Electronically delivered

January 27, 2022

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

RE: CCN: 245203
Cycle Start Date: January 5, 2022

Dear Administrator:

On January 18, 2022, we informed you that we may impose enforcement remedies.

On January 14, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 13, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 13, 2022.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 13, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villa At Bryn Mawr will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 13, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 July 5, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Revised Letter

Electronically delivered

February 1, 2022

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

RE: CCN: 245203
Cycle Start Date: January 5, 2022

This letter, sent on February 1, 2022, will replace the letter dated January 27, 2022. The effective date of the remedy of DDPNA, should be February 10, 2022.

Dear Administrator:

On January 18, 2022, we informed you that we may impose enforcement remedies.

On January 14, 2022, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
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Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	C 01/14/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/13/22 and 1/14/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT 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: H5203206C (MN80075), with deficiencies cited at F600, F607, and F609. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		2/10/22

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

Electronically Signed | 02/04/2022

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

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

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R1) was free from potential physical abuse by 1 of 1 staff (nurse aide (NA)-A). The facility also failed to follow the care planned interventions for R1 who had known behaviors, when R1's behaviors escalated as staff reportedly became frustrated, and R1's chest was scratched and her necklace during the incident. The facility also failed to keep R1 safe from potential further abuse when R1 was interview in the presence of NA-A and NA-A was not immediately suspended. Findings include: Review of the 1/10/22 at 12:51 p.m. report to the State Agency (SA) on 1/9/21 at midnight, NA-A was reported to have scratched R1's chest and ripped her gold necklace off R1's neck. Interview with NA-A identified R1 became upset and scratched NA-A on her arm. R1 reportedly then scratched herself on the chest and ripped her own necklace off. NA-A reported the incident to the nurse on duty. NA-A was suspended pending the investigation. R1 was placed on a "buddy system". R1 had diagnoses of schizophrenia, osteoporosis, muscle weakness, cataracts, anxiety disorder, bipolar disorder, and major depressive disorder. Review of the 1/14/22 at 6:48 p.m., 5 day report to the SA identified R1 had diagnoses of schizophrenia, osteoporosis, and major depression. R1 reported NA-A "grabbed my	F 600	F600: Free from abuse and neglect R1 will remain free from abuse All residents are at risk for abuse. each residents CP was reviewed for accuracy to ensure residents will remain free from abuse All staff were re-educated on facility Abuse Policy and Procedure for reporting Vulnerable Adult Incidents. Administrative team was re-educated on facility Abuse Policy and Procedure for suspending any staff members of suspected abuse. All staff were educated to not conduct alleged victim interviews in the presence of accused person. All staff were also educated on following care planned interventions when working with resident behaviors. All reported incidents will be reviewed by the Interdisciplinary team for gaps in the suspension and interview process after each incident x 90 days then weekly and on going. A root cause analysis will be completed on all incidents. All reported incidents will also be reviewed to ensure resident care plans were followed as it relates to behaviors x 90 days and on going. Results of audit results will be reviewed at QAPI to determine compliance	

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F 600	Continued From page 2	F 600		

necklace and scratched my neck". NA-A was suspended immediately. A skin assessment was conducted, and superficial scratches were noted to the resident's neck. When interview by the DON, R1 reportedly stated she "scratched herself, because she was frustrated with [NA-A} and wanted to get her fired". R1 had been interviewed by the surveyor and reportedly "changed her story" and stated she did not scratch herself. The facility concluded abuse was reported to be unsubstantiated by the SA and was also unsubstantiated by the facility based on their investigation. R1 was placed on the "buddy system" for cares. NA-A was an agency pool staff and was not to be allowed back at the facility. R1 stated she felt safe. R1's care plan and physician had been updated. The facility also determined R1's care plan and policies had been followed at the time of the incident.

Review of the facility investigation documents identified:
1) An emailed statement on 1/10/22 at 1:51 p.m., from NA-A identified R1 had put on her call light. NA-A reported she went into R1's room. R1 advised her she needed incontinent care so she proceeded to change her. While trying to change her. In the process, NA-A had asked her to help her so she could roll better (in bed). R1 reportedly got mad and said she could not and began to scream at NA-A and started "fighting me". R1 attempted to scratch NA-A's face so NA-A turned away. R1 reportedly scratched NA-A's arm and then scratched herself and cut the chain from her neck. R1 told NA-A she was going to lie to the administrator and tell her NA-A "did this to me" so NA-A reported that to the nurse.
2) A hand written statement by licensed practical nurse (LPN)-A that noted NA-A came out of R1's

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F 600	Continued From page 3	F 600		

room and reported R1 scratched her during care. LPN-A went into R1's room with NA-A. R1 stated NA-A scratched her neck and broke her chain off her neck. NA-A spoke and stated R1 had broken her own chain off her neck. R1 then stated NA-A was mad because she was unable to turn her. There was no indication why LPN-A interviewed R1 in the presence of her potential abuser. There was also no mention NA-A had reported to LPN-A the comments NA-A emailed to the administrator identifying R1 told her she was knowingly going to lie to the administrator and tell the administrator NA-A had abused her.

