Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2025

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

RE: CCN: 245203
Cycle Start Date: June 24, 2025

Dear Administrator:

On July 8, 2025 we notified you a remedy was imposed. On July 22, 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 July 18, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 24, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 8, 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 June 24, 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 delivered

August 6, 2025

Administrator
The Villas At Bryn Mawr LLC

275 PENN AVENUE NORTH
MINNEAPOLIS, MN 55405

Re: Reinspection Results
Event ID: JU4H-H2

Dear Administrator:

On July 22, 2025 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 June 24, 2025. 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 delivered
July 8, 2025

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

RE: CCN: 245203
Cycle Start Date: June 24, 2025

Dear Administrator:

On June 24, 2025, a 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D),whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On June 10, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 24, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective September 24, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 24, 2025.

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.

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

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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 June 24, 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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division

Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 24, 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

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.

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.

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
July 8, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: JU4H11

Dear Administrator:

The above facility was surveyed on June 18, 2025 through June 24, 2025 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2025

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	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to report the reasonable suspicion of a crime to law enforcement for 1 of 1 resident (R4) reviewed who made an allegation of sexual abuse. Findings include:	F0609	F609 - Reporting of Alleged Violations Immediate Corrective Action: Reviewed Reporting of suspicion of a crime policy and abuse policy and it remains current. Education with IDT members regarding policy. Corrective Action as it applies to others: Reviewed Reporting of suspicion of a crime policy and it remains current. Education with IDT members regarding policy. Date of Compliance: 7/18/2025 Recurrence will be prevented by: The Administrator/designee to review all OHFCs to ensure reporting of suspicion of a crime policy is followed weekly x 4 weeks. The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.	07/18/2025

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 06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas At Bryn Mawr LLC	275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405

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F0609 SS = D	Continued from page 1 R4's facesheet dated 6/24/25, indicated she admitted to the facility on 6/3/2004 and had diagnoses including hemiplegia and hemiparesis following cerebral infarction (one-sided paralysis and weakness after a stroke), need for assistance with personal care, adjustment disorder with anxiety, mild cognitive impairment, post-traumatic stress disorder, and moderate intellectual disabilities. R4's care plan dated 6/6/25, identified she was a vulnerable adult related to severe mobility limitation, severe sensory impairment, poor orientation to person place and time, history of physical aggression, ignoring personal safety, and inability to identify the boundaries of others. Nursing Home Incident Report #360521 dated 5/13/25, was submitted to the state agency (SA) and identified an allegation of sexual abuse, unwanted sexual contact. The description indicated the social services director (SSD) became aware of the allegation on 5/13/25 at 1:00 p.m. A resident reported to the SSD that R4 had been touched by another resident and R4 reported the resident "touched her over her pants near her genital area." R4 stated she did not like to be around the resident reported to have touched her. The report indicated providers were updated, families/guardians updated, and the facility would continue to investigate the incident. The report did not indicate law enforcement was notified. Nursing Home Incident Report Investigation Summary #59244 dated 5/15/25, was the five-day follow-up report submitted to the SA. The corrective actions section included question "since the initial report, has this allegation been reported to any additional agencies, if so which agency?" with answer of not applicable. The report did not indicate law enforcement was notified. R4's progress note dated 5/13/25 at 1:15 p.m., indicated R4 reported that another resident touched her inappropriately over the weekend while they were outside on the patio. R4's provider and guardian were notified. The progress note did not indicate law enforcement was notified. R4's progress note dated 5/14/25, indicated the SSD	F0609		

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 06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas At Bryn Mawr LLC	275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405

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F0609 SS = D	Continued from page 2 spoke with R4 about the alleged incident over the weekend. The nurse manager had reported asking R4 if she wanted to do a police report and R4 said no. R4 reported a male resident touching her private parts on the patio. The SSD asked R4 multiple times if she wanted to make a police report. R4 stated she did not trust the police and refused to report to them. During an interview on 6/24/25 at 9:33 a.m., the SSD stated she did not think the incident was reported to the police. During an interview on 6/24/25 at 8:56 a.m., the administrator stated she managed the investigation into the incident of R4's allegation of sexual abuse. The administrator stated it was not reported to the police because R4 refused to call the police or "have anything to do" with the police. The administrator verified the allegation was R4 was touched near or on her genital area. The administrator stated the facility had to report suspected crimes and must report allegations of sexual abuse. The administrator confirmed the allegation R4 made was not reported to law enforcement in accordance with regulation or facility policy. Facility policy titled Reporting Suspicion of a Crime dated 2/2025, included "The Administrator, Director of Nursing, or any other designated individual will report (within the required time frames) any reasonable suspicion of a crime against a resident to the state Survey Agency and local law enforcement agency." A list of examples of crimes that would be reportable in any jurisdiction included "sexual abuse." The policy included, "The timing of reporting will be based on the events that cause suspicion and will be as follows: If the event results in serious bodily injury, the suspicion will be reported immediately but not more than two hours after the individual first suspects that a crime has occurred. If the event does not result in serious bodily injury, the suspicion will be reported not more that [sic] twenty-four hours after the individual first suspects that a crime has occurred."	F0609		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F0657	F657 - Care Plan Timing and Revision Immediate Corrective Action: All residents on station 3’s care plans were updated to include 1:1 supervision when off the unit	07/18/2025

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 06/24/2025

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F0657 SS = D	Continued from page 3 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to revise the care plan for an elopement-safety related intervention for 1 of 1 resident (R1) reviewed for resident safety. Findings include: R1's Hospital discharge summary provider note dated 3/14/25, identified R1 had orders to reside in a locked unit due to profound cognitive impairment due to severe Traumatic Brain Injury (TBI). Psych evaluated and agreed R1 lacked decision making ability and had a history of an elopement at a hospital in September 2024. Needs 24/7 supervision. R1's Elopement Risk Evaluation dated 3/14/25, indicated R1 was at risk for elopement due to habit/history of wandering or attempts to leave the unit/building, was ambulatory or able to self-propel wheelchair, asking to	F0657	Continued from page 3 Corrective Action as it applies to others: The care plan policy was reviewed and remains current. Clinical leaders and social services were educated on updating care plans for station 3 residents. All staff have been educated to the new protocol in regards to 1:1 residents off station 3. Date of Compliance: 7/18/2025 Recurrence will be prevented by: The DON/designee to audit all new admissions and/or transfers onto station 3 weekly x4 weeks. The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.	

