility. Your facility was found to NOT be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5203195C (MN78672) with deficiencies cited at F755, F760, F804, and F809. H5203194C (MN78663) with deficiencies cited at F686, F755, F804, and F809. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		12/27/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/16/2021

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

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F 686	Continued From page 1 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to reduce the risk of pressure ulcers for 2 of 3 residents (R2, R4) reviewed for pressure ulcers. Findings include: R2's admission Minimum Data Set (MDS) dated 8/11/21, indicated R2 was cognitively intact with diagnoses of quadriplegia (inability to move both arms and legs), dysphagia (difficulty swallowing), and chronic pain syndrome. The MDS also indicated R2 was totally dependent on staff for bed mobility and transferring. R2's Care Area Assessment (CAA) dated 8/11/21, indicated R2 needed total assistance with activities of daily living (ADLs). The CAA also indicated R2 at risk for pressure ulcer development due to total assistance with bed mobility, and toileting. R2 was incontinent of bowel and bladder R2's Care Plan dated 11/16/21, indicated R2 required total assistance to be repositioned every two hours for pressure ulcer prevention. R4's significant change MDS dated 9/7/21, indicated staff were unable to complete assessment for cognitive ability and had diagnoses of stroke, dementia, and diabetes.	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcers R2 discharged from the facility on 12/6/21. R4's care plans are being followed as it relates to turning and repositioning Residents who are care planned to receive turning and repositioning have the potential to be affected by this practice. Care plans are being followed as it relates to turning and repositioning. Nurses and CNA's were educated on following resident care plans as it relates to turning and repositioning. DON/Designee will audit 3 residents a week for 3 weeks, and then 3 residents a month for one month. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 686	Continued From page 2	F 686		

R4's CAA dated 9/7/21, indicated R4 was at risk for pressure ulcers due to need of extensive assistance with bed mobility. The CAA further indicated R4 was incontinent of bowel and bladder.

R4's Care Plan dated 8/10/21, indicated R4 was at risk for skin breakdown, and should be checked and changed every two hours, and repositioned every one to two hours.

During continuous observation on 11/30/21, from 9:53 a.m. through 12:30 p.m. R2 and R4 (roommates) were observed in their room. Both were seated in their wheelchairs. At 10:00 a.m. R2 and R4 received their breakfast trays, but were not repositioned. At 10:16 a.m. nursing assistant (NA)-A entered and exited the room, then returned with a glass of water for R4. At 11:20 a.m. NA-A responded to R2's call light. She did not reposition either R2 or R4. At 11:59 a.m. registered nurse (RN)-C readjusted R2's neck pillow but did not reposition any other part of his body or turn on either side. RN-C did not reposition R4. During the 2 hour and 37 minute observation, no staff repositioned either R2 or R4.

During an interview on 11/30/21, at 10:17 a.m. R2 stated staff would not reposition him every two hours.

During an interview on 11/30/21, at 10:18 a.m. R4 stated staff frequently failed to reposition him.

During an interview on 11/30/21, at 10:35 a.m., NA-A she did not reposition either R2 or R4 since the beginning of the shift.

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F 686	Continued From page 3 During an interview on 12/1/21, at 4:44 p.m. the director of nursing (DON) stated staff should be following the facility's policy on pressure ulcer prevention and the resident's plan of care. The DON stated staff had enough time to reposition to residents for pressure ulcer prevention and should do so every two hours. The facility's Skin Protection Guideline dated 7/7/21, directed pressure was the primary cause of pressure ulcers and interventions included repositioning residents.	F 686		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		12/27/21

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F 755	Continued From page 4 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were administered as ordered for of 6 residents (R1, R3, R5, R6, R7, and R8) reviewed for medication administration. Findings include: The facility's census printed 11/30/21, indicated R1, R3, R5, R6, R7, and R8 were all present on the Station 5 unit on 11/26/21. R1's admission Minimum Data Set (MDS) dated 10/25/21, indicated had mildly impaired cognition with no behaviors or rejection of care and diagnoses of osteomyelitis (bone infection) of the cervical vertebrae (neck bones), arthritis, and diabetes. R1 had the following medications ordered: -- on 10/18/21, Atorvastatin calcium (anticholesterol drug) 20 milligrams (mg) by mouth at bedtime for heart disease -- on 10/18/21, Carvedilol (treat high blood pressure) 6.25 mg by mouth twice a day for hypertension -- on 10/18/21, MiraLAX Packet (laxative) 17 grams (GM) by mouth two times a day for constipation	F 755	F755 Pharmacy Services/Procedures/Pharmacist/Records R8 discharged from the facility on 12/7/21. R1, R3, R5, R6, and R7's medications are being administered as ordered. Residents that receive medications have the potential to be affected by this practice. Residents' medications are being administered as ordered. DON/Designee to monitor administration of medications utilizing the EMR and follow up as appropriate. Missed medications will be notated as a Medication error with provider notification and follow up. Nurses and TMA's were educated on administering medications as ordered and the internal process for missed medications. DON/Designee will audit 3 residents a week for 3 weeks, and then 3 residents a month for one month. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 755	Continued From page 5	F 755		

