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	09/29/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility neglected to provide care and services to a resident with mental health needs who refused assessments and interventions since admission on [DATE], R1 was not transferred to a higher level of care despite facility and provider awareness for 1 of 3 residents (R1) who were reviewed for neglect of care when R1 contacted emergency medical services (EMS) because she felt dizzy, was vomiting, and could not move her lower extremities. When EMS arrived R1 was adhered to her mattress and covered in urine and feces. R1 admitted to the hospital malnourished, with maggots around her groin, bra hook embedded down to the muscle layer, reddened folds to right flank, pressure ulcers from stage one to stage four covered her entire back, open areas to coccyx, and bilateral gluteus, and skin tears along her posterior thighs. The immediate jeopardy began on 9/21/25, when facility failed to send R1 to a higher level of care when they were unable to provide hygiene, assess her skin, identify the cause of the unpleasant smell and suspected foot wound, for a bedridden resident and identified on 9/25/25. The administrator, regional director of operations, and director of nursing (DON) were notified of the immediate jeopardy at 5:10 p.m. on 9/25/25. The immediate jeopardy was removed on 9/25/25, but noncompliance remained at the lower scope and severity level 2 D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Hospital Discharge summary dated [DATE], indicated R1 was treated for back pain, and they found an abnormal lesion on her spine. During the hospitalization she had fixed delusions and refused medical care. She was placed on a court hold related to unwillingness to care for spine lesions and refused to have the surgical screw removed from her shoulder. R1's admission data assessment dated [DATE], indicated she refused to let staff examine her skin.R1's 48-hour care plan dated 7/8/25, indicated she had a self-care deficit related to back pain and schizophrenia. Her mobility was altered. She was continent of bowel and bladder and required help from one staff member to toilet. She was at risk for skin breakdown. Interventions included staff would complete weekly skin assessments and report any breakdown to the provider, turning every 2 hours, pressure relieving mattress, and wheelchair cushion.R1's care plan focus dated 7/8/25, indicated she had a risk for skin impairment related to incontinence and refusal of care. She preferred to lay in bed all the time and did not want staff to wake her up. Implemented turn and reposition every 2-3 hours. Monitor skin integrity daily during cares, placed pressure redistribution mattress and wheelchair cushion, and report concerns to the provider. R1's care plan focus dated 7/9/25, indicated she was at risk for malnutrition. Interventions included offer food and fluids, and alternative meals as requested. Offer ice cream, yogurt, and pudding and encourage her to eat meals. She received a supplement. R1's provider note dated 7/9/25, indicated R1 had an odor of unknown etiology, the room had a malodorous smell, concerned of a foot wound, R1 was very private about her body. R1 refused to answer question if she had any open skin areas. R1's clinical nutrition evaluation dated 7/9/25, indicated her weight was 180.5 pounds (lbs.) R1's admission Minimum Data Set (MDS) dated [DATE], indicated she had normal cognition, mild depression, delusions, and rejection of cares. She used a wheelchair for mobility, needed the assistance of one with toileting, shower, dressing, and transfer. Needed set up assistance for hygiene needs, and staff set up her meals. She was continent of bladder and had frequent stool incontinence. She had depression, Schizophrenia, and back pain. She did not have a risk for pressure ulcers, or any skin injuries. She took antipsychotic and seizure medications. R1's care plan focus dated 7/14/25, indicated her behaviors were related to trauma when she was hit by a car and sustained life-threatening injuries. Interventions included applying Associated Clinic of Psychology (ACP) recommendations. Use a trauma informed approach to care, work at her pace, and build trust. Staff would update the provider regarding any behavior changes. R1's Risk verse Benefits document dated 7/14/25, indicated she had refused care and vaccinations. She was at risk for health, hospitalization and or death. R1's weekly skin assessment dated [DATE], 7/22/25, 8/6/25, 8/12/25, 8/19/25, 8/26/25, 9/2/25, 9/9/25, 9/12/25, and 9/16/25, indicated she refused a bath and her skin checked by staff. R1's provider note dated 7/16/25 indicated R1 had mild anemia with a hemoglobin of 11.5, her basic metabolic panel was unremarkable. Staff stated R1 has been intermittently refusing cares and medications. R1 refuses treatment for lytic lesions.R1's provider note dated 7/18/25 indicated she was seen for pain management and rehabilitation recommendation. R1 did not appear to be in distress, no breakdown in hands or heels, moves all extremities, R1 had decreased endurance, activity of daily living impairment, muscle weakness, deep vein