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	01/14/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300 Based on interview and document review, the facility failed to monitor 2 of 4 residents (R1, R4) following an unwitnessed fall. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had severe cognitive impairment with diagnoses which included stroke. R1's nursing note dated 1/4/25 indicated R1 fell and hit the right side of his forehead causing a bump. The note lacked size and description of the injury, and any indication of treatment. R1's electronic medical record (EMR) lacked documentation of monitoring of the injury and ongoing monitoring following the fall to include neuro checks and vital signs. R4's quarterly MDS dated [DATE] indicated R4 had intact cognition with diagnoses which included type 2 diabetes mellitus. R4's nursing note dated 1/6/25 indicated R4 was found laying on the floor next to his bed during morning rounds. The note lacked indication of any injury or treatment. R4's EMR lacked documentation of ongoing monitoring for injury and ongoing monitoring following the fall. On 1/13/25 at 2:20 p.m., licensed practical nurse (LPN)-A stated R1 had a bruise on his forehead from a fall. LPN-A confirmed the only documentation about the injury was in the initial fall note. LPN-A stated the documentation should have included definition of the injury including measurement, color, and skin temperature. On 1/14/25 at 11:15 a.m., registered nurse (RN)-A stated all injuries from a fall should be clearly documented to include location, size, color and if the skin was open. Neuro checks should be completed for all unwitnessed falls and all head strikes. Nurse's notes should be written every shift to include any new injuries or changes since the fall. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 2:29 p.m., regional nurse consultant (RN)-C stated neuro checks should be started for all unwitnessed falls even if the resident says they did not hit their head. The resident might be embarrassed and not want to tell the truth. Following a fall, a resident should be monitored for new/increased pain, injuries, and neuro checks. A nurse's note should be written every shift for 72 hours following the fall. RN-C confirmed there was a lack of monitoring following R1's fall on 1/4/25, and R4's fall on 1/6/25. On 1/14/25 at 4:08 p.m., nurse practitioner (NP) stated neuro checks, vital signs and general monitoring for injuries should be completed for all unwitnessed falls, and witnessed falls with head strike. Signs of a head injury include decreased mental status, nausea, vomiting, decrease in balance, and decrease in mobility. The facility Fall Prevention and Management policy dated 2/2024 instructed if a bump to the head is suspected or confirmed after a fall occurred, complete neuro checks and update the provider. Nursing should utilize the neuro flow sheet. Nursing staff will observe for delayed complications of a fall for 72 hours after an observed or suspected fall and will document findings in the medical record.