-- on 10/18/21, hydroxyzine hydrochloride (HCL) (antianxiety) 25 mg by mouth three times a day for anxiety
-- on 10/19/21, quetiapine fumarate (antipsychotic) 150 mg by mouth twice a day for psychosis
-- on 11/10/21, Amoxicillin (antibiotic) 500 mg by mouth three times a day for osteomyelitis of the vertebrae
-- on 11/19/21, melatonin (sleep enhancer) 5 mg by mouth at bedtime for sleeping
-- on 11/19/21, omeprazole (anti-heartburn) 20 mg capsule by mouth twice a day for gastroesophageal reflux disease (GERD)
-- on 11/19/21, acetaminophen (pain medicine) 325 mg 2 tablets by mouth three times a day for pain

R1's medication administration record (MAR) dated November 2021, indicated R1 did not receive the following ordered medications on 11/26/21:
-- 4:00 p.m. doses of acetaminophen and ompeprazole
-- 8:00 p.m. doses of acetaminophen, Amoxicillin, Atorvastatin, Carvedilol, Gabapentin, hydroxyzine HCL, melatonin, MiraLAX, and quetiapine fumarate

During an interview on 11/30/21, at 11:24 a.m. R1 stated his medications were always late "if I even get them." R1 stated, "They miss so many doses it's ridiculous, especially my antibiotics."

R3's admission MDS dated 11/18/21, indicated R3 had intact cognition, no behaviors or refusals of care, and diagnoses of diabetes and left lower leg amputation.

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F 755	Continued From page 6	F 755		

R3 had the following medications ordered:
-- on 11/12/21, Admelog SoloStar (insulin) 100 unit/milliliter (u/ml) one unit subcutaneously (SQ) three times a day for diabetes
-- on 11/12/21, Gabapentin (neuropathic pain reliever) capsule 300 mg three capsules by mouth two times a day for pain
-- on 11/12/21, propranolol (antianxiety) HCL 20 mg by mouth at bedtime for "diagnosis"
-- on 11/12/21, Semglee (insulin) 100 u/ml inject 15 SQ at bedtime for diabetes
-- on 11/18/21, Admelog Solution (insulin) 100 u/ml sliding inject per sliding scale: if blood glucose (BG) 200 to 249 - give 4 units; if 250 to 299 BG - give 6 units; if 300 to 349 BG - give 8 units; if 350 to 351 BG - give 10 units
-- on 11/18/21, sumatriptan succinate (antimigraine) 100 mg at 4:00 p.m. (BID) for migraine headaches
-- on 11/18/21, cyclobenzaprine HCL (msucle relaxant) 10 mg by mouth three times a day for muscle spasm
-- on 11/19/21, metformin HCL (antidiabetic) 500 mg by mouth at bedtime for diabetes

R3's medication administration record (MAR) dated November 2021, indicated R3 did not receive the following ordered medications on 11/26/21:
-- 4:00 p.m. doses of Admelog SoloStar, cyclobenzaprine hydrochloride, and sumatriptan succinate
-- 5:00 p.m. doses of Admelog Solution and cyclobenzaprine hydrochloride
-- 8:00 p.m. doses of Gabapentin and Smeglee
-- 9:00 p.m. dose of metformin HCL and propranolol HCL

During an interview on 12/30/21, at 2:46 p.m. R3

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F 755	Continued From page 7	F 755		

stated the facility was always late with medications and some days he never received his medications.

R5's admission MDS dated 9/24/21, indicated R5 had intact cognition and diagnoses of high blood pressure, chronic hepatitis, bipolar disorder, gastro-esophageal reflux disease (GERD), and an infected knee prosthesis with open wound on right knee.

R5's medication orders were:
-- on 9/17/21, acetaminophen (pain killer) 1000 mg by mouth three times a day for pain
-- on 9/17/21, buspirone HCL (antianxiety) 10 mg by mouth for anxiety
-- on 9/17/21, doxycycline monohydrate (antibiortic)100 mg by mouth twice a day for wound infection
-- on 9/17/21, duloxetine HCL (antidepressant) 20 mg by mouth twice a day for depression
-- on 9/17/21, ferrous sulfate (iron supplement) 325 mg by mouth twice a day for anemia
-- on 9/17/21, Gabapentin (neuropathic pain reliever) 600 mg by mouth twice a day for neuropathic pain
-- on 9/17/21, Gabapentin (neuropathic pain reliever) 1200 mg by mouth at bedtime for neuropathic pain
-- on 9/17/21, MiraLAX Packet (laxative)17 GM by mouth twice a day for constipation
-- on 9/17/21, pramipexole HCL (antispasm medication) 0.5 mg by mouth at bedtime for restless leg syndrome
-- on 9/17/21, Ramelteon (hypnotic to induce sleep) 8 mg by mouth at bedtime for trouble sleeping
-- on 9/17/21, senna-docusate sodium (laxative) 8.6-50 mg two tablets by mouth twice a day for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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constipation
-- on 9/17/21, Vitamin C (vitamin supplement) 500 mg by mouth two times a day for inadequate Vitamin C
-- on 10/13/21, Prostat Sugar Free Advanced Wound Care (AWC) (protein drink to help wound healing) (30 cc) two times a ad for supplement promotion of wound healing
-- on 10/15/21, cyclobenzaprine HCL (muscle relaxant) by mouth twice a day for muscle spasm relief
-- on 10/20/21, Trazodone HCL (antidepressant) 400 mg by mouth at bedtime for trouble sleeping
-- on 11/1/21, quetiapine fumarate (antipsychotic) 200 mg by mouth twice a day for bipolar disorder
-- on 11/1/21, quetiapine fumarate (antipsychotic) 500 mg by mouth at bedtime for bipolar disorder
-- on 11/11/21, Belbuca Film (pain reliever) 600 mcg place buccally (mouth cheeks) to dissolve at bedtime for pain

