

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 The Villas at Bryn Mawr LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Findings include:</p> <p>R4's facesheet dated 6/24/25, indicated she admitted to the facility on [DATE] 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R4's progress note dated 5/14/25, indicated the SSD 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was admitted to the facility on [DATE], 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),</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], 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).</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>R1's facility Progress Notes noted the following:</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p> <p>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 [NAME] 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.</p> <p>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.</p> <p>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.</p> <p>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 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 wandguard was put on his left wrist.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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 [NAME] avenue and [NAME] 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.</p> <p>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.</p> <p>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 indicated she was grateful he was not lost and that he was back safe.</p> <p>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.</p> <p>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.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to 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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R4's Trauma Questionnaire assessment dated [DATE], 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.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Villas at Bryn Mawr LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 275 Penn Avenue North Minneapolis, MN 55405	
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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Findings include:</p> <p>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.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was admitted to the facility on [DATE], 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview on 6/23/25 at 2:50 p.m., DON stated physician ordered medications should be available to all residents.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p>		