DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 16, 2024

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

RE: CCN: 245203
Cycle Start Date: August 12, 2024

Dear Administrator:

On August 22, 2024, we notified you a remedy was imposed. On September 9, 2024 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 September 4, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 6, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 22, 2024, 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 August 12, 2024. 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 16, 2024

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

Re: Reinspection Results
Event ID: OFB112

Dear Administrator:

On September 9, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 12, 2024. At this time these correction orders were found corrected.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 22, 2024

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

RE: CCN: 245203
Cycle Start Date: August 12, 2024

Dear Administrator:

On August 12, 2024, 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 widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 9, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of F.

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 September 6, 2024.

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 September 6, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 6, 2024, (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 $12,924; 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 August 12, 2024. 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. <u>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.</u>

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 August 12, 2024. 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 February 12, 2025 (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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period

allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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
August 22, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: OFB111

Dear Administrator:

The above facility was surveyed on August 6, 2024 through August 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BRYN MAWR LLC	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 8/6/24 through 8/9/24, and 8/12/24, 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: H52036642C (MN00105442) H52036622C (MN00105419) H52036402C (MN00105314) Deficiencies were issued at F689, F914, F944, F949. The survey resulted in an Immediate Jeopardy (IJ) at F689 when R2 reported difficulty breathing, and staff phoned 911 at approximately 2:09 a.m. on 7/29/24. When EMS arrived at the facility, the doors were locked. A staff member attempted to open the doors and were unable. EMS was unable to enter the building for approximately 10 minutes. This deficient practice had the potential to affect all 81 residents. The IJ began on 7/29/24, and the immediacy was removed on 8/9/24. The above findings constituted substandard quality of care, and an extended survey was conducted 8/9/24 and 8/12/24. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2024

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
	245203	A. BUILDING _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BRYN MAWR LLC	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	Continued From page 1 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 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a system in place to train staff on the process for unlocking the main entrance doors for emergency medical services (EMS) personnel after hours when the doors were locked from 10:00 p.m. to 7:00 a.m.. R2 had difficulty breathing, 911 was call, and EMS personnel could not gain entrance to the building for ten minutes. This deficient practice placed all 81 residents residing in the facility at risk for serious harm, impairment or death (immediate jeopardy [IJ]) for delayed EMS response. The IJ began on 7/29/24 at 2:29 a.m. when R2 reported difficulty breathing, and staff phoned 911 at approximately 2:09 a.m. on 7/29/24. When EMS arrived at the facility, the doors were locked. A staff member attempted to open the doors and were unable. EMS was unable to enter the building for approximately 10 minutes. The administrator	F 689	R1 discharged from the facility on 7/31/2024. All residents had potential to be affected by this. Emergency preparedness plan was reviewed and updated with instructions on locking and unlocking front door. Facility assessment was reviewed and updated. Instructions on how to lock and unlock the door were created and printed for staff on 8/8/2024. Education began with all nursing staff on how to lock and unlock the door with a return demonstration on 8/8/2024, and continues with all new hires and agency staff. Agency staff orientation packets	9/4/24

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 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BRYN MAWR LLC	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 689	Continued From page 2 and director of nursing (DON) were notified of the IJ on 8/8/24 at 4:51 p.m. The IJ was removed on 8/9/24 at 11:46 a.m., but noncompliance remained at the lower scope and severity level of an F, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The Daily Census dated 8/5/24 and provided by the facility on 8/6/24 indicated the facility census was 81 residents. R2's admission Minimum Data Set (MDS) dated 4/29/24, indicated R2 was cognitively intact, had no behaviors, and required assistance of two staff for transfers. R2's Diagnoses List undated, included kidney disease, diabetes, dialysis treatments, and left below the knee amputation. On 7/29/24 at 2:09 a.m., a progress note indicated R2 reported difficulty breathing and staff phoned 911, and emergency medical services (EMS) arrived at approximately 2:29 a.m. On 8/7/24 at 11:22 a.m., the administrator stated the front doors were locked at night, as some residents had a dealer dropping off drugs at night. The nurses had keys to the front doors at night. She was not aware there were issues unlocking the doors timely during the night. On 8/7/24 at 12:53 p.m., nursing assistant (NA)-A stated the nurse who was working on first floor on 7/29/24 night shift was an agency staff, and	F 689	updated to include training on locking and unlocking the front door. Administrator spoke with Chief Tyner and Captain Edwards on 8/12/24 regarding the plan for education, the code to the back door for emergencies, as well as writers contact information should any future issues arise. DON or designee will complete audits on all new agency staff, and new hires weekly x 4 weeks to ensure they were trained, and are able to lock and unlock the front door. QAPI will review audit results and recommend continued audit schedule.	