R5's medication administration record (MAR) dated November 2021, indicated R5 did not receive the following ordered medications on 11/26/21:
-- 4:00 p.m. doses of acetaminophen, buspirone HCL, ferrous sulfate, and Prostat Sugar Free AWC
-- 5:00 p.m. doses of Gabapentin 600 mg and quetiapine fumarate 200 mg
-- 8:00 p.m. doses of acetaminophen, Belbuca Film, buspirone HCL, cyclobenzaprine HCL, docycycline monohydrate, duloxetine HCL, MiraLAX, pramipexole HCL, senna-docuosate sodium, and Vitamin C
-- 9:00 p.m. doses of Gabapentin 1200 mg, quetiapine fumarate 500 mg, Ramelteon, and Trazodone HCL

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During an interview on 11/30/21, at 3:01 p.m. R5 stated the facility was always late with "everything" including medications.

R6's admission MDS dated 11/17/21, indicated R6 had intact cognition and alcoholic hepatitis, and diabetes.

R6's medication orders were:
-- on 11/10/21, clotrimazole cream (antifungal cream) 1% to skin topically twice a day
-- on 11/10/21, Minerin (moisturizer) creme cream to skin topically twice a day for irritation
-- on 11/10/21 Senna (laxative) 8.6 mg at 8:00 p.m. by mouth twice a day for constipation

R6's medication administration record (MAR) dated November 2021, indicated R6 did not receive the following ordered medications on 11/26/21:
-- 8:00 p.m. doses of Senna, Minerin creme cream, and clotrimazole cream

R7's admission MDS dated 10/29/21, indicated R7 had intact cognition and alcohol dependance, high blood pressure, diabetes, heart disease, and history of myocardial infarction (heart attack).

R7's medication orders were:
-- on 10/22/21 atorvastatin calcium (anticholesterol) 40 mg by mouth at bedtime for old myocardial infarction
-- on 10/22/21, glipizide (antidiabetic) 5 mg by mouth twice a day for diabetes
-- on 10/22/21, metformin hydrochloride (antifiabetic) 1000 mg twice a day with meals for diabetes
-- on 10/22/21, metoprolol tartrate (antihypertensive) 25 mg by mouth twice a day for

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high blood pressure

R7's medication administration record (MAR) dated November 2021, indicated R7 did not receive the following ordered medications on 11/26/21:
-- 5:00 p.m. doses of glipizide and metformin
-- 8:00 p.m. dose of metoprolol
-- 9:00 p.m. dose of atorvastatin calcium

R8's admission MDS dated 10/29/21, indicated R8 had intact cognition and alcoholic cirrhosis of the liver, hepatitis, and alcohol dependence.

R8's medication orders were:
-- on 9/17/21 Gabapentin (neuropathic pain reliever) 300 mg 2 capsules by mouth at bedtime for alcohol abuse
-- on 9/17/21 lactulose sodium (laxative) 10 GM/15 ml - 10 ml by mouth twice a day for alcohol abuse
-- on 9/17/21 rifaximin (antibiortic) 550 mg by mouth twice a day for intestine bacteria reduction
-- on 9/17/21 trazodone HCL (antidepressant) 50 mg by mouth at bedtime for insomnia
-- on 11/12/21 clobetasol propionate cream (steroid cream) 0.95% topically to both legs twice a day for rash

R8's medication administration record (MAR) dated November 2021, indicated R8 did not receive the following ordered medications on 11/26/21:
-- 4:00 p.m. doses of clobetasol propionate cream and lactulose sodium
-- 8:00 p.m. doses of Gabapentin, trazodone HCL, and rifaximin

The staffing schedule dated 11/26/21, indicated

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trained medication aide (TMA)-B was scheduled to work on the Station 5 unit from 2:30 p.m. through 11:00 p.m., and was the only name on the staffing schedule for the Station 5 unit .

During an interview on 12/1/21, at 3:52 p.m. TMA-B stated she worked days on a different unit on 11/26/21, and did not work from 2:30 p.m. through 11:00 p.m. on the Station 5 unit. TMA-B stated she did not give any medications to any residents after 2:30 p.m.

During an interview on 12/2/21, at 3:36 p.m. registered nurse (RN)-A stated if a medication error occurred (was late, missed, or wrong dose/medication), the facility should let the provider and guardian know. RN-A stated this would be documented in the progress note and in the incident reporting system. RN-A stated she was shocked evening shift medications were not administered on 11/26/21, except one medication given to R3 at 4:00 p.m. by RN-D, an agency nurse. RN-A verified TMA-B was scheduled to work on the Station 5 unit on 11/26/21. RN-A was unsure who worked on the Station 5 unit the evening of 11/26/21.