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 06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas At Bryn Mawr LLC	275 PENN AVENUE NORTH , MINNEAPOLIS, Minnesota, 55405

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F0657 SS = D	Continued from page 4 go home or other specific destinations, had cognitive deficit diagnosis and family had voiced concerns that resident may have a tendency to wander or elope. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified R1 was admitted to the facility on 3/14/25, had severe cognitive impairment and was independent with activities of daily living (ADL's) and mobility. R1 had diagnoses of traumatic brain injury (a brain injury caused by an external force, like a blow to the head or a jolt), R1's progress note dated 6/10/25 at 3:19 p.m., at around 12:50 p.m., R1 went down to see the baby goats that were in the front of the building with staff. Around 1:23 p.m., R1 was noted to be missing from the front parking lot. Therapeutic Recreational (TR) director immediately notified the administrator. Administrator immediately initiated elopement protocols. Administrator notified Minneapolis police. Minneapolis police sent several squad cars to patrol the area. At around 1:46 p.m., R1 returned to the facility with the police. R1 had no injuries. R1's care plan dated 6/11/25, identified focus of Risk Elopement identified with corresponding goals that included, the resident will not leave the building alone. Interventions included wanderguard in place, wanderguard will be monitored for proper functioning, door alarms will be answered promptly, guardian will be kept informed and will be invited to activities of their choosing. During an interview on 6/23/25 at 2:13 p.m. LPN-B stated the root cause of R1's elopement was lack of supervision and R1 was someone who definitely needed supervision. LPN-B stated after the elopement all Interdisciplinary Team (IDT) members met and went over the elopement policy and immediately started education to all staff that anyone residing on the locked unit needed 1:1 supervision when taken off the unit. LPN-B stated the care plan was not updated to reflect this and should have been. R1's care plan did not identify or include the implemented intervention that R1 required 1:1 supervision when being brought off the locked unit.	F0657		

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F0657 SS = D	Continued from page 5 During an interview on 6/23/25 at 2:50 p.m., DON stated the root cause of the elopement was inadequate supervision, the person responsible for watching R1 that day was brushed onto someone else. DON further stated he would expect the care plan to be updated to ensure 1:1 when removing R1 from locked unit and verified it was not on the care plan. During an interview on 6/23/25 at 3:17 p.m., the administrator stated the root cause of the elopement was lack of supervision from our staff. Administrator further stated she would expect the care plan to be revised to ensure 1:1 when removing R1 from locked unit. Facility Policy, Care Planning, revised 11/2024, identified ...Comprehensive Care Plan: The interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21?? day of admission of the resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of his or her care plan. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F0657		
F0689 SS = SQC-J	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.	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = SQC-J	Continued from page 6 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to provide adequate levels of supervision to prevent elopement for 1 of 1 residents (R1) who required 24/7 supervision, resided on a locked unit and left the facility without their knowledge. This resulted in an Immediate Jeopardy (IJ) situation for R1. The IJ began on 6/10/25, when R1 was not provided with adequate supervision during an outside activity which resulted in R1 leaving the facility at approximately 1:23 p.m., he was found by police at approximately 1:46 p.m. on a busy street about a half mile away from the facility. The administrator, director of nursing and regional nurse consultant (RNC)-A were notified of the immediate jeopardy on 6/24/25, at 11:42 a.m. The facility implemented immediate corrective action on 6/10/25 to prevent recurrence, so the IJ was issued at past non-compliance. Findings include: R1's Hospital discharge summary provider note dated 3/14/25, identified R1 had orders to reside in a locked unit due to profound cognitive impairment due to severe Traumatic Brain Injury (TBI) where the person has experienced a period of unconsciousness due to head trauma. Psych evaluated and agreed R1 lacked decision making ability and had a history of an elopement at the hospital in September 2024. Will need to continue to wear helmet on head when the head of bed is greater than 30 degrees until cranioplasty (repair the bone in the skull) is performed. Needs 24/7 supervision. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified R1 had severe cognitive impairment and was independent with activities of daily living. R1 had diagnoses of traumatic brain injury (a brain injury caused by an external force, blow to the head or a jolt), hemicraniotomy (a neurosurgical procedure where a portion of the skull is removed to relieve pressure on the brain), intracranial injury with loss of consciousness, nicotine dependence and metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the body).	F0689		

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F0689 SS = SQC-J	Continued from page 7 R1's Elopement Risk Evaluation dated 3/14/25, indicated R1 was at risk for elopement due to habit/history of wandering or attempts to leave the unit/building, was ambulatory or able to self-propel wheelchair, asking to go home or other specific destinations, cognitive deficit diagnosis and family had voiced concerns that resident may have a tendency to wander or elope. R1 scored a 5, which identified a score of 4 or greater indicated a potential for elopement. Goals of care identified R1 will not leave the building alone and will follow Leave of Absence (LOA) policy. Interventions identified wanderguard will be monitored for proper functioning, door alarms will be answered promptly, guardian will be kept informed and will be invited to activity of their choosing. R1's Care plan dated 3/14/25 identified a focus of at risk for elopement with corresponding goals R1 will not leave the building alone. Interventions included door alarms will be answered promptly, guardian will be kept informed and will be invited to activities of their choosing. R1's Care plan dated 6/11/25, identified focus of risk for elopement due to wandering, impaired cognition, statement of wanting to leave, and history of elopement with corresponding goals that included, the resident will not leave the building alone. Interventions included wanderguard in place, wanderguard will be monitored for proper functioning, door alarms will be answered promptly, guardian will be kept informed and will be invited to activities of their choosing. R1's facility Progress Notes noted the following: 6/10/25 at 2:09 p.m., R1 went downstairs in the front lobby with the activity director, took off, Minneapolis police was called, description of R1 was given, R1 was later brought back to the facility by officer, alert and oriented per resident baseline. 6/10/25 at 2:27 p.m., identified R1 did not return with white helmet. Writer asked R1 where his helmet was. R1 stated he threw the helmet away when he took off. 6/10/25 at 2:30 p.m., R1 was taken outside the facility to the parking lot to pet baby goats, At 1:23 p.m., R1 was noted missing by staff. Police were called. R1 was	F0689		

