STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Bryn Mawr LLC	275 Penn Avenue North Minneapolis, MN 55405

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on interview and document review, the facility failed to have a system in place to train staff on the process for unlocking the main entrance doors for emergency medical services (EMS) personnel after hours when the doors were locked from 10:00 p.m. to 7:00 a.m R2 had difficulty breathing, 911 was call, and EMS personnel could not gain entrance to the building for ten minutes. This deficient practice placed all 81 residents residing in the facility at risk for serious harm, impairment or death (immediate jeopardy [IJ]) for delayed EMS response. The IJ began on 7/29/24 at 2:29 a.m. when R2 reported difficulty breathing, and staff phoned 911 at approximately 2:09 a.m. on 7/29/24. When EMS arrived at the facility, the doors were locked. A staff member attempted to open the doors and were unable. EMS was unable to enter the building for approximately 10 minutes. The administrator and director of nursing (DON) were notified of the IJ on 8/8/24 at 4:51 p.m. The IJ was removed on 8/9/24 at 11:46 a.m., but noncompliance remained at the lower scope and severity level of an F, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The Daily Census dated 8/5/24 and provided by the facility on 8/6/24 indicated the facility census was 81 residents. R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact, had no behaviors, and required assistance of two staff for transfers. R2's Diagnoses List undated, included kidney disease, diabetes, dialysis treatments, and left below the knee amputation. On 7/29/24 at 2:09 a.m., a progress note indicated R2 reported difficulty breathing and staff phoned 911, and emergency medical services (EMS) arrived at approximately 2:29 a.m. On 8/7/24 at 11:22 a.m., the administrator stated the front doors were locked at night, as some residents had a dealer dropping off drugs at night. The nurses had keys to the front doors at night. She was not aware there were issues unlocking the doors timely during the night. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 8/7/24 at 12:53 p.m., nursing assistant (NA)-A stated the nurse who was working on first floor on 7/29/24 night shift was an agency staff, and couldn't find the key to open the door. NA-B tried to open the door, but didn't know how. NA-A was able to open the door with the keys from the first floor nursing station's medication cart after NA-B tried, and then asked for help from other staff on second floor. There had been other times when staff could not open the door. She did not report the problem to administration because she thought the nurses would. There was usually one nurse on first floor, one on second floor, and 4-5 NAs in the building on night shift. On 8/7/24 at 2:07 p.m., during a subsequent interview, the administrator stated only the nurse on first floor station one [near the front door] had the key to unlock the door at night. Reception staff didn't work at night, and the NAs could get the key from the nurse to unlock the door as needed. Staff were trained about a year ago to open the door, but she could not provide proof of the education. The NAs could open the door if they got the key from the nurse, but would have to remove the key from the key ring as it was on the first floor medication cart key ring. An email sent by the administrator on 8/8/24 at 2:32 p.m., indicated since 7/1/24, 123 shifts were covered by agency staff, of that, 30 were night shift nurses. On 8/7/24 at 2:56 p.m., registered nurse (RN)-A stated agency staff did not know how to unlock the door after hours. Staff who can open the door must know which keys go to which doors. On 8/7/24 at 3:10 p.m., licensed practical nurse (LPN)-A stated the nurse who worked first floor was responsible to open the door for EMS staff, or they could give the keys to another nurse or NA to unlock the doors. The key to the front door was on the key ring to the first floor medication cart. On 8/7/24 at 3:22 p.m., RN-B, an agency staff, stated no one had ever shown her how to unlock the front door after hours when it was locked. On 8/7/24 at 3:53 p.m., paramedic (P)-A stated when EMS arrived at the facility, the doors were locked. The staff member who attempted to open the doors could not do so, and left. The staff person came back with a staff who had keys to unlock the door, which allowed EMS to enter the building. EMS were unable to enter the building for up to 10 minutes. P-A stated, A breathing problem is a high priority call and emergency. The fire department arrived at the facility prior to the ambulance team. It was unusual the fire team was still outside, as typically the fire team was already with the resident when the ambulance team arrived. But this time the fire captain was pounding on the door to get in. The fire department has previously had significant issues getting access to this facility during other incidents in the night hours. On 8/7/24 at 4:44 p.m., NA-B stated R2 stated she was short of breath, It's not gotten that bad before and I haven't seen her go to the hospital for something like that. There was one key for the front door, the nurse on first floor kept it at night, and he had not been taught how to open the door. He had tried to open the door twice that night, and when he could not, he went to second floor to ask staff for help. He didn't know how long that took. He had not reported the issue to administration because he thought NA-A did. