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	01/23/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48040 Based on interview and document review, the facility failed to ensure a pain medication was re-ordered timely to prevent pain for 1 of 3 residents (R1) reviewed for pharmacy services. Findings include: R1's Admission Record dated 1/29/24 indicated R1's diagnoses included diabetic neuropathy, pain in left foot and post-traumatic stress disorder. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had alteration in comfort related to left toe amputation, required pain medication as ordered by the provider, and had intact cognition. R1's care plan dated 1/29/24, indicated R1 had left foot pain due to amputation with staff intervention to provide pain medication as ordered by the provider, document on effectiveness of pain medication and encourage R1 to verbalize discomfort. R1's Provider Order dated 1/29/24 indicated to monitor for pain daily, every shift. R1's Provider Order dated 10/1/24 included Belbuca Buccal Film (Buprenorphine HCL, a strong opioid pain medication used to manage severe and persistent pain) 300 micrograms (mcg) with indication to place and dissolve 300 mcg buccally (between the gums and the inner lining of the mouth and cheek) two times a day for pain. On 1/1/25 at 9:27 a.m. R1's progress note indicated Belbuca 300 mcg was not available, and the medication was reordered. R1's Medication Administration Record (MAR) dated 1/1/25 through 1/2/25 indicated R1 had not received Belbuca 300 mcg two times a day where a 9 was coded meaning other/see nurses notes for the morning administration and 6 coded on 1/1/25 indicating R1 was hospitalized in the evening. On 1/1/25 at 2:23 p.m. a progress note indicated the triage nurse was called and a new script for R1 Belbuca 300 mcg was going to be sent to the pharmacy. (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's medical record lacked evidence staff followed-up with the pharmacy on the lack of Belbuca 300 mcg supply, or updated R1's provider, from 12/30/24 through 1/1/25. On 1/1/25 at 9:13 p.m. a progress note indicated R1 was sent to the hospital per her request and the provider and the family were notified. On 1/1/25 at 6:50 p.m. a hospital emergency department (ED) note indicated R1 was seen for withdrawal. The note further indicated Belbuca 300 mcg was last given to R1 at the ED at 7:48 p.m. R1 was discharged back to the facility on [DATE] at 10:50 p.m. R1's medical record lacked evidence about what time she returned to the facility from the ED. On 1/22/25 at 3:10 p.m. LPN-A stated R1 came back from the hospital around 11:30 p.m. with no prescription refill. On 1/2/25 at 9:02 a.m. a progress note indicated Belbuca 300 mcg was not given, medication in order per pharmacy and will be delivered tonight. On 1/22/25 at 3:10 p.m. a licensed practical nurse (LPN)-A stated he called the triage nurse who was to notify the provider to send R1's new medication script to the pharmacy on 1/1/25 around 2:00 p.m. He did not call the pharmacy to follow up on the status of the medication. On 1/22/25 at 3:37 p.m. LPN-C stated he could not find Belbuca 300 mcg to give to R1 on 1/2/25 in the morning. He called the pharmacy who said the medication would be delivered at night on 1/2/25. On 1/23/25 at 1:25 p.m. LPN-B stated he was not given any report on R1's medication status on 1/1/25 morning. He could not find Belbuca 300 mcg to give to R1. The pharmacy had called to let him know R1 needed a new script from the provider for her Belbuca 300 mcg. He told LPN-A who was to follow up with the provider. On 1/23/25 at 9:54 a.m. the pharmacist (P)-A stated pharmacy services were available seven days a week, with weekdays until 5:30 p.m. and weekends until 2:30 p.m. Medications requiring reorder processes were marked with a red sticker identifying when it should be reordered. This allowed the pharmacy adequate time to process and dispense the medication. Belbuca 300 mcg order was reviewed, and R1 needed new script from the provider. The medication was not filled because they were waiting for a new script. On 1/2/25 at 11: 44 a.m., a script was received from nurse practitioner (NP)-A, and the medication was processed and dispensed to the facility at 7:30 p.m. On 1/23/25 at 10:47 a.m. NP-A stated he had no record of the staff calling to request a new script for R1 until 1/2/25. He was not notified when R1 was sent to the hospital, and never really understood what happened. He expected staff to call three or four days before a resident ran low on pain medication to ensure a safe administration of medication without unnecessary interruptions. On 1/23/25 at 12:28 p.m. R1 stated on 1/1/25 at 6:00 p.m. she called 911 because she was having withdrawal symptoms because she had not had her Belbuca 300 mcg. The nursing staff were not doing anything when she told them a day before about running low on her medication. She was shaking, and it was horrible. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 4:10 p.m. the director of nursing (DON) stated nursing staff should reorder controlled medications when a five to seven supply remained to avoid resident's missing doses. Staff should follow up with the pharmacy to make sure they received a new script from the provider, and document it in the progress note. The facility policy Controlled Substance Prescriptions dated 8/19 directed staff to contact the prescriber for direction when delivery of a medication will be delayed, or the medication is not, or will not be available. The facility policy Receiving Controlled Substances dated 4/18 directed controlled substances are reordered when a 5-7 supply remains to allow an appropriate time for transmittal of the required written prescription to the pharmacist and to assure an adequate supply is on hand.