DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 25, 2025

Administrator
The Villas At Bryn Mawr LLC
275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

RE: CCN: 245203

Cycle Start Date: September 29, 2025

Dear Administrator:

On October 15, 2025, we notified you a remedy was imposed. On November 12, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 15, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 30, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 15, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 29, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

October 15, 2025

Administrator
The Villas At Bryn Mawr LLC
275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

RE: CCN: 1780028878
Cycle Start Date: September 29, 2025

Dear Administrator:

On September 29, 2025, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 25, 2025, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location 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 October 30, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 30, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 30, 2025 (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 29, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Villas At Bryn Mawr LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 29, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 29, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request

electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 15, 2025

Administrator
The Villas At Bryn Mawr LLC
275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

Re: Event ID: 1D7C91-H1

Dear Administrator:

The above facility survey was completed on September 29, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The 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
F0000	INITIAL COMMENTS On 9/24/25 through 9/29/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52035164C(2626410), found in compliance H52035088C(2624291), H52035088C(2624376) with a deficiency issued at F600 The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility neglected to provide care and services to a resident (R1) with mental health needs who refused assessments and interventions since admission on 7/7/25, R1 was not transferred to a higher level of care resulting in R1's admission to a hospital being adhered to her mattress covered in urine and feces, malnourished, with maggots around her groin, orthopedic screw sticking out of her right shoulder, bra hook embedded down to the muscle layer, reddened folds to right flank, pressure ulcers from stage one to stage four covered her entire back, open areas to coccyx, bilateral gluteus, and skin tears along her posterior thighs. The IJ began on 9/21/25 and the immediacy was removed on 9/25/25. The above findings constituted substandard quality of care, and an extended survey was conducted from 9/25/25 to 9/29/25. 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.	F0000		10/15/2025
F0600 SS = SQC-J	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	F0600	Please accept the following Removal Plan for The Villas at Bryn Mawr regarding the Immediate Jeopardy identified by the MDH survey agency on September 25, 2025 at 5 pm. It was determined that all like-residents are at risk to be affected by this deficient practice. The facility is in compliance as of 9/25/25. R1 remains hospitalized.	10/15/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The 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
F0600 SS = SQC-J	Continued from page 1 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- §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 interview and document review, the facility neglected to provide care and services to a resident with mental health needs who refused assessments and interventions since admission on 7/7/25, R1 was not transferred to a higher level of care despite facility and provider awareness for 1 of 3 residents (R1) who were reviewed for neglect of care when R1 contacted emergency medical services (EMS) because she felt dizzy, was vomiting, and could not move her lower extremities. When EMS arrived R1 was adhered to her mattress and covered in urine and feces. R1 admitted to the hospital malnourished, with maggots around her groin, bra hook embedded down to the muscle layer, reddened folds to right flank, pressure ulcers from stage one to stage four covered her entire back, open areas to coccyx, and bilateral gluteus, and skin tears along her posterior thighs. The immediate jeopardy began on 9/21/25, when facility failed to send R1 to a higher level of care when they were unable to provide hygiene, assess her skin, identify the cause of the unpleasant smell and suspected foot wound, for a bedridden resident and identified on 9/25/25. The administrator, regional director of operations, and director of nursing (DON) were notified of the immediate jeopardy at 5:10 p.m. on 9/25/25. The immediate jeopardy was removed on 9/25/25, but noncompliance remained at the lower scope and severity level 2 D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Hospital discharge summary dated 7/7/25, indicated R1 was treated for back pain, and they found an abnormal lesion on her spine. During the hospitalization she had fixed delusions and refused medical care. She was placed on a court hold related to unwillingness to care for spine lesions and refused to have the surgical screw removed from her shoulder.	F0600	Continued from page 1 Facility completed a full house skin assessment for all residents. Facility completed a full house audit for residents who refuse skin assessments, care, services, and other assessments to determine interventions for their health and safety. Facility implemented and created a procedure specific to refusals of care including how to identify resident self-neglect and identifying action by the facility for resident’s self-neglect. Education completed with all staff prior to the beginning of their shift about the new changes to procedures regarding refusal of care. An email has been sent out to all staff and a sign has been posted at the timeclock regarding education. Education: Refusal of Care Procedure The philosophy of Monarch Healthcare Management is to provide quality long-term care in a loving and caring atmosphere. In accordance with Monarch Healthcare Management philosophy, this plan has been written to comply with Minnesota Statute (626.557) and Federal Guidelines for prevention of maltreatment of vulnerable adults in health care centers. Purpose: To protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. To promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. To promptly investigate, report and determine probable cause of unknown origin injuries. To identify and remedy any potentially abusive situations. Procedure implementation:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The 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