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 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BRYN MAWR LLC	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 689	Continued From page 3 couldn't find the key to open the door. NA-B tried to open the door, but didn't know how. NA-A was able to open the door with the keys from the first floor nursing station's medication cart after NA-B tried, and then asked for help from other staff on second floor. There had been other times when staff could not open the door. She did not report the problem to administration because she thought the nurses would. There was usually one nurse on first floor, one on second floor, and 4-5 NAs in the building on night shift. On 8/7/24 at 2:07 p.m., during a subsequent interview, the administrator stated only the nurse on first floor station one [near the front door] had the key to unlock the door at night. Reception staff didn't work at night, and the NAs could get the key from the nurse to unlock the door as needed. Staff were trained "about a year ago" to open the door, but she could not provide proof of the education. The NAs could open the door if they got the key from the nurse, but would have to remove the key from the key ring as it was on the first floor medication cart key ring. An email sent by the administrator on 8/8/24 at 2:32 p.m., indicated since 7/1/24, 123 shifts were covered by agency staff, of that, 30 were night shift nurses. On 8/7/24 at 2:56 p.m., registered nurse (RN)-A stated agency staff did not know how to unlock the door after hours. Staff who can open the door must know which keys go to which doors. On 8/7/24 at 3:10 p.m., licensed practical nurse (LPN)-A stated the nurse who worked first floor was responsible to open the door for EMS staff, or they could give the keys to another nurse or NA to	F 689		

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F 689	Continued From page 4 unlock the doors. The key to the front door was on the key ring to the first floor medication cart. On 8/7/24 at 3:22 p.m., RN-B, an agency staff, stated no one had ever shown her how to unlock the front door after hours when it was locked. On 8/7/24 at 3:53 p.m., paramedic (P)-A stated when EMS arrived at the facility, the doors were locked. The staff member who attempted to open the doors could not do so, and left. The staff person came back with a staff who had keys to unlock the door, which allowed EMS to enter the building. EMS were unable to enter the building for up to 10 minutes. P-A stated, "A breathing problem is a high priority call and emergency." The fire department arrived at the facility prior to the ambulance team. It was unusual the fire team was still outside, as typically the fire team was already with the resident when the ambulance team arrived. But this time the fire captain was pounding on the door to get in. The fire department has previously had significant issues getting access to this facility during other incidents in the night hours. On 8/7/24 at 4:44 p.m., NA-B stated R2 stated she was short of breath, "It's not gotten that bad before and I haven't seen her go to the hospital for something like that." There was one key for the front door, the nurse on first floor kept it at night, and he had not been taught how to open the door. He had tried to open the door twice that night, and when he could not, he went to second floor to ask staff for help. He didn't know how long that took. He had not reported the issue to administration because he thought NA-A did.	F 689		

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F 689	Continued From page 5 On 8/8/24 at 8:59 a.m., fire captain (FC)-A stated the facility had a two-step system lock on the facility front door, and night staff did not know how to open the door for the emergency call for R2. One staff came to the door twice, couldn't unlock the door, and left without speaking to the fire or ambulance staff. The staff person then came back with another staff who was unable to unlock the door, and it took 10 minutes to get the door unlocked. In 10 minutes, the resident could have gone from having difficulty breathing to full arrest or death. The fire department had been to the facility 23 times since July 1, 2024, and had difficulty getting into the facility "about every other call." "If there is a fire, they won't be able to get people out. Everyone needs to know how to let us in." On 8/8/24 at 9:41 a.m., NA-C stated she had not been trained how to unlock the door, and she didn't know who had a key to unlock the door. Agency staff who were working on 7/29/24 night shift did not know how to open the door. She did not report it to administration because the night NA staff was gone before administration came for day shift, and she thought the nurses would report it. It took 10-15 minutes to get the door open. On 8/8/24 at 10:35 a.m., the DON stated she was responsible for staff training, but did not train staff how to unlock the door, and agency staff education did not include how to unlock the front doors. A 10-minute delay could cause the death to someone who needed assistance. The facility had not met with fire staff in the last four years, and did not know they were having access problems. She did not know why staff didn't tell her about it. Staff	F 689		