3) A skin assessment documented by LPN-A who noted R1 had "self-inflicted scratches". R1 would not allow her to measure the scratches but she approximated them to be 2 to 3 inches in length with redness. There was no mention how LPN-A came to the determination R1's scratches had been self-inflicted without performing an investigation.

4) An interview documented as conducted later that day on 1/10/22, at an unknown time with R1 by the DON. R1 was noted to have reported to her, NA-A was "irritating her" so she scratched herself and pulled on her necklace and told her NA-A had done it. "She did not hurt or scratch me. I feel safe".

There was no indication the facility had performed a thorough investigation to include other staff who worked with NA-A, other residents NA-A had worked with, interviewed the pool staff agency to see if NA-A had any similar complaints made against her previously or any other documentation or record review. There is also no mention why NA-A was not allowed to return for work after the investigation, if the facility had deemed there had been no potential abuse by NA-A to R1.

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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) COMPLETION DATE
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Interview and observation on 1/13/22 at 9:36 a.m., with R1 about the incident identified NA-A came into her room "so angry" because she was working by herself and had to change R1's brief in the middle of the night on 1/9/22. R1 was unable to turn herself in bed and NA-A and R1 both became frustrated. NA-A scratched R1's chest and broke her necklace. R1 revealed a bright red, vertical scratch that was approximately one inch long in the middle of her chest. R1 became visibly upset when she took her broken, gold-colored, chain necklace out of her drawer. She stated it cost her over $500.00 and she remarked she "couldn't go out in public wearing a rubber key chain". R1 made repeated statements about not being able to leave the facility without wearing her beloved necklace. R1 further stated she did not scratch herself, "Why would I scratch myself?. R1 denied breaking her own necklace as it meant so much to her. R1 told the DON the following day about the incident and was told NA-A no longer worked at the facility and the SA would be notified. R1 also stated she felt the administrator "only cared about protecting [the facility]".

Interview on 1/13/22 at 10:12 a.m., with licensed practical nurse (LPN)-A identified on 1/9/22, at round midnight, nursing assistant (NA)-A came out of R1's room saying R1 had scratched her on her arm. LPN-A stated she did not see a scratch on NA-A's arm and went directly to R1's room. R1 told LPN-A that NA-A became upset because R1 couldn't turn herself onto her side when NA-A attempted to change R1's brief. R1 said during the incident, NA-A somehow scratched R1 on her chest and broke R1's necklace. NA-A denied the accusations, saying R1 scratched herself and

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broke her own necklace, but LPN-A stated she had not not believed R1 would break her own necklace in her opinion. R1 had the necklace for a long time and paid $600.00 for it. Upon assessment, R1 had a large, red scratch on her chest but she did not measure it. LPN-A had forgotten to notify the Administrator or director of nursing of the alleged abuse at the time it occurred.

Interview on 1/13/22 at 10:46 a.m., with registered nurse (RN)-B identified RN-B did not believe that R1 would have broken her own necklace in her opinion. R1's necklace was "precious to her" and she had been upset that it was broken.

R1's 8/16/21, annual Minimum Data Set (MDS) identified staff performed R1's cognitive test at that time without R1's participation. R1's memory was noted to be intact, and she had no hallucinations or delusions. She had no physical behaviors to herself or others reported and no refusal of cares, but did have some verbal behaviors noted.
R1's Care Area Assessment identified she triggered for cognitive loss, behaviors as reported above and mood. R1 had diagnoses of osteoporosis (weakened bones), inflammation of the spine, cataracts, and glaucoma, bipolar disorder, schizophrenia, and anxiety. R1 required extensive assistance of 1 staff while in bed and extensive assistance of 2 staff with transfers in and out of bed.

R1's current, undated care plan indicated R1 showed some symptoms associated with her mental health diagnoses like ruminating/rambling about topics, bringing up past negative events,

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refusing medications and cares at times, was easily irritated and was known to scream on the phone in her room. R1 had a history of feeling others were jealous of her. R1 could become physically aggressive (hitting, grabbing, throwing objects, ripping paper off walls) at others when upset or manic related to her bipolar disorder, but it was not noted her bipolar was not well managed with her medication regimen. R1 had threatened or tried to throw herself on floor also when manic and had made previous statements related to not eating or potentially eating large pieces of food to "choke resulting in death". R1 had made calls to 911 previously. R1 made allegations of abuse towards others and later had a history of retracting those statements. Those findings were noted in January of 2019. It was unclear if that portion of the care plan had been reviewed for accuracy in 2021 to identify if those behaviors were controlled with medications or were currently occurring.

Interview on 1/13/22 at 10:59 a.m., with RN-A stated she assisted the DON to assess R1 on 1/10/22, after the abuse allegation was reported. RN-A noted R1 had a red scratch on her chest and some "darkness" around her neck that R1 said occurred when NA-A became irritated when she had difficulty turning R1 during cares.