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F0689 SS = SQC-J	Continued from page 8 located, skin checks completed with no pain or discomfort noted. R1 was placed back on the secured unit, oriented to self, place, season and safe. 15-minute safety checks order initiated. 6/10/25 at 3:19 p.m., at around 12:50 p.m., R1 went down to see the baby goats that were in the front of the building with staff. Around 1:23 p.m., R1 was noted to be missing from the front parking lot. TR director immediately notified the administrator. Administrator immediately initiated elopement protocols. Administrator notified Minneapolis police. Minneapolis police sent several squad cars to patrol the area. At around 1:46 p.m., R1 returned to the facility with the police. R1 had no injuries. Skin check and vital signs completed by nurse. R1's guardian and primary care provider updated. Facility filed Office of Health Facility Complaints (OHFC) and started education and investigation. During an interview on 6/23/25 at 10:01 a.m., Director of therapy (DOT)-A indicated R1 had severe cognitive impairment due to his brain injury and would not be safe in the community unsupervised. R1 was quick and completely independent with mobility and would run. R1 was also very impulsive and does not have the insight to know if traffic lights are red or green he would run right through them. DOT-A stated the likelihood of R1 getting hurt unsupervised in the community was very high, when R1 eloped on 6/10/25, "he had the risk of being mugged, going with a stranger, getting hit by a car in traffic, we are lucky he wasn't killed." During observation and interview on 6/23/25 at 10:33 a.m., R1 was lying in his bed in his room with his helmet off. R1 stated a couple weeks ago he was outside with the goats, and he took off because he was mad and wanted a cigarette. R1 further stated the police came for him and it was not fun. "I was somewhere in Minneapolis, I did not know how to get back here, I was scared." During an interview on 6/23/25 at 11:11 a.m., Activity Director (AD)-A indicated on 6/10/25, she had brought three residents from the locked unit down to the goat activity and one of them was R1 around 1:05 p.m.. AD-A stated she went to bring another resident back up to the locked unit and asked the activity assistant (AA)-A to keep an eye on R1. When she got back around 1:10 p.m. R1 was gone. AD-A stated she immediately notified	F0689		

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F0689 SS = SQC-J	Continued from page 9 the administrator and started looking for R1 in our vehicles. AD-A further stated when she first brought R1 down another resident had given R1 a cigarette and the cigarette was removed which upset R1. The police did end up finding R1 about 4 blocks from the facility. During an interview on 6/23/25 at 1:54 p.m., AA-A stated R1 was outside on 6/10/25, when the baby goat petting activity was going on before lunch time. AA-A stated another resident had given R1 a cigarette and AD-A took it away from him and R1 was very upset and went to sit next to another resident. AA-A stated he had too many other residents to keep an eye on and was not aware R1 was going to take off like he did. AA-A stated AD-A came back down asked where R1 was and then we were all looking for him. During an interview on 6/23/25 at 10:59 a.m., nursing assistant (NA)-A stated she was working the secured unit where R1 resided the day he eloped. NA-A indicated R1 went to see the Billy goats outside and someone wasn't watching him, he was gone and he can run very fast. NA-A stated R1 was constantly asking to go outside, he was always looking to get out pacing up and down the halls to go for a walk trying to get out. During an interview on 6/23/25 at 10:41 a.m., licensed practical nurse (LPN)-A stated she was working the secured unit that R1 resided on the day he eloped. LPN-A indicated the activity director called her around lunch time and asked if R1 was on the unit and she told activity director he was not. LPN-A stated it was not safe for R1 to be outside unsupervised, if he was running trying to get away, he could have been killed in traffic. During an interview on 6/23/25 at 11:40 a.m., Receptionist (R)-A indicated she worked 6/10/25. AA-A asked her sometime before lunch if she had seen R1, she told him no. R-A stated she immediately went outside and started looking for him. The police found him about 4 blocks away from the facility. R-A further stated R1 resided on a locked unit and residents from the locked unit require supervision. During an interview on 6/23/25 at 2:13 p.m., LPN-B stated she was the unit manager for R1 and had worked the day R1 had eloped. LPN-B stated the root cause of R1's elopement was lack of supervision and R1 was	F0689		

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F0689 SS = SQC-J	Continued from page 10 someone who definitely needed supervision. LPN-B stated after the elopement all Interdisciplinary team (IDT) members met and went over the elopement policy and immediately started education to all staff that anyone residing on the locked unit needed 1:1 supervision when taken off the unit. LPN-B further stated R1 was also placed on 15-minute checks and a wanderguard was put on his left wrist. During an interview on 6/23/25 at 2:50 p.m., DON indicated he was notified R1 was missing via text message from the administrator. DON further indicated R1 was found 4 blocks away by police and brought back 20 minutes later to the facility unharmed. DON stated the root cause of the elopement was inadequate supervision, the person responsible for watching R1 that day was brushed onto someone else. DON further stated everyone residing on the locked unit required 1:1 supervision when outside the locked unit and are all at risk for elopement. During an interview on 6/23/25 at 3:17 p.m., administrator stated she was notified by AD-A at 1:23 p.m. that R1 was missing from the facility after an activity in the parking lot. Administrator indicated she shot out a group text message to all department heads to delegate directions and got in her car to search for R1. Administrator stated she flagged down the police in the road and gave them a picture of R1 and they assisted with the search of four squad cars. Administrator further stated R1 was found about 21 minutes later around 1:45 p.m., about a half mile from the facility, on the corner of Glenwood avenue and Russell avenue north by the police and was brought back unharmed without his helmet. Administrator stated the root cause of the elopement was lack of supervision from our staff. During an interview on 6/23/25 at 4:28 p.m., medical director (MD)-A indicated if the root cause of R1's elopement was lack of supervision and resided on a locked unit, an appropriate prevention intervention would be to provide 1:1 to supervision when taken off the unit. During an interview on 6/23/25 at 4:28 p.m., guardian (G)-A stated the facility notified her of R1's elopement from the facility on 6/10/25. G-A further stated she told the facility if R1 was unsupervised he would run, he was on a locked unit for a reason. G-A	F0689		