F0600 SS = SQC-J	Continued from page 2 R1's admission data assessment dated 7/7/25, indicated she refused to let staff examine her skin. R1's 48-hour care plan dated 7/8/25, indicated she had a self-care deficit related to back pain and schizophrenia. Her mobility was altered. She was continent of bowel and bladder and required help from one staff member to toilet. She was at risk for skin breakdown. Interventions included staff would complete weekly skin assessments and report any breakdown to the provider, turning every 2 hours, pressure relieving mattress, and wheelchair cushion. R1's care plan focus dated 7/8/25, indicated she had a risk for skin impairment related to incontinence and refusal of care. She preferred to lay in bed all the time and did not want staff to wake her up. Implemented turn and reposition every 2-3 hours. Monitor skin integrity daily during cares, placed pressure redistribution mattress and wheelchair cushion, and report concerns to the provider. R1's care plan focus dated 7/9/25, indicated she was at risk for malnutrition. Interventions included offer food and fluids, and alternative meals as requested. Offer ice cream, yogurt, and pudding and encourage her to eat meals. She received a supplement. R1's provider note dated 7/9/25, indicated R1 had an odor of unknown etiology, the room had a malodorous smell, concerned of a foot wound, R1 was very private about her body. R1 refused to answer question if she had any open skin areas. R1's clinical nutrition evaluation dated 7/9/25, indicated her weight was 180.5 pounds (lbs.) R1's admission Minimum Data Set (MDS) dated 7/13/25, indicated she had normal cognition, mild depression, delusions, and rejection of cares. She used a wheelchair for mobility, needed the assistance of one with toileting, shower, dressing, and transfer. Needed set up assistance for hygiene needs, and staff set up her meals. She was continent of bladder and had frequent stool incontinence. She had depression, Schizophrenia, and back pain. She did not have a risk for pressure ulcers, or any skin injuries. She took antipsychotic and seizure medications. R1's care plan focus dated 7/14/25, indicated her behaviors were related to trauma when she was hit by a car and sustained life-threatening injuries. Interventions included applying Associated Clinic of Psychology (ACP) recommendations. Use a trauma informed	F0600	Continued from page 2 When a resident refuses care, treatment, medications, assessments, etc. staff member will attempt to re-approach the resident. If the resident continues to refuse, it will be documented in the progress notes. Staff member will notify the provider. IDT will review progress notes for refusals daily during business hours and document refusals on the morning meeting form. If a resident has refused cares, treatment, medications, assessments frequently the IDT member will approach resident to determine if there is a root cause of refusal of care (i.e. want medication changed from PM to bed time, shower times preferences, etc). IDT member will document in a progress note. If resident continues to refuse, IDT will complete a risks vs benefit form and update the care plan. IDT will also discuss and implement an appropriate intervention. If resident continues to refuse, IDT will meet to determine the next steps such as a behavior contract, transfer to hospital, possible MAARC report, additional interventions, etc. If at any time the resident's refusal is causing self-harm, the provider will be updated immediately for order to send resident to hospital. The facility's Abuse Policy was reviewed and remains current. Facility will complete audits on 5 residents weekly x4 weeks for refusals of care and following the new procedure to be completed by DON or Administrator. Facility to complete random quizzes with staff to ensure understanding of facility's refusal of care procedure with 5 staff a week x 4 weeks. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The 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
F0600 SS = SQC-J	Continued from page 3 approach to care, work at her pace, and build trust. Staff would update the provider regarding any behavior changes. R1's Risk verse Benefits document dated 7/14/25, indicated she had refused care and vaccinations. She was at risk for health, hospitalization and or death. R1's weekly skin assessment dated 7/15/25, 7/22/25, 8/6/25, 8/12/25, 8/19/25, 8/26/25, 9/2/25, 9/9/25, 9/12/25, and 9/16/25, indicated she refused a bath and her skin checked by staff. R1's provider note dated 7/16/25 indicated R1 had mild anemia with a hemoglobin of 11.5, her basic metabolic panel was unremarkable. Staff stated R1 has been intermittently refusing cares and medications. R1 refuses treatment for lytic lesions. R1's provider note dated 7/18/25 indicated she was seen for pain management and rehabilitation recommendation. R1 did not appear to be in distress, no breakdown in hands or heels, moves all extremities, R1 had decreased endurance, activity of daily living impairment, muscle weakness, deep vein thrombosis risk, constipation risk, and skin breakdown risk due to decreased mobility. R1's Associated Clinic of Psychology (ACP) note date 7/21/25, indicated services were established. R1's facility doctor notes dated 7/22/25, indicated R1 refused a skin check, no distress, and R1 only permitted him to listen to her heart and lungs. No sign of infection, R1 denied any pain. R1 continued to have malodorous smell, and he was concerned she had a wound on her foot. R1's ACP note dated 8/1/25, indicated R1's chief complaint medication management. The ACP provider indicated R1 was malodorous and smelled of urine and fecal matter. R1 discussed her previous hospital stay, continues to have back pain and that is why she can not walk, but is working with physical therapy to get better as they check on her every once in a while. R1 was on a civil commitment with a Jarvis Order, with limited insight into her condition. A Psychotropic medication was increased. R1's ACP note dated 8/4/25 indicated R1 was wrapped in a blanket on an unmade mattress, less malodorous than prior visit, continues with delusional thinking, has poor insight and judgement. R1 does not appear to be ready to accept showers.	F0600		