During an interview on 12/1/21, at 4:44 p.m. the director of nursing (DON) stated she was unaware of all the missing and late administered medications. The DON stated she was aware of a couple late administered medications, "but not the extent of missing medications." The DON stated the nurse should contact the provider and document in the progress note when medications were missing; she was unsure who worked on the Station 5 unit on 11/26/21, in the evening shift.

The facility's Medication Administration - General

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F 755	Continued From page 12 Guidelines dated April 2018, directed medications would be administered as prescribed and in accordance with good nursing principles; the facility had sufficient staff and medication distribution system to ensure safe administration of medications without necessary interruptions; medication would be administered at the right time; medications were administered within 60 minutes of scheduled times except those ordered before or after mealtimes; and medications were administered according to facility established medication times.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin and antibiotics were administered in accordance with physician orders for 2 of 3 residents residing on the Station 5 unit (R3, R1) reviewed for significant medication error. Findings include: R3's admission Minimum Data Set (MDS) dated 11/18/21, indicated R3 had intact cognition, no behaviors or refusals of care, and diagnoses of diabetes and left lower leg amputation. R3's care plan dated 11/15/21 lacked a plan or interventions for addressing R3's diabetes or lack of glucose control.	F 760	F760 Residents are Free of Significant Med Errors R1's antibiotics are being administered as ordered. R3's insulin is being administered as ordered. All resident's insulin and antibiotics are being administered as ordered. DON/Designee to monitor administration of medications utilizing the EMR and follow up as appropriate. Missed medications will be notated as a Medication error with provider notification and follow up. Nurses were educated on administering insulin and antibiotics as ordered and on the internal process for missed mediations. TMA's were educated on administering oral antibiotics as ordered.	12/27/21

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F 760	Continued From page 13 R3's insulin order dated 11/18/21, was for Ademlog Solution 100 unit/milliliters (Insulin Lispro) Inject as per sliding scale according to blood glucose (BG) level: 200 to 249 BG - give 4 units 250 to 299 BG - give 6 units 300 to 349 BG - give 8 units 350 to 351 BG - give 10 units R3's insulin order dated 11/12/21, was for Semglee 100 unit/ml Solution pen-injector 15 units subcutaneously (SQ) at bedtime. R3's insulin order dated 11/13/21, was for Admelog SoloStar 100 unit/milliliters (ml) Solution pen-injector - 1 unit SQ three times a day. R3's medication administration record (MAR) dated November 2021, indicated R3 -- missed 5 out of 18 (28%) of Semglee doses -- missed 7 out of 54 (13%) of Admelog three times a day doses -- missed 1 out of 22 (4.5%) of Admelog sliding scale doses R3's medical record lacked documentation of reasons for missing medications. During interview on 11/30/21, at 10:28 a.m. registered nurse (RN)-A stated the actual time the medication was given was not recorded, therefore, it would be difficult to tell when medications were late. During an interview on 12/30/21, at 2:46 p.m. R3 stated the facility never gave him his insulin on time. R3 stated at his prior facility, his blood glucoses were monitored four times a day. R3 stated beginning in September they became	F 760	DON/Designee will audit 3 residents a week for 3 weeks, and then 3 residents a month for one month. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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better at testing, but he sometimes waited six hours for insulin.

During an interview on 12/1/21, at 11:27 a.m. medical doctor (MD)-A stated insulin should be given with meals and three times a day if ordered three times a day.

During an interview on 12/1/21, at 2:46 p.m. pharmacist (P)-A stated insulin should be given as ordered with sliding scale to get better blood glucose control.

R1's admission MDS dated 10/25/21, indicated had mildly impaired cognition with no behaviors or rejection of care and diagnoses of osteomyelitis (bone infection) of the cervical vertebrae (neck bones), arthritis, and diabetes.

R1's care plan dated 10/19/21, indicated R1 had subacute bacterial endocarditis and osteomyelitis of the cervical vertebrae; interventions were to administer antibiotics per physician orders. The care plan also indicated R1 had chronic pain related to his osteomyelitis.

R1's Ampicillin order dated 10/18/21, and expired on 11/10/21, indicated R1 was to receive 2000 milligrams (mg) of Ampicillin intravenously (IV) every four hours.

R1's Amoxicillin order dated 11/19/2021, indicated R1 was to received Amoxicillin 500 mg by mouth three times a day.

R1's MAR dated October 2021, indicated R1
- missed 2 out of 78 doses (2.5%) of intravenous Ampicillin
R1's MAR dated November 2021, indicated R1

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- missed 4 out of 60 doses (7%) of intravenous Ampicillin

R1's MAR dated November 2021, indicated R1 - missed 15 out of 60 doses (25%) of oral Amoxicillin; all but one dose was the missed 6:00 a.m. dose

During an interview on 11/30/21, at 11:24 a.m. R1 stated he missed six intravenous antibiotics and now that he was taking oral antibiotics, the facility usually missed his 6:00 a.m. dose, so he only got two doses each day instead of three. He stated he should be getting doses at 6:00 a.m., 12:00 p.m., and 10:00 p.m.

During an interview on 12/1/21, at 1:16 p.m. RN-B stated if medications were ordered three times a day, the facility can move administration times as long as the order is three times a day, and not at specified times in the order.