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F0689 SS = SQC-J	Continued from page 11 indicated she was grateful he was not lost and that he was back safe. Facility policy titled, Elopements policy revised 6/2023...the facility will implement interventions to minimize these risks and hazards as appropriate. For residents at risk of elopement Missing Resident Event Documentation should include an Admission assessment, which may indicate potential to wander or exit facility. Care plan that addresses potential to wander or exit facility and the measures taken to prevent wandering/elopement. All attempts to elope, efforts to locate, notification and results of efforts. Full observation/visualization after an elopement for any injuries or new symptoms or conditions which may have developed. Entries that are time specific to reflect the responsiveness and "Timeliness" of actions taken to locate and assess the resident. Bracelet alarm/device is in place and functioning (per TAR or other form of documentation), if applicable. The facility will implement the following plan for conducting internal and external searches to locate missing residents. If a resident is discovered missing or is suspected of having eloped, the charge nurse takes the following steps: The charge nurse will initiate a search of the unit upon which the resident resides, with all employees assigned to the unit. The charge nurse will notify the Administrator or nursing supervisor if the resident cannot be located on the assigned unit. The nursing supervisor will take over as the Search Coordinator in the absence of the Administrator. The past-noncompliance immediate jeopardy began on 6/10/25, and was removed on 6/10/25, when the facility implemented a systemic plan to ensure all residents were safe. On 6/10/25, a facility-wide elopement risk assessment was completed that day, and care plans were updated with individualized interventions. Staff received targeted education prior to their shifts on the elopement policy, and emphasizing the requirement for 1:1 supervision for residents from the secured unit when outside.	F0689		
F0742 SS = D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1)	F0742	F742 – Treatment/Services Mental/Psychosocial Concerns Immediate Corrective Action: R4 had a new trauma assessment completed.	07/18/2025

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F0742 SS = D	Continued from page 12 A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess a resident to determine the need for additional treatments and services for mental and psychosocial well-being for 1 of 1 resident (R4) reviewed who made an allegation of sexual assault and had a history of post-traumatic stress disorder (PTSD) and psychosocial adjustment difficulty. Findings include: R4's facesheet dated 6/24/25, indicated she admitted to the facility in 2004 and had diagnoses including post-traumatic stress disorder, adjustment disorder with anxiety, unspecified psychosis, mild cognitive impairment, and moderate intellectual disabilities. R4's trauma care plan dated 4/22/24, identified she was at risk for alterations in behavior related to trauma and diagnosis of PTSD. R4 declined when asked about potential triggers, was unable to articulate coping strategies, and reported no trauma on assessment. R4 saw psychology providers. Interventions included staff to consider past trauma when engaging in work with R4, utilize family and social support, and encourage collaboration with activities social services or psychiatry to improve social connections and minimize symptomology. R4's mood/behavior care plan dated 4/24/15, identified she had a behavior problem secondary to intellectual disability, drug induced mental disorder and PTSD, and adjustment disorder. Interventions included psychiatric/psychogeriatric consult as indicated, and anticipate and meet resident's needs. R4's psychosocial well-being care plan dated 4/16/15, identified she had a psychosocial well-being problem related to impairment related to history of stroke, organic personality disorder, history of alcohol dependence (not active), history of closed head injury	F0742	Continued from page 12 Corrective Action as it applies to others: The trauma informed care policy was reviewed and updated and remains current. Social services has been educated that trauma assessments will be completed upon admission, annually, and as needed following applicable events (i.e sexual assault allegations, abuse allegations, physical resident to resident altercations, etc.) Educate all staff regarding changes to the trauma informed care policy. Date of Compliance: 7/18/2025 Recurrence will be prevented by: The Administrator/designee will audit trauma assessments weekly x4 weeks to ensure completion. The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.	

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F0742 SS = D	Continued from page 13 with cognitive deficits. R4 was followed by the psychology clinic for additional psychosocial support and the providers would continue to follow R4 as needed while at the facility. R4's psychology provider note by licensed independent clinical social worker (LICSW)-A dated 4/28/25, indicated she was seen for mild neurocognitive disorder, adjustment disorders with anxiety, and alcohol use disorder with additional problems of PTSD and moderate intellectual difficulties. Continued services were needed to maintain and improve R4's current level of functioning. R4 denied symptoms of anxiety, psychosis, and PTSD and had no care concerns. Treatment plan included "overall client appears to be doing very well." R4's Trauma Questionnaire assessment dated 5/13/24, was the most recently completed trauma assessment. It included question "Have you had any traumatic experiences in the past that you feel we should be aware of that may affect your preferences or care needs" with answer "no." A note indicated R4 denied having trauma that impacts care. Nursing Home Incident Report #360521 dated 5/13/25, was submitted to the state agency (SA) and identified an allegation of sexual abuse, unwanted sexual contact. The description indicated the social services director (SSD) became aware of the allegation on 5/13/25 at 1:00 p.m. A resident reported to the SSD that R4 had been touched by another resident and R4 reported the resident "touched her over her pants near her genital area." R4 stated she did not like to be around the resident reported to have touched her but felt safe in the facility. R4 refused to go to the hospital, but skin check was completed with no concerns noted. The report indicated providers were updated, families/guardians updated, and psychology clinic updated. R4's progress note dated 5/13/25, indicated R4 reported that another resident touched her inappropriately over the weekend while they were outside on the patio. Skin check completed with scratch on lower left leg R4 stated she itched sometimes. R4 refused going to the hospital for evaluation and stated she felt safe in the facility. R4's provider and guardian were notified.	F0742		