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F0600 SS = SQC-J	Continued from page 4 R1's provider note dated 8/19/25 indicated she was seen in her room laying on her bed, paranoia and delusions noted during exam. R1's care conference dated 8/19/25, indicated no issues with pain, changes in her condition, or skin integrity. She was a full code. She needed the assistance from one staff to toilet. Staff would check and provide peri care every 2 to 3 hours. Resident stated she had bleeding from her gums. She indicated the reason she did not shower was a lack of privacy. They discussed her refusal of care, and it was emphasized if she were unwilling to comply with cares, the consequences would be a prolonged stay at the facility and poor prognosis. Dietary indicated her weight was 181.0 lbs. on 8/13/25, and she only ate ice cream, pudding, and yogurt. R1's ACP noted dated 9/5/25, indicated R1 was malodorous and lying in bed. Her insight and judgement are limited, reports being depressed, slightly more distressed. A medication for depression was prescribed. R1's ACP noted dated 9/8/25, indicated staff report concerns for mood, poor appetite, low intake, continuing to self-isolate, remaining in bed all of time, and will sometimes use provider towel to clean herself up, but is not showering. R1 is unkempt, wrapped in blanket lying on unmade mattress, poor oral hygiene and malodorous. R1's weight dated 9/10/25 by wheelchair at 9:00 p.m. was 180 lbs. R1's ACP note dated 9/15/25, indicated staff report ongoing concern for mood, low intake, continuing self-isolate in room. R1 remains in bed all the time. A county assessor visited to assess relocation services. R1 hospital note dated 9/21/25, indicated she was admitted to the hospital after she called EMS. She arrived with the mattress adhered to her. Her bra and a pill were stuck to her back. Urine, stool, and wounds were found along with maggots on her groin. Records indicated R1 weighed 152 lbs. upon admission. R1's care plan intervention dated 9/22/25 for a focus of refusing cares and fixed delusions, indicated she was private about her body and refused help to bathe and complete skin checks. She refused to answer the provider when asked if she had any open wounds. Interview with the physician assistant (PA)-A on 9/24/25 at 9:11 a.m., stated R1 had to be decontaminated before surgery, her entire back was a	F0600		