During an interview on 12/1/21, at 2:46 p.m. pharmacist (P)-A stated antibiotic medications should be given on time and within the designated time frame; if ordered every four hours, should be given every four hours and if ordered every eight hours, should be given every eight hours. P-A stated if antibiotics were not given on time, the therapeutic level would not be maintained and the antibiotic will be less effective. P-A stated doses should not be missed.

During an interview on 12/2/21, at 3:36 p.m. RN-A stated if a medication error occured (is late, missed, or wrong dose/medication), the facility should let the provider and guardian know. RN-A stated this should be documented in the progress note and in the incident reporting system. RN-A

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verified the following:
- R2 missed 6 intravenous antibiotics in October 2021 and November 2021
- R2 missed 15 doses of antibiotic in November 2021, mostly the 6:00 a.m. dose
- if an antibiotic is missed, then the therapeutic level of the medication is not met

RN-A stated the facility needed to teach staff about giving medications on time and it "was a huge problem not giving medications on time." RN-A also stated, "I'm shocked this many medications were missed." RN-A stated the facility "tried" to staff the unit with a trained medication adie (TMA), but because a nurse always had to administer insulin or other injectables (subcutaneous, intramuscular, or intravenous), a nurse from another floor came down to the Station 5 unit to administer the medications.

During an interview on 12/1/21, at 4:44 p.m. the director of nursing (DON) stated she was unaware of all the missing and late administered medications. The DON she was aware of a couple, "but not the extent of missing medications." The DON verified medications should be given one hour before to one hour after the scheduled time, and the facility had the ability to be flexible with the scheduled times after contacting the provider for approval. The DON also stated insulin should be given as ordered. The DON stated the nurse should contact the provider and document in the progress note when medications were missing.

The facility's Medication Administration - General Guidelines dated April 2018, directed medications would be administered as prescribed and in accordance with good nursing principles; the

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F 760	Continued From page 17 facility had sufficient staff and medication distribution system to ensure safe administration of medications without necessary interruptions; medication would be administered at the right time; medications were administered within 60 minutes of scheduled times except those ordered before or after mealtimes; and medications were administered according to facility established medication times.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was prepared, maintained, and served at warm, palatable temperatures for 7 of 7 residents (R2, R4, R10, R11, R12, R13, and R14) who were observed to be served and/or complained about inappropriate food temperature or palatability. Findings include: On 11/30/21, at 10:00 a.m. R2's breakfast tray was observed to be placed on his bedside table, and the serving aide left the room. At 10:20 a.m. nursing assistant (NA)-A came to feed R2. R2 was served oatmeal which was observed to be	F 804	F804 E- Nutritive Value palatability/temp R2, R4, R10, R11, R12, R13, and R14 are being served food that is prepared, maintained, and served at a warm and palatable temperature. Residents that reside at Bryn have the potential to be affected by this practice. Residents that reside at Bryn are receiving meals that is prepared, maintained, and served at a warm and palatable temperature. Food is being prepared and temped appropriately and served in a timely manner to ensure food palatability and temperatures are maintained.	12/27/21

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F 804	Continued From page 18 dried out with a firm, hard crusted layer on top. NA-A diced the oatmeal in chunks to feed R2. On 11/30/21, at 10:38 a.m. R4 was interviewed and stated his breakfast was "crap" because it was cold and had no taste. On 11/30/21, at 10:53 a.m. R2 was interviewed and stated his oatmeal was cold, thick, and did not taste good. R2 stated meals are always cold and late. On 11/30/21, at 12:21 p.m. R14 was interviewed and stated, "Please don't eat the food, it is so horrible." R14 stated she didn't eat the food if she could avoid it. On 12/01/21, at 8:50 a.m. dietary aide (DA)-A was interviewed and stated he prepped the steam tables for food service and the temperatures were not checked at the steam table before serving; temperatures were checked in the kitchen before being sent to the resident units. On 12/01/21, at 9:03 a.m. R14 was interviewed and stated she did not eat breakfast today because the food was cold and did not taste good. On 12/01/21, at 11:30 a.m. head cook (C)-A was interviewed and stated he checked the food's temperature prior to the food leaving the kitchen, and recorded the temperatures in a log. On 12/01/21, 11:32 a.m. kitchen manager (KM)-A stated hot food was to be heated to 165 degrees Fahrenheit (F) and then be stored at 135 F. KM-A stated kitchen staff performed temperature checks before the food left the kitchen. KM-A	F 804	Administrator/Designee has educated Dietary staff, Nursing assistants, licensed nurses, and managers on meal service process and timely delivery to ensure food is palatable on delivery and temperature is maintained. Administrator/Designee will audit food service for palatability and temperatures 3 times a week for 3 weeks, then 3 times monthly for 1 month.	