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F0742 SS = D	Continued from page 14 R4's progress note by the SSD dated 5/14/25, indicated the SSD spoke with R4 about the alleged incident over the weekend. R4 reported a male resident touching her private parts on the patio. The SSD asked R4 multiple times if she wanted to make a police report and R4 declined. The SSD did a check in with R4 to evaluate her mood. R4 reported feeling safe in the facility, stated she was not afraid of the alleged perpetrator, and would avoid him. Social services would follow-up as needed. In review of R4's record, there was no indication a trauma assessment had been completed after R4's allegations of inappropriate sexual touching by another resident. During an interview on 6/23/25 at 1:36 p.m., R4 stated no one had ever touched her inappropriately. R4 noted there were people she didn't like, and she stayed away from them and would watch television in her room. R4 stated her mood was okay. During an interview on 6/24/25 at 8:56 a.m., the administrator stated R4 had alleged that she was touched inappropriately by another resident on her leg or genital area. R4 had refused to notify the police or go to the hospital, but a skin check was completed with no injuries noted. The administrator indicated R4's psychosocial well-being was assessed through a skin check, a meeting with the SSD and the psychology clinic. The administrator stated R4 had a long mental health history and had PTSD. The administrator confirmed R4's last trauma assessment was completed 5/13/24, was over a year old, and R4 had denied that trauma impacted her care. The administrator stated trauma assessments should be completed after incidents like an allegation of sexual abuse and she would have expected a trauma assessment to have been completed for R4. The administrator was not sure how often trauma assessments should be completed. When asked how the facility assessed R4 to see if she had trauma from the incident, the administrator stated the SSD had talked to R4. The administrator confirmed R4's psychology clinic had been notified of the alleged incident, stated the SSD would know the details of this, and she would expect them to be notified so they would assess a resident's psychosocial health. In a follow up interview on 6/24/25 at 9:58 a.m., the administrator stated trauma assessments were done on admission and as the facility felt was needed but did not think they had a policy about this.	F0742		

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F0742 SS = D	Continued from page 15 During an interview on 6/24/25 at 9:33 a.m., the SSD stated trauma assessments were completed on admission and she assumed they had to be done yearly but hadn't seen that written anywhere, it was just what she had been told. They were also completed as needed. The SSD stated a resident-to-resident altercation would cause trauma and after an allegation of abuse was made a trauma assessment should be completed within a couple of days. The SSD confirmed she had not completed a trauma assessment with R4 after R4 alleged sexual abuse, but had talked to her and R4 had said it wasn't a big deal and didn't want to talk about it. The SSD stated R4 had a history of trauma and PTSD. The SSD stated it was important to complete a trauma assessment, so staff were aware if she had trauma from the incident. The SSD stated she thought she had notified R4's psychologist, LICSW-A, of the allegation, but did not remember the details or have documentation of this. During an interview on 6/23/25 at 3:11 p.m., LICSW-A stated she was R4's psychotherapy provider and had been seeing her since last year. LICSW-A stated she had not been notified by the facility of R4's allegation of resident-to-resident sexual abuse. LICSW-A stated this was something she would typically be notified of when she met with the facility's social worker when she arrived at the facility for her visits. In a continued interview on 6/24/25 at 2:07 p.m., LICSW-A stated R4's medical history included PTSD, but she worked with R4 around her adjustment disorder and anxiety in the context of her cognition. R4 had cognitive impairment and some difficulty in executive functioning. LICSW-A stated she would assess someone after an allegation of sexual abuse for signs of distress, changes to behavior, changes from typical appetite and sleeping, and the client's report. LICSW-A stated someone's response to potential sexual abuse would be very specific to the individual. For someone with a diagnosis of PTSD how it affected someone would depend on what the original trauma was and how active related symptoms were. LICSW-A noted best practice was to do an assessment for trauma after an allegation of sexual abuse. Facility policy titled Trauma Informed Care dated 2/24/23, indicated the facility supported a culture of emotional well-being and physical safety for staff, residents and visitors. Trauma-informed care was culturally sensitive and person-centered. Staff were	F0742		

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F0742 SS = D	Continued from page 16 aware of individualized strategies to help eliminate, mitigate or sensitively address a resident's triggers. Resident-Care Strategies included, "1. As part of the comprehensive assessment, staff will identify history of trauma when possible. 2. Residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident. 3. IDT team will monitor the effects of the approaches to ensure they are implemented as intended and are having the desired effect to achieve the goals of care. Care plans will be updated as needed."	F0742		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F0755	F755 – Pharmacy Services/Procedures/Pharmacist/Records Immediate Corrective Action: R1's nicotine lozenge order was changed to nicotine gum. Corrective Action as it applies to others: The pharmacy manual was reviewed and remains current. Full house audit completed of all residents on nicotine lozenges. Currently no active orders for nicotine lozenges. Date of Compliance: 7/18/2025 Recurrence will be prevented by: DON/designee will audit all residents weekly x4 weeks to ensure nicotine lozenges are available. The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.	07/18/2025

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F0755 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R1) reviewed for resident safety. Findings include: R1's order summary dated 3/14/25, identified an order for Nicotine min mouth/throat lozenge (Nicotine Polacrilex) give 2 mg by mouth every 1 hour as needed for nicotine craving related to nicotine dependence. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified R1 was admitted to the facility on 3/14/25, had severe cognitive impairment, was independent with activities of daily living (ADL's) and mobility. Further identified R1 used tobacco. R1 had diagnoses of traumatic brain injury (a brain injury caused by an external force, like a blow to the head or a jolt) and nicotine dependence. R1's medication administration record (MAR) dated June 2025, identified an order for Nicotine min mouth/throat lozenge (Nicotine Polacrilex) give 2 mg by mouth every 1 hour as needed for nicotine craving related to nicotine dependence. From 6/1/25 to 6/24/25 were all blank spaces indicating R1 did not receive any nicotine lozenges for his diagnosis of nicotine withdrawal. During observation and interview on 6/23/25 at 10:33 a.m., R1 was lying in his bed in his room with his helmet off. R1 was asked what he enjoyed doing at the facility and he stated, "I like to smoke cigarettes." R1 put his shoes and helmet on got up and stated. "I am going with you." R1 walked out of his room into the hallway. R1 walked up to the medication cart and stated to licensed practical nurse (LPN)-A, that he wanted a cigarette. At 10:41 a.m., LPN-A told R1 you don't have any cigarettes. This surveyor asked LPN-A if R1 had an order for nicotine lozenges and LPN-A stated that R1 did not have an order for nicotine lozenges. LPN-A checked R1's orders and she stated there was an order for nicotine lozenges dated 3/14/25. LPN-A stated R1 always asked for a cigarette non-stop and that he could not have any due to his guardian. LPN-A had never given R1 a nicotine lozenge even though she worked the unit frequently. LPN-A checked the medication cart and	F0755		