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F 689	Continued From page 6 should wait at the door when 911 was called. The door was locked at night for night shift, and was unlocked in time for morning shift to enter. On 8/8/24 at 2:13 p.m., the administrator stated two nurses and four NAs work night shift. On 8/8/24 at 2:35 p.m., RN-A stated the doors were secured from entering the building and exiting the building. Agency staff usually did not know how to open the door, but should be taught by facility staff. On 8/8/24 at 2:50 p.m., P-B stated EMS staff had trouble getting in the facility during the night. On 8/8/24 at 2:54 p.m., a sign on the front door directed visitors to the back of the building if they were unable to get in, and to ring the bell to alert staff. Receptionist (R)-A stated the sign had been posted for a couple of months. On 8/8/24 at 3:24 p.m. the maintenance staff (M)-A stated there were no problems with locking the doors, and they only locked from the inside, and not the outside. The staff should know how to open it. A lock was installed during COVID, and he had not heard of anyone having access issues at night. Usually when visitors came, the nurses opened the door. Nurses should be at the door to let EMS in at night. The nurses lock the door anywhere between 8 p.m. to 10:30 p.m. The facility "put the lock on because residents tried to leave at night." On 8/9/24 at 1:16 p.m., during a subsequent interview, P-B stated when his EMS crew came at	F 689		

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F 689	Continued From page 7 night, it took up to 10 minutes for staff to let them in the door. This had occurred 3-4 times over the previous four weeks. He had commented about the delays to the staff each time, but had not contacted facility administration. The EMS crew pounded on the doors to get staff to let them in. A policy for locking the door was requested and not provided. The immediate jeopardy that began on 7/29/24 was removed on 8/9/24, after nursing staff was educated about the unlocking the doors timely for emergency personnel, with the expectation staff would meet emergency personnel at the front door, assist them to the elevator, and direct them to the resident who required emergency assistance. The facility provided education about how to unlock the front doors, and staff demonstrated they could open the front doors. The facility educated staff how to push the doors open with the emergency bar for emergency egress, posted instructions at each nursing station that had a key to the door, and provided instructions for who to call for maintenance including maintenance staff, the DON, and the administrator. The facility contacted the Minneapolis fire chief to ensure the fire department staff were aware of the building door codes. This was verified through observation, interview and document review.	F 689		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after	F 914		9/4/24

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F 914	Continued From page 8 March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a privacy curtain for 3 or 3 residents (R1,R3, R6) who shared a room and were reviewed for a clean home-like environment. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/18/24 indicated R1 was cognitively intact. R1's Diagnoses List undated, included adjustment disorder with depressed mood, weakness, and unsteadiness on feet. R1's care plan dated 2/6/24, indicated R1 utilized a two-wheeled walker, and required assistance with transfers and to get out of bed. On 8/7/24 at 9:31 a.m., R1's room was observed to have a privacy curtain that was torn and unusable, and shielded R1's roommate from the doorway, but did not provide privacy from R1's view. R1 was sitting on the side of his bed, and stated he had never had a privacy curtain, nor had his roommate, and he had to watch staff help his roommate dress and undress. He did not want to eat in the dining room, but also did not want to watch staff dress and undress his roommate while he was eating. He was embarrassed watching his roommate dress, and it made him feel, "Real down."	F 914	R1, R3 and R6 all have privacy curtains in their rooms. Full house audit was completed to identify what rooms did not have privacy curtains and tracks. Minnesota department of health Resident Bill of Rights was reviewed as it relates to privacy, and remains current. Staff education initiated to staff on how to report missing/damaged curtains through TELS system. Administrator or designee will complete audits for 10 resident rooms weekly x 4 weeks to ensure each bed has a privacy curtain. QAPI will review audit results and recommend continued audit schedule.	

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F 914	Continued From page 9 R3's quarterly MDS dated 6/4/24, indicated R3 had severe cognitive impairment, and required assistance of two staff for bed mobility and transfers. R3's Diagnoses List undated, included major depressive disorder, personal history of traumatic brain injury, and cognitive communication deficit. R3's care plan dated 10/14/21, indicated R3 was dependent upon staff for all cares. R6's quarterly MDS dated 6/3/24 indicated moderate cognitive impairment and no behaviors. R6's Diagnoses List undated, included alcohol use, psychoactive substance abuse, history of homelessness, and anxiety. R6's care plan dated 3/24/24, indicated he was at risk for alteration in psychosocial well-being related to a history of homelessness. R6's Face Sheet printed 8/8/24, indicated he was his own decision-maker. On 8/6/24 at 2:00 p.m., R3 and R6's door was observed open. R6 had his pants down, and was masturbating. The room lacked a privacy curtain on either side of the room. Nursing assistant (NA)-H was present and acknowledged R3 could see R6 masturbate, but wouldn't want to. NA-H covered R6 with a sheet. R6 pushed the sheet off and yelled at NA-H to leave the room. On 87/24 at 10:12 a.m., housekeeper (HK)-A	F 914		