Interview on 1/13/22 at 11:15 a.m., with NA-B identified she often worked with R1 who was "sweet and easy" if staff follow R1's directions on how she prefers things to be done. R1 told NA-B that NA-A was rude to her and broke her necklace when NA-A attempted to change R1's brief on 1/9/22. R1 bought her necklace approximately two years ago for over $500.00. NA-B stated R1 "loved" her necklace and

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although R1 has had behaviors, NA-B did not believe R1 would break her own necklace.

Interview on 1/13/22 at 3:51 p.m., with NA-A identified the facility was "short staffed" the night of 1/9/22, resulting in NA-A working alone on station 2. R1 put her call light on after midnight and wanted her brief changed. NA-A told R1 to roll herself onto her side, however, R1 required an assist of 1 staff member for bed mobility and was unable to. NA-A told R1 "I can't do it by myself", which upset R1. R1 then scratched NA-A's arm and reportedly "began scratching herself" so she left R1's room to get LPN-A for assistance. When LPN-A and NA-A returned to R1's room, R1 was upset and told LPN-A, NA-A had scratched her on her chest and broke her necklace. NA-A had argued R1 scratched herself and broke her own necklace. NA-A continued working until the end of her shift at 7:00 a.m. and was not immediately suspended pending an investigation.

Interview on 1/13/22 at 10:04 a.m., with the DON identified R1 reported to her that NA-A had scratched her chest and broke her necklace when she became frustrated with R1 during cares on 1/9/22. The DON stated R1 later had reportedly "changed her story" and said she scratched herself and didn't want NA-A to get fired or get in trouble. There was no mention if the DON had been aware LPN-A had allowed NA-A to be present during R1's interview related to the allegations, or why NA_A had not been immediately suspended and sent home.

Review of the 11/28/17, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy identified physical

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F 600	Continued From page 8 abuse was the willful infliction of injury to a resident. The policy defined willful as the individual acting deliberately, not that they necessarily intended to inflict injury or harm on the resident. The policy further indicated that any staff accused of alleged abuse against a resident would be immediately removed from the facility for the protection of the resident. Immediately upon receiving a report of alleged abuse, the administrator and or designee was to coordinate the delivery of appropriate medical and/or psychosocial care and attention. Staff were to ensure the safety and well-being of the resident and roommate if applicable, and other residents who have the potential to be affected. Staff were to remove the resident alleged to have caused the abuse from the situation and wait for further instruction from the administrator if possible. Staff were to assess and interview the resident affected and interview other residents who may be affected to determine injury and identify immediate interventions. Staff were to notify the SA "as indicated". If an injury was inexplicable, abuse and caregiver neglect substantiated, or a therapeutic error resulted in an injury, the policy noted a report was to be made to the SA within 24 hours of the initial findings. Allegations of abuse that did not result in serious bodily injury were also to be reported no later than 24 hours. There was no mention the facility had reviewed and/or revised the policy annually to ensure it met current federal requirements.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		2/10/22

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F 607	Continued From page 9 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facility abuse policies were followed and updated and/or revised annually for accuracy, when 1 of 1 resident (R1) was potentially physically abused by 1 of 1 staff (nurse aide (NA)-A). The facility also failed to ensure R1 was safe from potential further abuse when R1 was interviewed in the presence of NA-A and when NA-A was not immediately suspended pending investigation. Findings include: Review of the 1/10/22 at 12:51 p.m. report to the State Agency (SA) on 1/9/21 at midnight, NA-A was reported to have scratched R1's chest and ripped her gold necklace off R1's neck. Interview with NA-A identified R1 became upset and scratched NA-A on her arm. R1 reportedly then scratched herself on the chest and ripped her own necklace off. NA-A reported the incident to the nurse on duty. NA-A was noted to have been suspended pending the investigation, although the report failed to mention if this occurred immediately. R1 was placed on a "buddy system". R1 had diagnoses of schizophrenia, osteoporosis, muscle weakness, cataracts, anxiety disorder, bipolar disorder, and major	F 607	F607: Develop/implement abuse/neglect policies R1 will remain free from abuse All residents are at risk for abuse All staff were re-educated on facility Abuse Policy and Procedure for reporting Vulnerable Adult Incidents. All staff were educated to not conduct alleged victim interviews in the presence of accused person. Administrative team was re-educated on facility Abuse Policy and Procedure for immediately suspending any staff members of suspected abuse. Abuse policy was reviewed on 1/15/22.Education will be completed by 2/10/2022 All reported incidents will be reviewed by the Interdisciplinary team for gaps in the suspension and interview process after each incident x 90 days then weekly and on going. All reported incidents will also be reviewed to ensure resident care plans were followed as it relates to behaviors x 90 days and on going. Results of audit results will be reviewed at QAPI to determine compliance	

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depressive disorder.