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F 804	Continued From page 19 stated she could not be sure food was leaving the kitchen hot. During an interview on 12/01/21, at 12:19 p.m. R10 stated the food was always cold and did not taste good, and R12 stated the food was always cold. On 12/01/21, at 12:21 p.m. R13 stated meals were often cold often, especially breakfast. During an interview on 12/1/21, at 5:11 p.m. the administrator stated the facility received lots of complaints about meals; it was an ongoing issue brought up "all the time" at Resident Council. The administrator stated complaints included food being cold, and not flavorful. A policy on food palatability was requested and not provided.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F 809		12/27/21

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F 809	Continued From page 20 §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve meals in a timely manner in 1 of 3 dining rooms (Station 2 unit). This had the potential to affect all 43 residents who resided on Station 2 unit. Findings include: The facility's meal service schedule printed 11/30/21, indicated Station 2 unit breakfast began at 8:30 a.m. and lunch began at 12:30 p.m. On 11/30/21, at 9:53 a.m. breakfast trays were still being served to residents on Station 2 unit. On 11/30/21, at 10:00 a.m. R2 and R4's breakfast trays were observed brought into their room and placed on their bedside tables. During an interview on 11/30/21, at 10:03 a.m. NA-A stated they were supposed to start serving breakfast at 8:30 a.m., and at 10:00 a.m. they were still serving breakfast. NA-A stated the nursing assistants were responsible for passing the meal trays, but it was difficult to get the meals served in a timely manner. During an interview on 11/30/21, at 10:53 a.m. R2 stated meals were always late, which made them cold and lacking in taste. During an interview on 11/30/21, at 12:21 p.m.	F 809	F809-E Frequency of meals/snack at bedtime Meals are being served in a timely manner per dining room mealtimes. Residents that eat in the dining room that reside at Bryn Mawr a Villa center have the potential to be affected by this practice. Residents that eat in the dining room are being served in a timely manner. Facility has scheduled IDT members to each dining room to assist with meal service and ensure dining service is timely. Administrator/designee has educated Certified Nursing assistants, Dietary staff, Licensed Nurses, and Managers in all departments on meal service times, timely meal service, and new schedule for dining support. Administrator/Designee to audit meal service for timeliness 3 times a week for 3 weeks, then 3 times per month for 1 month. Results of audits with be reviewed at QAPI for continued quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	C 12/01/2021

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

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F 809	Continued From page 21	F 809		

R14 stated she didn't eat the food when she could avoid it.

During an interview on 12/01/21, at 9:24 a.m. physical therapist (PT)-A stated residents who ate in their rooms typically got their breakfast between 10:00 a.m. and 11:00 a.m. PT-A also stated lunches were always served late, and had witnessed them served as late as 2:00 p.m. or 3:00 p.m.

During an interview on 12/01/21, at 10:02 a.m. licensed practical nurse (LPN)-A stated all meals were late just about every single day.

During an interview on 12/01/21, at 11:32 a.m. the kitchen manager (KM)-A stated she noticed meals were getting out later in the day, but she was not aware of how late.

During a group interview on 12/01/21, at 12:19 p.m. R10, R11, and R12 stated the food was late every day.

During an interview on 12/01/21, at 12:21 p.m. R13 stated meals were always late.

During an interview on 12/1/21, at 4:44 p.m. the director of nursing (DON) stated she had noticed trays sometimes arrived on the floors late. The DON stated, "Something happened in the kitchen" and they were hiring new staff.

During an interview on 12/1/21, at 5:11 p.m. the administrator acknowledged complaints about meals was an ongoing issue, including timeliness, warmth, and palatability. The administrator stated they were in the process of "bumping up the mealtimes," but need to work with the kitchen

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

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F 809	Continued From page 22 staff because they would need to adjust the staff working hours. A policy on meal service was requested, but not provided.	F 809		

Electronically delivered
December 14, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 849311

Dear Administrator:

The above facility was surveyed on November 30, 2021 through December 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

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

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

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

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/30/21, through 12/1/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5203195C (MN78672) with licensing orders issued at 4659.0600 Subp 1, and 4658.1320 A.B.C. H5203194C (MN78663) with licensing orders issued at 4658.0525 Subp 3, 4658.0600 Subp1, and 4658.1320 A.B.C. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning to reduce the risk of pressure ulcers	2 900	corrected	12/27/21

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2 900	Continued From page 3 for 2 of 3 residents (R2, R4) reviewed for pressure ulcers. Findings include: R2's admission Minimum Data Set (MDS) dated 8/11/21, indicated R2 was cognitively intact with diagnoses of quadriplegia (inability to move both arms and legs), dysphagia (difficulty swallowing), and chronic pain syndrome. The MDS also indicated R2 was totally dependent on staff for bed mobility and transferring. R2's Care Area Assessment (CAA) dated 8/11/21, indicated R2 needed total assistance with activities of daily living (ADLs). The CAA also indicated R2 at risk for pressure ulcer development due to total assistance with bed mobility, and toileting. R2 was incontinent of bowel and bladder R2's Care Plan dated 11/16/21, indicated R2 required total assistance to be repositioned every two hours for pressure ulcer prevention. R4's significant change MDS dated 9/7/21, indicated staff were unable to complete assessment for cognitive ability and had diagnoses of stroke, dementia, and diabetes. R4's CAA dated 9/7/21, indicated R4 was at risk for pressure ulcers due to need of extensive assistance with bed mobility. The CAA further indicated R4 was incontinent of bowel and bladder. R4's Care Plan dated 8/10/21, indicated R4 was at risk for skin breakdown, and should be checked and changed every two hours, and repositioned every one to two hours.	2 900		