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F0755 SS = D	Continued from page 18 informed the medication was not available and was unsure of why. LPN-A informed R1 she would check into getting nicotine lozenge for him. R1 stated, thank you and walked away. During an interview on 6/23/25 at 2:13 p.m. LPN-B stated she was the unit manager for R1 and that he should not be smoking cigarettes due to his guardian did not give him permission to. LPN-B was not aware that R1's prescribed as needed nicotine lozenges were not available to him. LPN-B stated physician ordered medications should be available to each resident. During an interview on 6/23/25 at 2:50 p.m., DON stated physician ordered medications should be available to all residents. During an interview on 6/23/25 at 3:17 p.m., the administrator stated she was unaware that R1's nicotine lozenges were not available to him when he was having a nicotine craving for a cigarette. Administrator stated medications that are ordered by the physician should be available to the resident. Facility policy, Medication Error Procedure, reviewed, 1/2020, identified the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication related problems such as; adverse drug reactions (ADRs) and side effects. Medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate. Medication errors will be rectified according to standard of practice and the facilities pharmacy policy for preventing and detecting adverse consequences and medication errors. Review of Facility policy, Medication Error Procedure reviewed 1/2020, did not identify physician ordered medications not being available to residents as a medication error.	F0755		

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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: No Information	20000		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse	20570	corrected	07/08/2025

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

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20570	Continued from page 1 with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to revise the care plan for an elopement-safety related intervention for 1 of 1 resident (R1) reviewed for resident safety. Findings include: R1's Hospital discharge summary provider note dated 3/14/25, identified R1 had orders to reside in a locked unit due to profound cognitive impairment due to severe Traumatic Brain Injury (TBI). Psych evaluated and agreed R1 lacked decision making ability and had a history of an elopement at a hospital in September 2024. Needs 24/7 supervision. R1's Elopement Risk Evaluation dated 3/14/25, indicated R1 was at risk for elopement due to habit/history of wandering or attempts to leave the unit/building, was ambulatory or able to self-propel wheelchair, asking to go home or other specific destinations, had cognitive deficit diagnosis and family had voiced concerns that resident may have a tendency to wander or elope. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified R1 was admitted to the facility on 3/14/25, had severe cognitive impairment and was independent with activities of daily living (ADL's) and mobility. R1 had diagnoses of traumatic brain injury (a brain injury caused by an external force, like a blow to the head or a jolt), R1's progress note dated 6/10/25 at 3:19 p.m., at around 12:50 p.m., R1 went down to see the baby goats that were in the front of the building with staff. Around 1:23 p.m., R1 was noted to be missing from the front parking lot. Therapeutic Recreational (TR) director immediately notified the administrator. Administrator immediately initiated elopement	20570		

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20570	Continued from page 2 protocols. Administrator notified Minneapolis police. Minneapolis police sent several squad cars to patrol the area. At around 1:46 p.m., R1 returned to the facility with the police. R1 had no injuries. R1's care plan dated 6/11/25, identified focus of Risk Elopement identified with corresponding goals that included, the resident will not leave the building alone. Interventions included wanderguard in place, wanderguard will be monitored for proper functioning, door alarms will be answered promptly, guardian will be kept informed and will be invited to activities of their choosing. During an interview on 6/23/25 at 2:13 p.m. LPN-B stated the root cause of R1's elopement was lack of supervision and R1 was someone who definitely needed supervision. LPN-B stated after the elopement all Interdisciplinary Team (IDT) members met and went over the elopement policy and immediately started education to all staff that anyone residing on the locked unit needed 1:1 supervision when taken off the unit. LPN-B stated the care plan was not updated to reflect this and should have been. R1's care plan did not identify or include the implemented intervention that R1 required 1:1 supervision when being brought off the locked unit. During an interview on 6/23/25 at 2:50 p.m., DON stated the root cause of the elopement was inadequate supervision, the person responsible for watching R1 that day was brushed onto someone else. DON further stated he would expect the care plan to be updated to ensure 1:1 when removing R1 from locked unit and verified it was not on the care plan. During an interview on 6/23/25 at 3:17 p.m., the administrator stated the root cause of the elopement was lack of supervision from our staff. Administrator further stated she would expect the care plan to be revised to ensure 1:1 when removing R1 from locked unit. Facility Policy, Care Planning, revised 11/2024, identified ...Comprehensive Care Plan: The interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop	20570		

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20570	Continued from page 3 and implement a comprehensive individualized care plan no later than the 21?? day of admission of the resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of his or her care plan. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		
21475	Social Services: General Requirements CFR(s): MN Rule 4658.1005 Subp. 1 Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess a resident to determine the need for additional treatments and services for mental and psychosocial well-being for 1 of 1 resident (R4) reviewed who made an allegation of sexual assault and had a history of post-traumatic stress disorder (PTSD) and psychosocial adjustment difficulty.	21475	corrected	07/08/2025

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21475	Continued from page 4 Findings include: R4's facesheet dated 6/24/25, indicated she admitted to the facility in 2004 and had diagnoses including post-traumatic stress disorder, adjustment disorder with anxiety, unspecified psychosis, mild cognitive impairment, and moderate intellectual disabilities. R4's trauma care plan dated 4/22/24, identified she was at risk for alterations in behavior related to trauma and diagnosis of PTSD. R4 declined when asked about potential triggers, was unable to articulate coping strategies, and reported no trauma on assessment. R4 saw psychology providers. Interventions included staff to consider past trauma when engaging in work with R4, utilize family and social support, and encourage collaboration with activities social services or psychiatry to improve social connections and minimize symptomology. R4's mood/behavior care plan dated 4/24/15, identified she had a behavior problem secondary to intellectual disability, drug induced mental disorder and PTSD, and adjustment disorder. Interventions included psychiatric/psychogeriatric consult as indicated, and anticipate and meet resident's needs. R4's psychosocial well-being care plan dated 4/16/15, identified she had a psychosocial well-being problem related to impairment related to history of stroke, organic personality disorder, history of alcohol dependence (not active), history of closed head injury with cognitive deficits. R4 was followed by the psychology clinic for additional psychosocial support and the providers would continue to follow R4 as needed while at the facility. R4's psychology provider note by licensed independent clinical social worker (LICSW)-A dated 4/28/25, indicated she was seen for mild neurocognitive disorder, adjustment disorders with anxiety, and alcohol use disorder with additional problems of PTSD and moderate intellectual difficulties. Continued services were needed to maintain and improve R4's current level of functioning. R4 denied symptoms of anxiety, psychosis, and PTSD and had no care concerns. Treatment plan included "overall client appears to be doing very well."	21475		