Review of the 1/14/22 at 6:48 p.m., 5 day report to the SA identified R1 had diagnoses of schizophrenia, osteoporosis, and major depression. R1 reported NA-A "grabbed my necklace and scratched my neck". NA-A was suspended immediately. A skin assessment was conducted, and superficial scratches were noted to the resident's neck. When interview by the DON, R1 reportedly stated she "scratched herself, because she was frustrated with [NA-A} and wanted to get her fired". R1 had been interviewed by the surveyor and reportedly "changed her story" and stated she did not scratch herself. The facility concluded abuse was reported to be unsubstantiated by the SA and was also unsubstantiated by the facility based on their investigation. R1 was placed on the "buddy system" for cares. NA-A was an agency pool staff and was not to be allowed back at the facility. R1 stated she felt safe. R1's care plan and physician had been updated. The facility also determined R1's care plan and policies had been followed at the time of the incident.

Review of the facility investigation documents identified:
1) An emailed statement on 1/10/22 at 1:51 p.m., from NA-A identified R1 had put on her call light. NA-A reported she went into R1's room. R1 advised her she needed incontinent care so she proceeded to change her. While trying to change her. In the process, NA-A had asked her to help her so she could roll better (in bed). R1 reportedly got mad and said she could not and began to scream at NA-A and started "fighting me". R1 attempted to scratch NA-A's face so NA-A turned away. R1 reportedly scratched NA-A's arm and

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then scratched herself and cut the chain from her neck. R1 told NA-A she was going to lie to the administrator and tell her NA-A "did this to me" so NA-A reported that to the nurse.
2) A hand written statement by licensed practical nurse (LPN)-A that noted NA-A came out of R1's room and reported R1 scratched her during care. LPN-A went into R1's room with NA-A. R1 stated NA-A scratched her neck and broke her chain off her neck. NA-A spoke and stated R1 had broken her own chain off her neck. R1 then stated NA-A was mad because she was unable to turn her. There was no indication why LPN-A interviewed R1 in the presence of her potential abuser. There was also no mention NA-A had reported to LPN-A the comments NA-A emailed to the administrator identifying R1 told her she was knowingly going to lie to the administrator and tell the administrator NA-A had abused her.
3) A skin assessment documented by LPN-A who noted R1 had "self-inflicted scratches". R1 would not allow her to measure the scratches but she approximated them to be 2 to 3 inches in length with redness. There was no mention how LPN-A came to the determination R1's scratches had been self-inflicted without performing an investigation.
4) An interview documented as conducted later that day on 1/10/22, at an unknown time with R1 by the DON. R1 was noted to have reported to her, NA-A was "irritating her" so she scratched herself and pulled on her necklace and told her NA-A had done it. "She did not hurt or scratch me. I feel safe".
There was no indication the facility had performed a thorough investigation to include other staff who worked with NA-A, other residents NA-A had worked with, interviewed the pool staff agency to see if NA-A had any similar complaints made

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against her previously or any other documentation or record review. There is also no mention why NA-A was not allowed to return for work after the investigation, if the facility had deemed there had been no potential abuse by NA-A to R1.

Interview and observation on 1/13/22 at 9:36 a.m., with R1 about the incident identified NA-A came into her room "so angry" because she was working by herself and had to change R1's brief in the middle of the night on 1/9/22. R1 was unable to turn herself in bed and NA-A and R1 both became frustrated. NA-A scratched R1's chest and broke her necklace. R1 revealed a bright red, vertical scratch that was approximately one inch long in the middle of her chest. R1 became visibly upset when she took her broken, gold-colored, chain necklace out of her drawer. She stated it cost her over $500.00 and she remarked she "couldn't go out in public wearing a rubber key chain". R1 made repeated statements about not being able to leave the facility without wearing her beloved necklace. R1 further stated she did not scratch herself, "Why would I scratch myself?. R1 denied breaking her own necklace as it meant so much to her. R1 told the DON the following day about the incident and was told NA-A no longer worked at the facility and the SA would be notified. R1 also stated she felt the administrator "only cared about protecting [the facility]".

Interview on 1/13/22 at 10:12 a.m., with licensed practical nurse (LPN)-A identified on 1/9/22, at round midnight, nursing assistant (NA)-A came out of R1's room saying R1 had scratched her on her arm. LPN-A stated she did not see a scratch on NA-A's arm and went directly to R1's room. R1

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told LPN-A that NA-A became upset because R1 couldn't turn herself onto her side when NA-A attempted to change R1's brief. R1 said during the incident, NA-A somehow scratched R1 on her chest and broke R1's necklace. NA-A denied the accusations, saying R1 scratched herself and broke her own necklace, but LPN-A stated she had not not believed R1 would break her own necklace in her opinion. R1 had the necklace for a long time and paid $600.00 for it. Upon assessment, R1 had a large, red scratch on her chest but she did not measure it. LPN-A had forgotten to notify the Administrator or director of nursing of the alleged abuse at the time it occurred.