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 8/8/24 at 8:59 a.m., fire captain (FC)-A stated the facility had a two-step system lock on the facility front door, and night staff did not know how to open the door for the emergency call for R2. One staff came to the door twice, couldn't unlock the door, and left without speaking to the fire or ambulance staff. The staff person then came back with another staff who was unable to unlock the door, and it took 10 minutes to get the door unlocked. In 10 minutes, the resident could have gone from having difficulty breathing to full arrest or death. The fire department had been to the facility 23 times since July 1, 2024, and had difficulty getting into the facility about every other call. If there is a fire, they won't be able to get people out. Everyone needs to know how to let us in. On 8/8/24 at 9:41 a.m., NA-C stated she had not been trained how to unlock the door, and she didn't know who had a key to unlock the door. Agency staff who were working on 7/29/24 night shift did not know how to open the door. She did not report it to administration because the night NA staff was gone before administration came for day shift, and she thought the nurses would report it. It took 10-15 minutes to get the door open. On 8/8/24 at 10:35 a.m., the DON stated she was responsible for staff training, but did not train staff how to unlock the door, and agency staff education did not include how to unlock the front doors. A 10-minute delay could cause the death to someone who needed assistance. The facility had not met with fire staff in the last four years, and did not know they were having access problems. She did not know why staff didn't tell her about it. Staff should wait at the door when 911 was called. The door was locked at night for night shift, and was unlocked in time for morning shift to enter. On 8/8/24 at 2:13 p.m., the administrator stated two nurses and four NAs work night shift. On 8/8/24 at 2:35 p.m., RN-A stated the doors were secured from entering the building and exiting the building. Agency staff usually did not know how to open the door, but should be taught by facility staff. On 8/8/24 at 2:50 p.m., P-B stated EMS staff had trouble getting in the facility during the night. On 8/8/24 at 2:54 p.m., a sign on the front door directed visitors to the back of the building if they were unable to get in, and to ring the bell to alert staff. Receptionist (R)-A stated the sign had been posted for a couple of months. On 8/8/24 at 3:24 p.m. the maintenance staff (M)-A stated there were no problems with locking the doors, and they only locked from the inside, and not the outside. The staff should know how to open it. A lock was installed during COVID, and he had not heard of anyone having access issues at night. Usually when visitors came, the nurses opened the door. Nurses should be at the door to let EMS in at night. The nurses lock the door anywhere between 8 p.m. to 10:30 p.m. The facility put the lock on because residents tried to leave at night. On 8/9/24 at 1:16 p.m., during a subsequent interview, P-B stated when his EMS crew came at night, it took up to 10 minutes for staff to let them in the door. This had occurred 3-4 times over the previous four weeks. He had commented about the delays to the staff each time, but had not contacted facility administration. The EMS crew pounded on the doors to get staff to let them in. A policy for locking the door was requested and not provided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The immediate jeopardy that began on 7/29/24 was removed on 8/9/24, after nursing staff was educated about the unlocking the doors timely for emergency personnel, with the expectation staff would meet emergency personnel at the front door, assist them to the elevator, and direct them to the resident who required emergency assistance. The facility provided education about how to unlock the front doors, and staff demonstrated they could open the front doors. The facility educated staff how to push the doors open with the emergency bar for emergency egress, posted instructions at each nursing station that had a key to the door, and provided instructions for who to call for maintenance including maintenance staff, the DON, and the administrator. The facility contacted the Minneapolis fire chief to ensure the fire department staff were aware of the building door codes. This was verified through observation, interview and document review.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation and interview, the facility failed to provide a privacy curtain for 3 or 3 residents (R1,R3, R6) who shared a room and were reviewed for a clean home-like environment. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 was cognitively intact. R1's Diagnoses List undated, included adjustment disorder with depressed mood, weakness, and unsteadiness on feet. R1's care plan dated 2/6/24, indicated R1 utilized a two-wheeled walker, and required assistance with transfers and to get out of bed. On 8/7/24 at 9:31 a.m., R1's room was observed to have a privacy curtain that was torn and unusable, and shielded R1's roommate from the doorway, but did not provide privacy from R1's view. R1 was sitting on the side of his bed, and stated he had never had a privacy curtain, nor had his roommate, and he had to watch staff help his roommate dress and undress. He did not want to eat in the dining room, but also did not want to watch staff dress and undress his roommate while he was eating. He was embarrassed watching his roommate dress, and it made him feel, Real down. R3's quarterly MDS dated [DATE], indicated R3 had severe cognitive impairment, and required assistance of two staff for bed mobility and transfers. R3's Diagnoses List undated, included major depressive disorder, personal history of traumatic brain injury, and cognitive communication deficit. R3's care plan dated 10/14/21, indicated R3 was dependent upon staff for all cares. R6's quarterly MDS dated [DATE] indicated moderate cognitive impairment and no behaviors. R6's Diagnoses List undated, included alcohol use, psychoactive substance abuse, history of homelessness, and anxiety. R6's care plan dated 3/24/24, indicated he was at risk for alteration in psychosocial well-being related to a history of homelessness. R6's Face Sheet printed 8/8/24, indicated he was his own decision-maker. On 8/6/24 at 2:00 p.m., R3 and R6's door was observed open. R6 had his pants down, and was masturbating. The room lacked a privacy curtain on either side of the room. Nursing assistant (NA)-H was present and acknowledged R3 could see R6 masturbate, but wouldn't want to. NA-H covered R6 with a sheet. R6 pushed the sheet off and yelled at NA-H to leave the room. On 87/24 at 10:12 a.m., housekeeper (HK)-A stated R3 and R6 did not have privacy curtains. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 11:22 a.m., the administrator stated she had not ordered privacy curtains, but each side of the room should have one. On 8/8/24 at 10:35 a.m., the director of nursing (DON) stated all the rooms should have privacy curtains for cares, if the resident needed space alone, and the curtains should be in good repair and usable. A policy for privacy curtains was requested but not provided.