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21475	Continued from page 5 R4's Trauma Questionnaire assessment dated 5/13/24, was the most recently completed trauma assessment. It included question "Have you had any traumatic experiences in the past that you feel we should be aware of that may affect your preferences or care needs" with answer "no." A note indicated R4 denied having trauma that impacts care. Nursing Home Incident Report #360521 dated 5/13/25, was submitted to the state agency (SA) and identified an allegation of sexual abuse, unwanted sexual contact. The description indicated the social services director (SSD) became aware of the allegation on 5/13/25 at 1:00 p.m. A resident reported to the SSD that R4 had been touched by another resident and R4 reported the resident "touched her over her pants near her genital area." R4 stated she did not like to be around the resident reported to have touched her but felt safe in the facility. R4 refused to go to the hospital, but skin check was completed with no concerns noted. The report indicated providers were updated, families/guardians updated, and psychology clinic updated. R4's progress note dated 5/13/25, indicated R4 reported that another resident touched her inappropriately over the weekend while they were outside on the patio. Skin check completed with scratch on lower left leg R4 stated she itched sometimes. R4 refused going to the hospital for evaluation and stated she felt safe in the facility. R4's provider and guardian were notified. R4's progress note by the SSD dated 5/14/25, indicated the SSD spoke with R4 about the alleged incident over the weekend. R4 reported a male resident touching her private parts on the patio. The SSD asked R4 multiple times if she wanted to make a police report and R4 declined. The SSD did a check in with R4 to evaluate her mood. R4 reported feeling safe in the facility, stated she was not afraid of the alleged perpetrator, and would avoid him. Social services would follow-up as needed. In review of R4's record, there was no indication a trauma assessment had been completed after R4's allegations of inappropriate sexual touching by another resident.	21475		

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21475	Continued from page 6 During an interview on 6/23/25 at 1:36 p.m., R4 stated no one had ever touched her inappropriately. R4 noted there were people she didn't like, and she stayed away from them and would watch television in her room. R4 stated her mood was okay. During an interview on 6/24/25 at 8:56 a.m., the administrator stated R4 had alleged that she was touched inappropriately by another resident on her leg or genital area. R4 had refused to notify the police or go to the hospital, but a skin check was completed with no injuries noted. The administrator indicated R4's psychosocial well-being was assessed through a skin check, a meeting with the SSD and the psychology clinic. The administrator stated R4 had a long mental health history and had PTSD. The administrator confirmed R4's last trauma assessment was completed 5/13/24, was over a year old, and R4 had denied that trauma impacted her care. The administrator stated trauma assessments should be completed after incidents like an allegation of sexual abuse and she would have expected a trauma assessment to have been completed for R4. The administrator was not sure how often trauma assessments should be completed. When asked how the facility assessed R4 to see if she had trauma from the incident, the administrator stated the SSD had talked to R4. The administrator confirmed R4's psychology clinic had been notified of the alleged incident, stated the SSD would know the details of this, and she would expect them to be notified so they would assess a resident's psychosocial health. In a follow up interview on 6/24/25 at 9:58 a.m., the administrator stated trauma assessments were done on admission and as the facility felt was needed but did not think they had a policy about this. During an interview on 6/24/25 at 9:33 a.m., the SSD stated trauma assessments were completed on admission and she assumed they had to be done yearly but hadn't seen that written anywhere, it was just what she had been told. They were also completed as needed. The SSD stated a resident-to-resident altercation would cause trauma and after an allegation of abuse was made a trauma assessment should be completed within a couple of days. The SSD confirmed she had not completed a trauma assessment with R4 after R4 alleged sexual abuse, but had talked to her and R4 had said it wasn't a big deal and didn't want to talk about it. The SSD stated R4 had a history of trauma and PTSD. The SSD stated it was important to complete a trauma assessment, so staff were aware if she had trauma from the incident. The SSD stated she thought she had	21475		

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21475	Continued from page 7 notified R4's psychologist, LICSW-A, of the allegation, but did not remember the details or have documentation of this. During an interview on 6/23/25 at 3:11 p.m., LICSW-A stated she was R4's psychotherapy provider and had been seeing her since last year. LICSW-A stated she had not been notified by the facility of R4's allegation of resident-to-resident sexual abuse. LICSW-A stated this was something she would typically be notified of when she met with the facility's social worker when she arrived at the facility for her visits. In a continued interview on 6/24/25 at 2:07 p.m., LICSW-A stated R4's medical history included PTSD, but she worked with R4 around her adjustment disorder and anxiety in the context of her cognition. R4 had cognitive impairment and some difficulty in executive functioning. LICSW-A stated she would assess someone after an allegation of sexual abuse for signs of distress, changes to behavior, changes from typical appetite and sleeping, and the client's report. LICSW-A stated someone's response to potential sexual abuse would be very specific to the individual. For someone with a diagnosis of PTSD how it affected someone would depend on what the original trauma was and how active related symptoms were. LICSW-A noted best practice was to do an assessment for trauma after an allegation of sexual abuse. Facility policy titled Trauma Informed Care dated 2/24/23, indicated the facility supported a culture of emotional well-being and physical safety for staff, residents and visitors. Trauma-informed care was culturally sensitive and person-centered. Staff were aware of individualized strategies to help eliminate, mitigate or sensitively address a resident's triggers. Resident-Care Strategies included, "1. As part of the comprehensive assessment, staff will identify history of trauma when possible. 2. Residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident. 3. IDT team will monitor the effects of the approaches to ensure they are implemented as intended and are having the desired effect to achieve the goals of care. Care plans will be updated as needed." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies and procedures to ensure medically related social services	21475		