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R1's Care Area Assessment identified she triggered for cognitive loss, behaviors as reported above and mood. R1 had diagnoses of osteoporosis (weakened bones), inflammation of the spine, cataracts, and glaucoma, bipolar disorder, schizophrenia, and anxiety. R1 required extensive assistance of 1 staff while in bed and extensive assistance of 2 staff with transfers in

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F 607	Continued From page 14 and out of bed. R1's current, undated care plan indicated R1 showed some symptoms associated with her mental health diagnoses like ruminating/rambling about topics, bringing up past negative events, refusing medications and cares at times, was easily irritated and was known to scream on the phone in her room. R1 had a history of feeling others were jealous of her. R1 could become physically aggressive (hitting, grabbing, throwing objects, ripping paper off walls) at others when upset or manic related to her bipolar disorder, but it was not noted her bipolar was not well managed with her medication regimen. R1 had threatened or tried to throw herself on floor also when manic and had made previous statements related to not eating or potentially eating large pieces of food to "choke resulting in death". R1 had made calls to 911 previously. R1 made allegations of abuse towards others and later had a history of retracting those statements. Those findings were noted in January of 2019. It was unclear if that portion of the care plan had been reviewed for accuracy in 2021 to identify if those behaviors were controlled with medications or were currently occurring. Interview on 1/13/22 at 10:59 a.m., with RN-A stated she assisted the DON to assess R1 on 1/10/22, after the abuse allegation was reported. RN-A noted R1 had a red scratch on her chest and some "darkness" around her neck that R1 said occurred when NA-A became irritated when she had difficulty turning R1 during cares. Interview on 1/13/22 at 11:15 a.m., with NA-B identified she often worked with R1 who was "sweet and easy" if staff follow R1's directions on	F 607		

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F 607	Continued From page 15	F 607		

how she prefers things to be done. R1 told NA-B that NA-A was rude to her and broke her necklace when NA-A attempted to change R1's brief on 1/9/22. R1 bought her necklace approximately two years ago for over $500.00. NA-B stated R1 "loved" her necklace and although R1 has had behaviors, NA-B did not believe R1 would break her own necklace.

Interview on 1/13/22 at 3:51 p.m., with NA-A identified the facility was "short staffed" the night of 1/9/22, resulting in NA-A working alone on station 2. R1 put her call light on after midnight and wanted her brief changed. NA-A told R1 to roll herself onto her side, however, R1 required an assist of 1 staff member for bed mobility and was unable to. NA-A told R1 "I can't do it by myself", which upset R1. R1 then scratched NA-A's arm and reportedly "began scratching herself" so she left R1's room to get LPN-A for assistance. When LPN-A and NA-A returned to R1's room, R1 was upset and told LPN-A, NA-A had scratched her on her chest and broke her necklace. NA-A had argued R1 scratched herself and broke her own necklace. NA-A continued working until the end of her shift at 7:00 a.m. and was not immediately suspended pending an investigation.

Interview on 1/13/22 at 10:04 a.m., with the DON identified R1 reported to her that NA-A had scratched her chest and broke her necklace when she became frustrated with R1 during cares on 1/9/22. The DON stated R1 later had reportedly "changed her story" and said she scratched herself and didn't want NA-A to get fired or get in trouble. There was no mention if the DON had been aware LPN-A had allowed NA-A to be present during R1's interview related to the

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	245203	A. BUILDING _____ B. WING _____	C 01/14/2022

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 607	Continued From page 16 allegations, or why NA_A had not been immediately suspended and sent home. Review of the 11/28/17, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy identified physical abuse was the willful infliction of injury to a resident. The policy defined willful as the individual acting deliberately, not that they necessarily intended to inflict injury or harm on the resident. The policy further indicated that any staff accused of alleged abuse against a resident would be immediately removed from the facility for the protection of the resident. Immediately upon receiving a report of alleged abuse, the administrator and or designee was to coordinate the delivery of appropriate medical and/or psychosocial care and attention. Staff were to ensure the safety and well-being of the resident and roommate if applicable, and other residents who have the potential to be affected. Staff were to remove the resident alleged to have caused the abuse from the situation and wait for further instruction from the administrator if possible. Staff were to assess and interview the resident affected and interview other residents who may be affected to determine injury and identify immediate interventions. Staff were to notify the SA "as indicated". If an injury was inexplicable, abuse and caregiver neglect substantiated, or a therapeutic error resulted in an injury, the policy noted a report was to be made to the SA within 24 hours of the initial findings. Allegations of abuse that did not result in serious bodily injury were also to be reported no later than 24 hours. There was no mention the facility had reviewed and/or revised the policy annually to ensure it met current federal requirements.	F 607		

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F 609	Continued From page 17	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an alleged violation of staff to resident abuse was reported no later than 2 hours to the State Agency (SA) for 1 of 1 residents (R1) who reported an allegation of physical abuse.	F 609	F609: Failure to Report Alleged Violations of Abuse Incident involving R1 was reported to the state agency on 1/10//2022 All residents are at risk for abuse and neglect	2/10/22

