Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52032761M
Compliance #: H52038200C

Date Concluded: July 8, 2026

Name, Address, and County of Licensee Investigated:
The Villas at Bryn Mawr
275 Penn Ave N
Minneapolis, MN 55405-1296
Hennepin County

Facility Type: Nursing Home

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when facility staff failed to assess, develop and implement interventions and supervision to prevent the resident from consuming foods or fluids by mouth.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility failed to implement the order indicating nothing by mouth, however, there was not a preponderance of evidence where the consumed food came from. When the resident was found unresponsive, staff responded and contacted 911. The resident was transferred to the hospital for further evaluation and admitted with a diagnosis of possible acute tonsillitis (sudden swelling of tonsils, sore throat, fever and difficulty swallowing), aspiration pneumonitis (lung infection when foods, liquids, inhaled into the lungs) and sepsis (life-threatening extreme body response to infection).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted emergency services and a family member. The investigation included review of the resident record(s), hospital records, pharmacy records, emergency services records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policies and federal investigation information.

The resident resided in a skilled nursing facility. The resident's diagnoses included dysphagia, impaired cognition, protein-calorie malnutrition and feeding via a G-tube. The resident's care plan included assistance with redirection and monitor for food seeking. The resident's assessment indicated severe cognitive impairment, independence with most activities of daily living and dependence on staff for tube feedings. The resident had a history of food seeking behaviors and wandered the dining room and hallway areas during mealtimes and had a roommate that kept consumable items in the room. The resident was educated on the risk versus benefit of consuming food and fluids orally, however, a note indicated the resident shrugged when asked if the education was understood. The resident's record indicated facility staff interacted with the resident at different times throughout the day, evening and night shifts for tube feedings, incontinence cares and medications. The resident's record indicated the resident was regularly seen by a rounding provider.

A rounding provider note indicated the resident reported twice she was taking food and fluids by mouth during the time the resident was ordered nothing by mouth. Chest x-rays were ordered each time due to concern for silent aspiration (food and fluid enter airway without triggering cough). Four days before the resident was found unresponsive, a provider visited and noted the resident had a cough with coarse lung sounds (can indicate fluid or mucus in lungs). The provider again ordered x-rays however, results were not documented prior to the resident's hospitalization.

An internal investigation indicated oncoming night shift staff were told the resident had pulled out her feeding tube and the resident was observed sleeping during shift change rounds. A couple hours after shift change unlicensed staff entered the resident's room to assist the roommate and observed the resident "was not breathing well." Unlicensed staff notified licensed staff, checked vital signs and called 911.

Emergency service records indicated when emergency personnel arrived the resident had a pulse of 158, respirations between 44 and 50 breaths per minute, a body temperature of 105.5 Fahrenheit (F) and rale sounds in both lungs (can indicate fluid or airway obstruction of lungs). The resident required ten liters per minute of oxygen supplement due to respiratory distress. Additionally, the emergency service report indicated facility staff reported to emergency personnel that the resident had been equally unresponsive at dinnertime the evening before and it was unclear to emergency personnel how long the resident had been unconscious. Emergency service records indicated facility staff were unable to provide pertinent details to questions from emergency personnel, and the resident was transported to a hospital.

Hospital records indicated the presence of possible acute tonsillitis (sudden swelling of tonsils, sore throat, fever and difficulty swallowing), aspiration pneumonitis (lung infection when foods, liquids, inhaled into the lungs) and sepsis (life-threatening extreme body response to infection). Hospital records indicated food was suctioned from the resident's airway during intubation (insertion of tube to support airway) and per emergency room note, it was reported facility staff attempted to feed the resident by mouth, however, the resident was nothing by mouth. The resident's intubation in the emergency room was further complicated when the resident went into a brief cardiac arrest that required hospital staff to perform cardiopulmonary resuscitation (CPR). Hospital records indicated the resident had a complicated medical history. After a lengthy hospitalization the resident discharged to a new facility with a trach tube (device to maintain airway) surgically placed.

A hospital record note that facility staff fed the resident by mouth was contradicted by interviews completed with facility staff.

During an interview, licensed staff #1 stated the resident was nothing by mouth and received tube feedings. Licensed staff #1 recalled the resident was a wanderer and would go room to room. Licensed staff #1 had not seen the resident the night of the incident but was called by licensed staff #3 and told the resident was gasping for air. Licensed staff #3 was instructed to call 911.

During an interview, licensed staff #2 stated he did rounds before giving shift report to licensed staff #3 and the resident "was fine". Licensed staff #2 stated the resident had a roommate and meals were brought to the roommate three times a day. The roommate required staff to assist with feeding and the roommate's food was not left unattended. Licensed staff #2 stated the resident was monitored for food seeking behaviors because she was nothing by mouth however the resident was not on regularly scheduled checks.

During an interview, licensed staff #3 stated the resident was nothing by mouth, was tube fed and only observed by licensed staff #3 one time because he worked nights, and the resident slept during the night shift. Licensed staff #3 stated rounding checks were done right away when he started his shift. He would peek in the doors, observe if residents were breathing and if the residents were sleeping. Licensed staff #3 stated unlicensed staff had entered the resident's room to assist the roommate a couple hours later and staff observed the resident's gasping breaths. Licensed staff #3 stated he went to call the facility nurse in charge and 911 while unlicensed staff gathered vital signs. Licensed staff #3 stated the vital signs charted in the resident's record were not correct because the machine shut off and had to be turned back on. The last recorded vitals that showed up when the machine turned back on were thought to be the resident's and documented into the resident's chart. The oximeter (records oxygen levels) wasn't working, and the recorded temperature was not necessarily correct. Licensed staff #3 contradicted licensed staff #2 and stated the resident's roommate was taken to the dining room three times a day for meals.

During an interview, unlicensed staff stated she was called to the resident's room to assist another unlicensed staff with the resident's roommate. The unlicensed staff stated while assisting the roommate she noticed the resident was making breathing sounds like someone with asthma struggling to breathe. Unlicensed staff stated she notified a licensed staff, gathered the resident's vital signs then returned to a lower floor where she was assigned. Unlicensed staff stated sometimes at shift change management would tell unlicensed staff if the resident was seen with food, it should be taken away. Unlicensed staff stated monitoring was conducted throughout the shift and mostly in the dining room. The resident was encouraged to sit near the nurse's station for more frequent observations by staff.

During an interview, a family member stated nobody had determined exactly how the resident got access to food, if it was given to her by another resident or if she had somehow taken food. The resident was nothing by mouth due to earlier medical events that caused throat damage and food was found in the resident's throat when transported to the hospital. After a couple months the resident discharged from the hospital to a new skilled nursing facility.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Unavailable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility observed the resident in distress and summoned emergency services.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS AT BRYN MAWR LLC	**275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 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
20000	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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint # H52032761M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	20000		

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