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2 900	Continued From page 4 During continuous observation on 11/30/21, from 9:53 a.m. through 12:30 p.m. R2 and R4 (roommates) were observed in their room. Both were seated in their wheelchairs. At 10:00 a.m. R2 and R4 received their breakfast trays, but were not repositioned. At 10:16 a.m. nursing assistant (NA)-A entered and exited the room, then returned with a glass of water for R4. At 11:20 a.m. NA-A responded to R2's call light. She did not reposition either R2 or R4. At 11:59 a.m. registered nurse (RN)-C readjusted R2's neck pillow but did not reposition any other part of his body or turn on either side. RN-C did not reposition R4. During the 2 hour and 37 minute observation, no staff repositioned either R2 or R4. During an interview on 11/30/21, at 10:17 a.m. R2 stated staff would not reposition him every two hours. During an interview on 11/30/21, at 10:18 a.m. R4 stated staff frequently failed to reposition him. During an interview on 11/30/21, at 10:35 a.m., NA-A she did not reposition either R2 or R4 since the beginning of the shift. During an interview on 12/1/21, at 4:44 p.m. the director of nursing (DON) stated staff should be following the facility's policy on pressure ulcer prevention and the resident's plan of care. The DON stated staff had enough time to reposition to residents for pressure ulcer prevention and should do so every two hours. The facility's Skin Protection Guideline dated 7/7/21, directed pressure was the primary cause of pressure ulcers and interventions included repositioning residents.	2 900		

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2 900	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee could conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was prepared, maintained, and served at warm, palatable temperatures for 7 of 7 residents (R2, R4, R10, R11, R12, R13, and R14) who were observed to be served and/or complained about inappropriate food temperature or palatability.	2 960	corrected	12/27/21

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2 960	Continued From page 6 Findings include: On 11/30/21, at 10:00 a.m. R2's breakfast tray was observed to be placed on his bedside table, and the serving aide left the room. At 10:20 a.m. nursing assistant (NA)-A came to feed R2. R2 was served oatmeal which was observed to be dried out with a firm, hard crusted layer on top. NA-A diced the oatmeal in chunks to feed R2. On 11/30/21, at 10:38 a.m. R4 was interviewed and stated his breakfast was "crap" because it was cold and had no taste. On 11/30/21, at 10:53 a.m. R2 was interviewed and stated his oatmeal was cold, thick, and did not taste good. R2 stated meals are always cold and late. On 11/30/21, at 12:21 p.m. R14 was interviewed and stated, "Please don't eat the food, it is so horrible." R14 stated she didn't eat the food if she could avoid it. On 12/01/21, at 8:50 a.m. dietary aide (DA)-A was interviewed and stated he prepped the steam tables for food service and the temperatures were not checked at the steam table before serving; temperatures were checked in the kitchen before being sent to the resident units. On 12/01/21, at 9:03 a.m. R14 was interviewed and stated she did not eat breakfast today because the food was cold and did not taste good. On 12/01/21, at 11:30 a.m. head cook (C)-A was interviewed and stated he checked the food's temperature prior to the food leaving the kitchen,	2 960		

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2 960	Continued From page 7 and recorded the temperatures in a log. On 12/01/21, 11:32 a.m. kitchen manager (KM)-A stated hot food was to be heated to 165 degrees Fahrenheit (F) and then be stored at 135 F. KM-A stated kitchen staff performed temperature checks before the food left the kitchen. KM-A stated she could not be sure food was leaving the kitchen hot. During an interview on 12/01/21, at 12:19 p.m. R10 stated the food was always cold and did not taste good, and R12 stated the food was always cold. On 12/01/21, at 12:21 p.m. R13 stated meals were often cold often, especially breakfast. During an interview on 12/1/21, at 5:11 p.m. the administrator stated the facility received lots of complaints about meals; it was an ongoing issue brought up "all the time" at Resident Council. The administrator stated complaints included food being cold, and not flavorful. A policy on food palatability was requested and not provided. SUGGESTED METHOD OF CORRECTION: The dietary manager designee could review and revise policies and procedures related to food palatability and food service. The dietary manager or designee could educate staff to ensure meals are served timely, and at the proper temperature. The dietary manager or designee could perform audits, and results of any audits could be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One	2 960		

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2 960	Continued From page 8 (21) days	2 960		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error	21545		12/27/21

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 9 report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin and antibiotics were administered in accordance with physician orders for 2 of 3 residents residing on the Station 5 unit (R3, R1) reviewed for significant medication error. Findings include: R3's admission Minimum Data Set (MDS) dated 11/18/21, indicated R3 had intact cognition, no behaviors or refusals of care, and diagnoses of diabetes and left lower leg amputation. R3's care plan dated 11/15/21 lacked a plan or interventions for addressing R3's diabetes or lack of glucose control. R3's insulin order dated 11/18/21, was for Ademlog Solution 100 unit/milliliters (Insulin Lispro) Inject as per sliding scale according to blood glucose (BG) level: 200 to 249 BG - give 4 units 250 to 299 BG - give 6 units 300 to 349 BG - give 8 units 350 to 351 BG - give 10 units R3's insulin order dated 11/12/21, was for	21545	corrected	