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F 609	Continued From page 18 Findings include: Review of the 1/10/22 at 12:51 p.m. report to the State Agency (SA) on 1/9/21 at midnight, NA-A was reported to have scratched R1's chest and ripped her gold necklace off R1's neck. Interview with NA-A identified R1 became upset and scratched NA-A on her arm. R1 reportedly then scratched herself on the chest and ripped her own necklace off. NA-A reported the incident to the nurse on duty. NA-A was noted to have been suspended pending the investigation. R1 was placed on a "buddy system". R1 had diagnoses of schizophrenia, osteoporosis, muscle weakness, cataracts, anxiety disorder, bipolar disorder, and major depressive disorder. There was mention why the allegation was not reported within 2 hrs. Review of the 1/14/22 at 6:48 p.m., 5 day report to the SA identified R1 had diagnoses of schizophrenia, osteoporosis, and major depression. R1 reported NA-A "grabbed my necklace and scratched my neck". NA-A was suspended immediately. A skin assessment was conducted, and superficial scratches were noted to the resident's neck. When interview by the DON, R1 reportedly stated she "scratched herself, because she was frustrated with [NA-A} and wanted to get her fired". R1 had been interviewed by the surveyor and reportedly "changed her story" and stated she did not scratch herself. The facility concluded abuse was reported to be unsubstantiated by the SA and was also unsubstantiated by the facility based on their investigation. R1 was placed on the "buddy system" for cares. NA-A was an agency pool staff and was not to be allowed back at the facility. R1 stated she felt safe. R1's care plan and physician had been updated. The facility also determined	F 609	All staff were re-educated that potential abuse needs to be reported to the state agency within 2 hours. Abuse policy and procedure was reviewed on 1/15/22 All reported incidents will be reviewed within 24 hours to ensure timely reporting to state agency x 90 days and on going. Audit results will be reviewed at QAPI to ensure compliance	

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F 609	Continued From page 19	F 609		

R1's care plan and policies had been followed at the time of the incident. There was no mention in the investigation the facility had identified staff failed to report the allegation to the SA within 2 hours as required.

Review of the facility investigation documents identified:
1) An emailed statement on 1/10/22 at 1:51 p.m., from NA-A identified R1 had put on her call light. NA-A reported she went into R1's room. R1 advised her she needed incontinent care so she proceeded to change her. While trying to change her. In the process, NA-A had asked her to help her so she could roll better (in bed). R1 reportedly got mad and said she could not and began to scream at NA-A and started "fighting me". R1 attempted to scratch NA-A's face so NA-A turned away. R1 reportedly scratched NA-A's arm and then scratched herself and cut the chain from her neck. R1 told NA-A she was going to lie to the administrator and tell her NA-A "did this to me" so NA-A reported that to the nurse.
2) A hand written statement by licensed practical nurse (LPN)-A that noted NA-A came out of R1's room and reported R1 scratched her during care. LPN-A went into R1's room with NA-A. R1 stated NA-A scratched her neck and broke her chain off her neck. NA-A spoke and stated R1 had broken her own chain off her neck. R1 then stated NA-A was mad because she was unable to turn her. There was no indication why LPN-A interviewed R1 in the presence of her potential abuser. There was also no mention NA-A had reported to LPN-A the comments NA-A emailed to the administrator identifying R1 told her she was knowingly going to lie to the administrator and tell the administrator NA-A had abused her.
3) A skin assessment documented by LPN-A who

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F 609	Continued From page 20 noted R1 had "self-inflicted scratches". R1 would not allow her to measure the scratches but she approximated them to be 2 to 3 inches in length with redness. There was no mention how LPN-A came to the determination R1's scratches had been self-inflicted without performing an investigation. 4) An interview documented as conducted later that day on 1/10/22, at an unknown time with R1 by the DON. R1 was noted to have reported to her, NA-A was "irritating her" so she scratched herself and pulled on her necklace and told her NA-A had done it. "She did not hurt or scratch me. I feel safe". There was no indication the facility had performed a thorough investigation to include other staff who worked with NA-A, other residents NA-A had worked with, interviewed the pool staff agency to see if NA-A had any similar complaints made against her previously or any other documentation or record review. There is also no mention why NA-A was not allowed to return for work after the investigation, if the facility had deemed there had been no potential abuse by NA-A to R1. Interview and observation on 1/13/22 at 9:36 a.m., with R1 about the incident identified NA-A came into her room "so angry" because she was working by herself and had to change R1's brief in the middle of the night on 1/9/22. R1 was unable to turn herself in bed and NA-A and R1 both became frustrated. NA-A scratched R1's chest and broke her necklace. R1 revealed a bright red, vertical scratch that was approximately one inch long in the middle of her chest. R1 became visibly upset when she took her broken, gold-colored, chain necklace out of her drawer. She stated it cost her over $500.00 and she	F 609		

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F 609	Continued From page 21	F 609		

remarked she "couldn't go out in public wearing a rubber key chain". R1 made repeated statements about not being able to leave the facility without wearing her beloved necklace. R1 further stated she did not scratch herself, "Why would I scratch myself?. R1 denied breaking her own necklace as it meant so much to her. R1 told the DON the following day about the incident and was told NA-A no longer worked at the facility and the SA would be notified. R1 also stated she felt the administrator "only cared about protecting [the facility]".