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F 914	Continued From page 10 stated R3 and R6 did not have privacy curtains. On 8/7/24 at 11:22 a.m., the administrator stated she had not ordered privacy curtains, but each side of the room should have one. On 8/8/24 at 10:35 a.m., the director of nursing (DON) stated all the rooms should have privacy curtains for cares, if the resident needed space alone, and the curtains should be in good repair and usable. A policy for privacy curtains was requested but not provided.	F 914		
F 941 SS=B	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide training about communicating with non-English speaking residents who were identified as residents the facility may serve, for 5 of 5 staff (nursing assistant [NA]-G, NA-H, NA-I, registered nurse [RN]-A, licensed practical nurse [LPN]-B) reviewed. The facility identified two residents who were non-English speaking. Findings include: Review of sampled staff training identified the following staff lacked training for communicating with non-English speaking residents: 1) NA-G	F 941	Staff Identified during this time of the survey as not having been educated on communication with non- English speakers were reeducated. Staff education regarding communication with non- English speaking residents has been initiated on 8/20/2024. This education has been included in the facilities new hire orientation training through the facilities online training system. Administrator or designee will complete audits of 5 new hires will be completed weekly x4 weeks to ensure communication training has been completed . QAPI will review audit results and recommend continued audit schedule.	9/4/24

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F 941	Continued From page 11 2) NA-H 3) NA-I 4) RN-A 5) LPN-B On 8/12/24 at 12:54 p.m., nursing assistant (NA)-D could not recall training for communicating with non-English speaking residents. On 8/12/24 at 12:57 p.m., NA-E could not recall training for communicating with non-English speaking residents. but stated there was one resident in the facility who was non-English speaking. On 8/12/24 at 1:00 p.m., NA-F could not recall training for communicating with non-English speaking residents. Review of the Facility Assessment (FA) dated 7/3/24, indicated the facility accepted residents who required interpreter services. The FA lacked indication staff was trained annually on communicating with residents who were non-English speaking. On 8/12/24 at 1:14 p.m., RN-C and the director of nursing (DON) were interviewed. RN-C stated communication with non-English speaking residents was an area the facility missed for training.	F 941		
F 944 SS=B	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program	F 944		9/4/24

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F 944	Continued From page 12 mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide mandatory training on the facility's Quality Assurance Performance Improvement Program (QAPI) which included the goals and various elements of the program, and how the facility intended to implement the program, staff's role in the facility's QAPI program, and how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program for 5 of 5 staff (nursing assistant [NA]-G, NA-H, NA-I, registered nurse [RN]-A, licensed practical nurse [LPN]-B) reviewed for QAPI training. Findings include: On 8/12/24 at 12:54 p.m., nursing assistant (NA)-D could not recall what QAPI was, nor any training about QAPI, or the QAPI program. On 8/12/24 at 12:57 p.m., NA-E could not recall what QAPI was, nor any training about QAPI, or the QAPI program. On 8/12/24 at 1:00 p.m., NA-F could not recall what QAPI was, nor any training about QAPI, or the QAPI program. Review of sampled staff training identified the following staff had no QAPI training noted as provided on the facility's plan for the following staff reviewed: 1) NA-G	F 944	Staff Identified during this time of the survey as not having been educated on QAPI were educated. Staff education regarding QAPI has been initiated on 8/20/2024. This education has been included in the facilities new hire orientation training through the facilities online training system. Administrator or designee will complete audits of 5 new hires will be completed weekly x4 weeks to ensure QAPI training has been completed . QAPI will review audit results and recommend continued audit schedule.	

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F 944	Continued From page 13 2) NA-H 3) NA-I 4) RN-A 5) LPN-B On 8/12/24 at 1:14 p.m., during an interview with registered nurse (RN)-C and the director of nursing (DON), RN-C stated QAPI was an area the facility missed for training. The DON stated she was just trained on QAPI in the past week. On 8/12/24 at 11:01 a.m., the administrator stated she was unaware the facility didn't provide mandatory training on the facility's QAPI program. Review of the August 23, 2023 Quality Plan identified the plan provided for overall quality improvement within the facility and revisions would be communicated to the governing board, residents, families, and employees through meetings and written communication. Review of the July 18, 2024 QAPI meeting minutes indicated nursing was responsible for initiatives related to pressure ulcers, physical restraints, falls, falls with major injury, anti-anxiety/hypnotic medications, catheters, incontinence, and worsening activities of daily living. The minutes lacked indication mandatory training was provided to staff.	F 944		
F 949 SS=D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at	F 949		9/4/24