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F 0941 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 44654 Based on interview and document review, the facility failed to provide training about communicating with non-English speaking residents who were identified as residents the facility may serve, for 5 of 5 staff (nursing assistant [NA]-G, NA-H, NA-I, registered nurse [RN]-A, licensed practical nurse [LPN]-B) reviewed. The facility identified two residents who were non-English speaking. Findings include: Review of sampled staff training identified the following staff lacked training for communicating with non-English speaking residents: 1) NA-G 2) NA-H 3) NA-I 4) RN-A 5) LPN-B On 8/12/24 at 12:54 p.m., nursing assistant (NA)-D could not recall training for communicating with non-English speaking residents. On 8/12/24 at 12:57 p.m., NA-E could not recall training for communicating with non-English speaking residents. but stated there was one resident in the facility who was non-English speaking. On 8/12/24 at 1:00 p.m., NA-F could not recall training for communicating with non-English speaking residents. Review of the Facility Assessment (FA) dated 7/3/24, indicated the facility accepted residents who required interpreter services. The FA lacked indication staff was trained annually on communicating with residents who were non-English speaking. On 8/12/24 at 1:14 p.m., RN-C and the director of nursing (DON) were interviewed. RN-C stated communication with non-English speaking residents was an area the facility missed for training.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 44654 Based on interview and document review, the facility failed to provide mandatory training on the facility's Quality Assurance Performance Improvement Program (QAPI) which included the goals and various elements of the program, and how the facility intended to implement the program, staff's role in the facility's QAPI program, and how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program for 5 of 5 staff (nursing assistant [NA]-G, NA-H, NA-I, registered nurse [RN]-A, licensed practical nurse [LPN]-B) reviewed for QAPI training. Findings include: On 8/12/24 at 12:54 p.m., nursing assistant (NA)-D could not recall what QAPI was, nor any training about QAPI, or the QAPI program. On 8/12/24 at 12:57 p.m., NA-E could not recall what QAPI was, nor any training about QAPI, or the QAPI program. On 8/12/24 at 1:00 p.m., NA-F could not recall what QAPI was, nor any training about QAPI, or the QAPI program. Review of sampled staff training identified the following staff had no QAPI training noted as provided on the facility's plan for the following staff reviewed: 1) NA-G 2) NA-H 3) NA-I 4) RN-A 5) LPN-B On 8/12/24 at 1:14 p.m., during an interview with registered nurse (RN)-C and the director of nursing (DON), RN-C stated QAPI was an area the facility missed for training. The DON stated she was just trained on QAPI in the past week. On 8/12/24 at 11:01 a.m., the administrator stated she was unaware the facility didn't provide mandatory training on the facility's QAPI program. Review of the August 23, 2023 Quality Plan identified the plan provided for overall quality improvement within the facility and revisions would be communicated to the governing board, residents, families, and employees through meetings and written communication. (continued on next page)

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the July 18, 2024 QAPI meeting minutes indicated nursing was responsible for initiatives related to pressure ulcers, physical restraints, falls, falls with major injury, anti-anxiety/hypnotic medications, catheters, incontinence, and worsening activities of daily living. The minutes lacked indication mandatory training was provided to staff.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 44654 Based on interview and document review, the facility failed to ensure 3 of 5 staff (nursing assistant [NA]-G, NA-H, NA-I) received annual training on behaviors in Alzheimer's disease or related disorders, problem solving with challenging behaviors, and communication skills. Findings include: Review of NA-G's, NA-H's, and NA-I's training transcripts lacked identification they completed annual training on Alzheimer's Disease, behavioral health, communication skills, or problem solving with challenging behaviors. Review of the Facility Assessment (FA) dated 7/3/24, indicated the facility accepted residents with psychiatric and mood disorders, and with impaired cognition. The FA indicated staff were trained annually on dementia management and how to address the care of the cognitively impaired residents. On 8/12/24 at 1:14 p.m., during interview with registered nurse (RN)-C and the director of nursing (DON), RN-C acknowledged NA-G, NA-H, and NA-I had not received annual annual training for behavioral health. A behavioral health training policy was requested and not provided.