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21545	Continued From page 10 Semglee 100 unit/ml Solution pen-injector 15 units subcutaneously (SQ) at bedtime. R3's insulin order dated 11/13/21, was for Admelog SoloStar 100 unit/milliliters (ml) Solution pen-injector - 1 unit SQ three times a day. R3's medication administration record (MAR) dated November 2021, indicated R3 -- missed 5 out of 18 (28%) of Semglee doses -- missed 7 out of 54 (13%) of Admelog three times a day doses -- missed 1 out of 22 (4.5%) of Admelog sliding scale doses R3's medical record lacked documentation of reasons for missing medications. During interview on 11/30/21, at 10:28 a.m. registered nurse (RN)-A stated the actual time the medication was given was not recorded, therefore, it would be difficult to tell when medications were late. During an interview on 12/30/21, at 2:46 p.m. R3 stated the facility never gave him his insulin on time. R3 stated at his prior facility, his blood glucoses were monitored four times a day. R3 stated beginning in September they became better at testing, but he sometimes waited six hours for insulin. During an interview on 12/1/21, at 11:27 a.m. medical doctor (MD)-A stated insulin should be given with meals and three times a day if ordered three times a day. During an interview on 12/1/21, at 2:46 p.m. pharmacist (P)-A stated insulin should be given as ordered with sliding scale to get better blood	21545		

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21545	Continued From page 11 glucose control. R1's admission MDS dated 10/25/21, indicated had mildly impaired cognition with no behaviors or rejection of care and diagnoses of osteomyelitis (bone infection) of the cervical vertebrae (neck bones), arthritis, and diabetes. R1's care plan dated 10/19/21, indicated R1 had subacute bacterial endocarditis and osteomyelitis of the cervical vertebrae; interventions were to administer antibiotics per physician orders. The care plan also indicated R1 had chronic pain related to his osteomyelitis. R1's Ampicillin order dated 10/18/21, and expired on 11/10/21, indicated R1 was to receive 2000 milligrams (mg) of Ampicillin intravenously (IV) every four hours. R1's Amoxicillin order dated 11/19/2021, indicated R1 was to received Amoxicillin 500 mg by mouth three times a day. R1's MAR dated October 2021, indicated R1 - missed 2 out of 78 doses (2.5%) of intravenous Ampicillin R1's MAR dated November 2021, indicated R1 - missed 4 out of 60 doses (7%) of intravenous Ampicillin R1's MAR dated November 2021, indicated R1 - missed 15 out of 60 doses (25%) of oral Amoxicillin; all but one dose was the missed 6:00 a.m. dose During an interview on 11/30/21, at 11:24 a.m. R1 stated he missed six intravenous antibiotics and now that he was taking oral antibiotics, the facility usually missed his 6:00 a.m. dose, so he only got	21545		

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21545	Continued From page 12	21545		

two doses each day instead of three. He stated he should be getting doses at 6:00 a.m., 12:00 p.m., and 10:00 p.m.

During an interview on 12/1/21, at 1:16 p.m. RN-B stated if medications were ordered three times a day, the facility can move administration times as long as the order is three times a day, and not at specified times in the order.

During an interview on 12/1/21, at 2:46 p.m. pharmacist (P)-A stated antibiotic medications should be given on time and within the designated time frame; if ordered every four hours, should be given every four hours and if ordered every eight hours, should be given every eight hours. P-A stated if antibiotics were not given on time, the therapeutic level would not be maintained and the antibiotic will be less effective. P-A stated doses should not be missed.

During an interview on 12/2/21, at 3:36 p.m. RN-A stated if a medication error occured (is late, missed, or wrong dose/medication), the facility should let the provider and guardian know. RN-A stated this should be documented in the progress note and in the incident reporting system. RN-A verified the following:
- R2 missed 6 intravenous antibiotics in October 2021 and November 2021
- R2 missed 15 doses of antibiotic in November 2021, mostly the 6:00 a.m. dose
- if an antibiotic is missed, then the therapeutic level of the medication is not met

RN-A stated the facility needed to teach staff about giving medications on time and it "was a huge problem not giving medications on time." RN-A also stated, "I'm shocked this many medications were missed." RN-A stated the facility "tried" to staff the unit with a trained

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medication adie (TMA), but because a nurse always had to administer insulin or other injectables (subcutaneous, intramuscular, or intravenous), a nurse from another floor came down to the Station 5 unit to administer the medications.

During an interview on 12/1/21, at 4:44 p.m. the director of nursing (DON) stated she was unaware of all the missing and late administered medications. The DON she was aware of a couple, "but not the extent of missing medications." The DON verified medications should be given one hour before to one hour after the scheduled time, and the facility had the ability to be flexible with the scheduled times after contacting the provider for approval. The DON also stated insulin should be given as ordered. The DON stated the nurse should contact the provider and document in the progress note when medications were missing.

The facility's Medication Administration - General Guidelines dated April 2018, directed medications would be administered as prescribed and in accordance with good nursing principles; the facility had sufficient staff and medication distribution system to ensure safe administration of medications without necessary interruptions; medication would be administered at the right time; medications were administered within 60 minutes of scheduled times except those ordered before or after mealtimes; and medications were administered according to facility established medication times.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to medication administration and errors. The

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21545	Continued From page 14 DON or designee could educate staff to ensure medications are correctly administered The DON or designee could perform audits, and results of any audits could be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		