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21475	Continued from page 8 are provided to each resident throughout their stay and upon discharge and make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. The facility should identify other residents who are at risk for the deficient practice, review, re-educate staff to policies and procedures, and audit services to be provided by social services for a measurable amount of time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21475		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 1 of 1 resident (R1) reviewed for resident safety. Findings include: R1's order summary dated 3/14/25, identified an order for Nicotine min mouth/throat lozenge (Nicotine Polacrilex) give 2 mg by mouth every 1 hour as needed for nicotine craving related to nicotine dependence. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified R1 was admitted to the facility on 3/14/25, had severe cognitive impairment, was independent with activities of daily living (ADL's) and mobility. Further identified R1 used tobacco. R1 had diagnoses of traumatic brain injury (a brain injury caused by an external force, like a blow to the head or a jolt) and nicotine dependence. R1's medication administration record (MAR) dated June 2025, identified an order for Nicotine min mouth/throat lozenge (Nicotine Polacrilex) give 2 mg by mouth every 1 hour as needed for nicotine craving related to	21550	corrected	07/08/2025

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21550	Continued from page 9 nicotine dependence. From 6/1/25 to 6/24/25 were all blank spaces indicating R1 did not receive any nicotine lozenges for his diagnosis of nicotine withdrawal. During observation and interview on 6/23/25 at 10:33 a.m., R1 was lying in his bed in his room with his helmet off. R1 was asked what he enjoyed doing at the facility and he stated, "I like to smoke cigarettes." R1 put his shoes and helmet on got up and stated. "I am going with you." R1 walked out of his room into the hallway. R1 walked up to the medication cart and stated to licensed practical nurse (LPN)-A, that he wanted a cigarette. At 10:41 a.m., LPN-A told R1 you don't have any cigarettes. This surveyor asked LPN-A if R1 had an order for nicotine lozenges and LPN-A stated that R1 did not have an order for nicotine lozenges. LPN-A checked R1's orders and she stated there was an order for nicotine lozenges dated 3/14/25. LPN-A stated R1 always asked for a cigarette non-stop and that he could not have any due to his guardian. LPN-A had never given R1 a nicotine lozenge even though she worked the unit frequently. LPN-A checked the medication cart and informed the medication was not available and was unsure of why. LPN-A informed R1 she would check into getting nicotine lozenge for him. R1 stated, thank you and walked away. During an interview on 6/23/25 at 2:13 p.m. LPN-B stated she was the unit manager for R1 and that he should not be smoking cigarettes due to his guardian did not give him permission to. LPN-B was not aware that R1's prescribed as needed nicotine lozenges were not available to him. LPN-B stated physician ordered medications should be available to each resident. During an interview on 6/23/25 at 2:50 p.m., DON stated physician ordered medications should be available to all residents. During an interview on 6/23/25 at 3:17 p.m., the administrator stated she was unaware that R1's nicotine lozenges were not available to him when he was having a nicotine craving for a cigarette. Administrator stated medications that are ordered by the physician should be available to the resident. Facility policy, Medication Error Procedure, reviewed, 1/2020, identified the interdisciplinary team evaluates medication usage in order to prevent and detect adverse	21550		

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21550	Continued from page 10 consequences and medication related problems such as; adverse drug reactions (ADRs) and side effects. Medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate. Medication errors will be rectified according to standard of practice and the facilities pharmacy policy for preventing and detecting adverse consequences and medication errors. Review of Facility policy, Medication Error Procedure reviewed 1/2020, did not identify physician ordered medications not being available to residents as a medication error. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for medication administration to include processes related to how medication is ordered into the electronic medical record and ensure availability to residents. Staff could be educated on the need to ensure medications are avaiable to residents as ordered. The DON or designee could review all current resident medication orders to ensure medications are available and audit medication storage for medication availability per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		

Plan of Correction

F609 - Reporting of Alleged Violations

Immediate Corrective Action:

Reviewed Reporting of suspicion of a crime policy and abuse policy and it remains current.

Education with IDT members regarding policy.

Corrective Action as it applies to others:

Reviewed Reporting of suspicion of a crime policy and it remains current.

Education with IDT members regarding policy.

Full house audit of all grievances and OHFCs/MAARC reports in the last 30 days.

Date of Compliance:

7/18/2025

Recurrence will be prevented by:

The Administrator/designee to review all OHFCs to ensure reporting of suspicion of a crime policy is followed weekly x 4 weeks.

The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.

F657 - Care Plan Timing and Revision

Immediate Corrective Action:

All residents on station 3's care plans were updated to include 1:1 supervision when off the unit

Corrective Action as it applies to others:

The care plan policy was reviewed and remains current.
Clinical leaders and social services were educated on updating care plans for station 3 residents.
All staff have been educated to the new protocol in regards to 1:1 residents off station 3.

Date of Compliance:

7/18/2025

Recurrence will be prevented by:

The DON/designee to audit all new admissions and/or transfers onto station 3 weekly x4 weeks.

The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.

F755 – Pharmacy Services/Procedures/Pharmacist/Records

Immediate Corrective Action:

R1's nicotine lozenge order was changed to nicotine gum.

Posted medication not available protocol at each nurse's station.

Corrective Action as it applies to others:

The pharmacy manual was reviewed and remains current.
We reviewed medication not available protocol and it remains current.
Full house audit completed of all residents on nicotine lozenges. Currently no active orders for nicotine lozenges.
Full house audit of all PRN medications to ensure a supply is available.4
Education to all nurses and TMAs regarding medications being available for administration and the medication not available protocol.

Date of Compliance:

7/18/2025

Recurrence will be prevented by:

DON/designee will audit all residents weekly x4 weeks to ensure nicotine lozenges are available.

Quiz 5 staff members weekly x4 weeks on medication not available protocol.

Audit 5 residents medications weekly to ensure PRN medications are available.

The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.

F742 – Treatment/Services Mental/Psychosocial Concerns

Immediate Corrective Action:

R4 had a new trauma assessment completed.

Corrective Action as it applies to others:

The trauma informed care policy was reviewed and updated and remains current.
Social services has been educated that trauma assessments will be completed upon admission, annually, and as needed following applicable events (i.e sexual assault allegations, abuse allegations, physical resident to resident altercations, etc.)
Full house audit of trauma assessments for all residents to ensure completion and care plans updated to reflect assessments.
Educate all staff regarding changes to the trauma informed care policy.

Date of Compliance:

7/18/2025

Recurrence will be prevented by:

The Administrator/designee will audit trauma assessments weekly x4 weeks to ensure completion and after OHFC/significant events.

The results of weekly audits and quizzes will be shared with the QAPI committee for review and to determine the need for ongoing or enhanced corrective strategies.