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F0600 SS = SQC-J	Continued from page 5 pressure ulcer, and her bra strap hooks broke down the skin into the muscle in her back. R1's INR was so high related to malnutrition that the surgery had to be performed in two episodes. Interview on 9/24/25 at 11:15 a.m., registered nurse (RN)-A stated every time she attempted to help R1, she would yell no and get out. She was unable to touch the resident during her stay, she told the manager and provider regarding the refusal of care. They would bring her linen, and bathing supplies to help her clean up. They would stand outside the room with the door cracked to encourage her, but the resident refused. The room smelled, and when a new resident was assigned to the same room, they ended up walking out the door and family stated it was because of the smell in the room. Interview on 9/24/25 at 2:27 p.m., social worker (SW)-A indicated they did not report to the state concerns regarding rejection of care. R1 was visited by ACP weekly and a psychiatrist monthly. They were trying to build trust with her. Every time she saw R1, she would always be in bed with 2 to 3 blankets covering her. Interview on 9/24/25 at 2:48 p.m., the DON indicated she did not know the severity of R1's condition. She did not feel R1 was trying to harm herself. They had ACP and the psychiatrist assessing her regularly. The facility medical doctor saw her on 9/13/25, and did not bring any concerns regarding a need to transfer to the hospital. They were trying to balance R1's refusals while maintaining her right to refuse care. They had no indication what was happening to the resident under the covers. Interview on 9/25/25 at 9:10 a.m., the administrator stated when a resident refused care the process included, updating the provider, complete a risk verse benefit assessment, educate, and update the care plan. She did not feel the situation rose to the level of self-harm, but more self-neglect on R1's part. She did not have a change in condition or indicated a need for hospitalization. Since R1 left the facility, they did an investigation and taught their staff to find a way to negotiate the residence compliance with care. Interview on 9/25/25 at 9:50 a.m., medical director (MD-A) stated a higher level of care would be the skilled nursing facility or a hospital. He was unable to say if R1 had self-injuring behaviors. He wished the hospital would have pursued a guardianship for her so they would have had more help to manage her behaviors. Interview on 9/25/25 at 2:16 p.m., Paramedic (P)-A	F0600		

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F0600 SS = SQC-J	Continued from page 6 stated R1 called EMS because she lost feeling in both of her legs. He found her lying directly on the vinyl mattress top. She had a urine and feces-soaked towel between her legs, and a basin with bloody emesis next to the bed. They were unable to roll her in bed because her body was adhered to the mattress. They cut the top layer of the mattress off to transport her. She looked sick, dehydrated, and the room smelled like infection, urine, and stool. Staff told him R1 refused to let them care for her. His emotions got the best of him, and he was unable to engage with the staff anymore. He just focused on transporting R1 to the hospital. The immediate jeopardy that began on 9/21/25, was removed on 9/25/25, when the facility completed a full house skin check audit. If a resident had refused, a skin check was done. They audited all care plans for refusing skin checks. Updated target behavior orders to include a section regarding refusal of cares, showers, and skin checks. Clinical team would attend weekly ACP meetings to discuss concerning behaviors and update care plans. Morning meeting agenda now includes a section for refusal of care. In case of refusal staff would update the individual department team (IDT) meetings, schedule care conference, do a behavior contract or other individual specific interventions.	F0600		

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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: On 9/24/25 to 9/29/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey. H52035164C(2626410)	20000		10/15/2025

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

Minnesota State Department of Health

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20000	Continued from page 1 H52035088C(2624291) H52035088C(2624376) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		