Interview on 1/13/22 at 10:12 a.m., with licensed practical nurse (LPN)-A identified on 1/9/22, at round midnight, nursing assistant (NA)-A came out of R1's room saying R1 had scratched her on her arm. LPN-A stated she did not see a scratch on NA-A's arm and went directly to R1's room. R1 told LPN-A that NA-A became upset because R1 couldn't turn herself onto her side when NA-A attempted to change R1's brief. R1 said during the incident, NA-A somehow scratched R1 on her chest and broke R1's necklace. NA-A denied the accusations, saying R1 scratched herself and broke her own necklace, but LPN-A stated she had not not believed R1 would break her own necklace in her opinion. R1 had the necklace for a long time and paid $600.00 for it. Upon assessment, R1 had a large, red scratch on her chest but she did not measure it. LPN-A had forgotten to notify the Administrator or director of nursing of the alleged abuse at the time it occurred.

Interview on 1/13/22 at 10:04 a.m., with the DON identified R1 reported to her that NA-A had scratched her chest and broke her necklace when she became frustrated with R1 during cares

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F 609	Continued From page 22 on 1/9/22. The DON stated R1 later had reportedly "changed her story" and said she scratched herself and didn't want NA-A to get fired or get in trouble. There was no mention if the DON had identified or been aware the incident was not reported within 2 hours of the allegation being made or took a systemic approach at that time to correct the deficient practice. Review of the 11/28/17, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy identified staff were to notify the SA "as indicated". If an injury was inexplicable, abuse and caregiver neglect substantiated, or a therapeutic error resulted in an injury, the policy noted a report was to be made to the SA within 24 hours of the initial findings. Allegations of abuse that did not result in serious bodily injury were also to be reported no later than 24 hours. There was no mention the facility had reviewed and/or revised the policy annually to ensure it met current federal requirements.	F 609		

Electronically delivered
January 27, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: H7S311

Dear Administrator:

The above facility was surveyed on January 13, 2022 through January 14, 2022 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00175	A. BUILDING: _____ B. WING _____	C 01/14/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/13/22, and 1/14/22, 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 complaint was found to be SUBSTANTIATED: H5203206C (MN80075), with a related licensing order issued at 1980. 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 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.	2 000		

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21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that	21980		2/10/22

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21980	Continued From page 3 the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure an alleged violation of staff to resident abuse was reported no later than 2 hours, to the State Agency (SA) for 1 of 1 residents (R1) who reported allegations of physical abuse. Findings include: Review of the 1/10/22 at 12:51 p.m. report to the State Agency (SA) on 1/9/21 at midnight, NA-A was reported to have scratched R1's chest and ripped her gold necklace off R1's neck. Interview with NA-A identified R1 became upset and scratched NA-A on her arm. R1 reportedly then scratched herself on the chest and ripped her own necklace off. NA-A reported the incident to the nurse on duty. NA-A was noted to have been suspended pending the investigation. R1 was placed on a "buddy system". R1 had diagnoses of schizophrenia, osteoporosis, muscle weakness, cataracts, anxiety disorder, bipolar disorder, and major depressive disorder. There was mention why the allegation was not reported within 2 hrs. Review of the 1/14/22 at 6:48 p.m., 5 day report	21980	corrected	

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	00175	A. BUILDING: _____ B. WING _____	C 01/14/2022

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to the SA identified R1 had diagnoses of schizophrenia, osteoporosis, and major depression. R1 reported NA-A "grabbed my necklace and scratched my neck". NA-A was suspended immediately. A skin assessment was conducted, and superficial scratches were noted to the resident's neck. When interview by the DON, R1 reportedly stated she "scratched herself, because she was frustrated with [NA-A} and wanted to get her fired". R1 had been interviewed by the surveyor and reportedly "changed her story" and stated she did not scratch herself. The facility concluded abuse was reported to be unsubstantiated by the SA and was also unsubstantiated by the facility based on their investigation. R1 was placed on the "buddy system" for cares. NA-A was an agency pool staff and was not to be allowed back at the facility. R1 stated she felt safe. R1's care plan and physician had been updated. The facility also determined R1's care plan and policies had been followed at the time of the incident. There was no mention in the investigation the facility had identified staff failed to report the allegation to the SA within 2 hours as required.