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F 949	Continued From page 14 §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 staff (nursing assistant [NA]-G, NA-H, NA-I) received annual training on behaviors in Alzheimer's disease or related disorders, problem solving with challenging behaviors, and communication skills. Findings include: Review of NA-G's, NA-H's, and NA-I's training transcripts lacked identification they completed annual training on Alzheimer's Disease, behavioral health, communication skills, or problem solving with challenging behaviors. Review of the Facility Assessment (FA) dated 7/3/24, indicated the facility accepted residents with psychiatric and mood disorders, and with impaired cognition. The FA indicated staff were trained annually on dementia management and how to address the care of the cognitively impaired residents. On 8/12/24 at 1:14 p.m., during interview with registered nurse (RN)-C and the director of nursing (DON), RN-C acknowledged NA-G, NA-H, and NA-I had not received annual annual training for behavioral health. A behavioral health training policy was requested and not provided.	F 949	Staff Identified during this time of the survey as not having been educated on behavioral health were educated. Staff education regarding behavioral health has been initiated on 8/20/2024. This education has been included in the facilities new hire orientation training through the facilities online training system. Administrator or designee will complete audits of 5 new hires will be completed weekly x4 weeks to ensure behavioral health training has been completed . QAPI will review audit results and recommend continued audit schedule.	

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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 On 8/6/24 through 8/9/24 and 8/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the	2 000		

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2 000	Continued From page 1 following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52036642C (MN00105442) H52036622C (MN00105419) H52036402C (MN00105314) A licensing order was issued at 4658.1415 Subp 4. 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	2 000		

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 _____	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 2 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a privacy curtain for 3 or 3 residents (R1,R3, R6) who shared a room and were reviewed for a clean home-like environment. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/18/24 indicated R1 was cognitively intact.	21685	corrected	9/4/24

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21685	Continued From page 3 R1's Diagnoses List undated, included adjustment disorder with depressed mood, weakness, and unsteadiness on feet. R1's care plan dated 2/6/24, indicated R1 utilized a two-wheeled walker, and required assistance with transfers and to get out of bed. On 8/7/24 at 9:31 a.m., R1's room was observed to have a privacy curtain that was torn and unusable, and shielded R1's roommate from the doorway, but did not provide privacy from R1's view. R1 was sitting on the side of his bed, and stated he had never had a privacy curtain, nor had his roommate, and he had to watch staff help his roommate dress and undress. He did not want to eat in the dining room, but also did not want to watch staff dress and undress his roommate while he was eating. He was embarrassed watching his roommate dress, and it made him feel, "Real down." R3's quarterly MDS dated 6/4/24, indicated R3 had severe cognitive impairment, and required assistance of two staff for bed mobility and transfers. R3's Diagnoses List undated, included major depressive disorder, personal history of traumatic brain injury, and cognitive communication deficit. R3's care plan dated 10/14/21, indicated R3 was dependent upon staff for all cares. R6's quarterly MDS dated 6/3/24 indicated moderate cognitive impairment and no behaviors. R6's Diagnoses List undated, included alcohol	21685		

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21685	Continued From page 4 use, psychoactive substance abuse, history of homelessness, and anxiety. R6's care plan dated 3/24/24, indicated he was at risk for alteration in psychosocial well-being related to a history of homelessness. R6's Face Sheet printed 8/8/24, indicated he was his own decision-maker. On 8/6/24 at 2:00 p.m., R3 and R6's door was observed open. R6 had his pants down, and was masturbating. The room lacked a privacy curtain on either side of the room. Nursing assistant (NA)-H was present and acknowledged R3 could see R6 masturbate, but wouldn't want to. NA-H covered R6 with a sheet. R6 pushed the sheet off and yelled at NA-H to leave the room. On 87/24 at 10:12 a.m., housekeeper (HK)-A stated R3 and R6 did not have privacy curtains. On 8/7/24 at 11:22 a.m., the administrator stated she had not ordered privacy curtains, but each side of the room should have one. On 8/8/24 at 10:35 a.m., the director of nursing (DON) stated all the rooms should have privacy curtains for cares, if the resident needed space alone, and the curtains should be in good repair and usable. A policy for privacy curtains was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the director of building and grounds to	21685		

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21685	Continued From page 5 develop a maintenance program to ensure privacy curtains are managed/repaired to ensure each resident has privacy in their room. The DON or designee could educate all appropriate staff in the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		