Review of the facility investigation documents identified:
1) An emailed statement on 1/10/22 at 1:51 p.m., from NA-A identified R1 had put on her call light. NA-A reported she went into R1's room. R1 advised her she needed incontinent care so she proceeded to change her. While trying to change her. In the process, NA-A had asked her to help her so she could roll better (in bed). R1 reportedly got mad and said she could not and began to scream at NA-A and started "fighting me". R1 attempted to scratch NA-A's face so NA-A turned away. R1 reportedly scratched NA-A's arm and then scratched herself and cut the chain from her

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neck. R1 told NA-A she was going to lie to the administrator and tell her NA-A "did this to me" so NA-A reported that to the nurse.
2) A hand written statement by licensed practical nurse (LPN)-A that noted NA-A came out of R1's room and reported R1 scratched her during care. LPN-A went into R1's room with NA-A. R1 stated NA-A scratched her neck and broke her chain off her neck. NA-A spoke and stated R1 had broken her own chain off her neck. R1 then stated NA-A was mad because she was unable to turn her. There was no indication why LPN-A interviewed R1 in the presence of her potential abuser. There was also no mention NA-A had reported to LPN-A the comments NA-A emailed to the administrator identifying R1 told her she was knowingly going to lie to the administrator and tell the administrator NA-A had abused her.
3) A skin assessment documented by LPN-A who noted R1 had "self-inflicted scratches". R1 would not allow her to measure the scratches but she approximated them to be 2 to 3 inches in length with redness. There was no mention how LPN-A came to the determination R1's scratches had been self-inflicted without performing an investigation.
4) An interview documented as conducted later that day on 1/10/22, at an unknown time with R1 by the DON. R1 was noted to have reported to her, NA-A was "irritating her" so she scratched herself and pulled on her necklace and told her NA-A had done it. "She did not hurt or scratch me. I feel safe".
There was no indication the facility had performed a thorough investigation to include other staff who worked with NA-A, other residents NA-A had worked with, interviewed the pool staff agency to see if NA-A had any similar complaints made against her previously or any other documentation or record review. There is also no

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mention why NA-A was not allowed to return for work after the investigation, if the facility had deemed there had been no potential abuse by NA-A to R1.

Interview and observation on 1/13/22 at 9:36 a.m., with R1 about the incident identified NA-A came into her room "so angry" because she was working by herself and had to change R1's brief in the middle of the night on 1/9/22. R1 was unable to turn herself in bed and NA-A and R1 both became frustrated. NA-A scratched R1's chest and broke her necklace. R1 revealed a bright red, vertical scratch that was approximately one inch long in the middle of her chest. R1 became visibly upset when she took her broken, gold-colored, chain necklace out of her drawer. She stated it cost her over $500.00 and she remarked she "couldn't go out in public wearing a rubber key chain". R1 made repeated statements about not being able to leave the facility without wearing her beloved necklace. R1 further stated she did not scratch herself, "Why would I scratch myself?. R1 denied breaking her own necklace as it meant so much to her. R1 told the DON the following day about the incident and was told NA-A no longer worked at the facility and the SA would be notified. R1 also stated she felt the administrator "only cared about protecting [the facility]".

Interview on 1/13/22 at 10:12 a.m., with licensed practical nurse (LPN)-A identified on 1/9/22, at round midnight, nursing assistant (NA)-A came out of R1's room saying R1 had scratched her on her arm. LPN-A stated she did not see a scratch on NA-A's arm and went directly to R1's room. R1 told LPN-A that NA-A became upset because R1 couldn't turn herself onto her side when NA-A attempted to change R1's brief. R1 said during

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the incident, NA-A somehow scratched R1 on her chest and broke R1's necklace. NA-A denied the accusations, saying R1 scratched herself and broke her own necklace, but LPN-A stated she had not not believed R1 would break her own necklace in her opinion. R1 had the necklace for a long time and paid $600.00 for it. Upon assessment, R1 had a large, red scratch on her chest but she did not measure it. LPN-A had forgotten to notify the Administrator or director of nursing of the alleged abuse at the time it occurred.

Interview on 1/13/22 at 10:04 a.m., with the DON identified R1 reported to her that NA-A had scratched her chest and broke her necklace when she became frustrated with R1 during cares on 1/9/22. The DON stated R1 later had reportedly "changed her story" and said she scratched herself and didn't want NA-A to get fired or get in trouble. There was no mention if the DON had identified or been aware the incident was not reported within 2 hours of the allegation being made or took a systemic approach at that time to correct the deficient practice.

Review of the 11/28/17, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy identified staff were to notify the SA "as indicated". If an injury was inexplicable, abuse and caregiver neglect substantiated, or a therapeutic error resulted in an injury, the policy noted a report was to be made to the SA within 24 hours of the initial findings. Allegations of abuse that did not result in serious bodily injury were also to be reported no later than 24 hours. There was no mention the facility had reviewed and/or revised the policy annually to ensure it met current federal requirements.

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21980	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes. The facility should re-educate staff to the policies and procedures, and audit all complaints of alleged abuse or neglect for a set period of time. The results of the audits should be brought to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		