

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 02/27/2026
NAME OF PROVIDER OR SUPPLIER 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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure newly developed areas of skin breakdown were promptly assessed to determine interventions needed to promote healing, ensure recommendations and orders for pressure ulcer care were acted upon timely to facilitate healing and reduce the risk of continued worsening for 1 of 4 residents (R4) reviewed. R4 developed skin breakdown on 12/6/25, that was not addressed until several days later and when R4 was seen by a wound care provider for the developed pressure injuries then the recommendations for care were not implemented until weeks later causing harm to R4 when he developed more pressure ulcers and his existing ones worsened. The facility took corrective action prior to the onsite survey, and these findings are being issued at past non-compliance. Findings include: R4's Monarch Healthcare Management (MHM) Weekly Skin Inspection, dated 11/30/25, identified R4 had a shower and listed a section to record his skin condition. The evaluation identified R4 allowed the skin inspection with findings recorded, Skin clean [,] dry and intact. R4's significant change Minimum Data Set (MDS), dated [DATE], identified R4 had moderate cognitive impairment, required moderate assistance with bed mobility (side-to-side rolling), and had no current unhealed pressure ulcer or injuries. R4's progress note, dated 12/3/25, identified R4's MDS was changed to a significant change in status (SCSA) MDS as R4 sustained a fall with a wrist fracture and was needing more assistance with cares transfers since returning from the hospital (on 12/2/25). R4's Braden Evaluation, dated 12/3/25, identified R4 had slightly limited sensory perception, had rare moisture exposure, and walked occasionally. This Braden evaluation scored R4 with a score, 19.0 [low risk]. R4's MHM Weekly Skin Inspection, dated 12/6/25, identified R4 had a shower and listed the same section to record R4's skin condition. This identified R4 allowed the skin examination to be completed and recorded, Ongoing open area on left buttock, other skin clean dry and intact. The evaluation lacked any measurements or wound characteristics of the area; no recorded dictation on what, if any, treatment was done for the area. R4's corresponding Pressure Ulcer/Injury Care Area Assessment (CAA), signed 12/11/25, identified R4 had frequent bowel and bladder incontinence, and required assistance with bed mobility and transfers causing the CAA to trigger for completion. The CAA outlined R4 had multiple medical conditions including a recent fall with a wrist fracture, dementia, diabetes mellitus, and stage III kidney disease. The CAA recorded, He does not have any pressure ulcers. The CAA identified R4 was at risk for skin breakdown and outlined the care plan focus would be to minimize his risk for them. R4's MHM Weekly Skin Inspection, dated 12/11/25, identified R4 had a bed bath and allowed a skin check to be done. The skin examination recorded, Noted redness and wound to his scrotum. The evaluation lacked dictation if this was the same area identified on 12/6/25, or if that prior area had healed or remained. The completed evaluation lacked any recorded treatments being done to the site(s). R4's SW - Skin Issues note, dated 12/12/25, identified R4 had a new skin issue acquired in-house on the sacrococcygeal area. This was recorded as moisture-associated skin damage (MASD) and measured 4.42 (L) X</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 245203	If continuation sheet Page 1 of 5

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>(D) with a total surface area of 0.35 (cm). The wound had light drainage present and a wound bed of 100% dermis. The note recorded a treatment for each wound with the pressure ulcer treatment listed as, Clean with WC or bath wipe, apply Triad Paste, BID & PRN. **Start APM and ensure Q2 hours repositioning orders are in place. Further, PA-A asked to have the RD evaluate and consider adding wound healing supplement and protein supplement. R4's care plan, last reviewed 12/26/25, identified R4 had bowel and bladder incontinence and directed staff to check and change him every 2-3 hours and as needed. The care plan identified R4 was at risk for an alteration in skin integrity due to his past stroke history and cognitive impairments. R4 had a history of pressure ulcer(s) to his buttocks. A goal was listed for skin breakdown to be resolved by the next review period along with interventions including: - Staff to remind patient to offload and offer assistance to nap after each meal (resolved 12/16/25). - Monitor skin integrity during cares and weekly inspection by the nurse. - Assist of two with turning and repositioning (initiated 4/23/23). - Low air loss air bed, pressure redistribution (initiated 12/24/25). - Weekly measurements and assessment of wound (initiated 12/24/25). - Monitor for skin breakdown and signs of infection. Report to MD (initiated 12/24/25) - Followed by wound care (initiated 12/24/25). R4's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 12/2025, identified R4's medication administrations and treatments with staff initials to show them as completed. This identified the following orders: - MASD Buttock / Sacrum . Clean with WC or bath wipe, apply Triad Paste, BID [twice daily] & PRN, started on 12/17/25 and discontinued on 12/24/25. This was recorded as completed twice a day until 12/23/25. - Pressure Injury / Sacrum . Cleaned with WC or bath wipe, apply Triad Paste, BID & PRN, started on 12/24/25 and discontinued on 12/31/25. This was recorded as completed for each administration. - Air mattress - Monitor for working order and replace as needed, started on 12/29/25. This was first recorded as completed on 12/29/25 (PM shift). There were no recorded PRN treatments in these areas. The treatment on the TAR started on 12/17/25 (Triad Paste) was the first recorded treatment being done for R4's developed skin breakdown despite it being recorded by the staff on 12/6/25. There was no intervention recorded to demonstrate the barrier cream application (see 12/12/25 progress note) was being done or had been consistently completed. R4's Aeri's History & Physical, dated 12/30/25, identified R4 was seen by NP-A for a regulatory visit. A physical exam recorded R4 as in no acute distress and did not mention or review his skin condition or areas of breakdown. The NP identified R4 had no concerns and that his blood sugars remained elevated. NP-A wrote orders for laboratory monitoring and to increase his scheduled insulin dose. R4's SW - Skin Issues note, dated 12/30/25, identified R4 had multiple skin issues present with more new areas recorded. These included: - #001 Sacrum; Pressure ulcer/Injury; deteriorating status. The staging was recorded as unstageable and wound measured 8.9 (L) X 5.8 (W) X 0.3 (D) with no undermining or tunneling present. - #002 Rear left thigh; MASD; unknown status. The area measured 0.9 (L) X 0.9 (W) X 0.1 (D) and was without undermining or tunneling. - #003 Scrotum; MASD; new wound acquired. The area measured 3.29 (L) X 3.24 (W) X 0.1 (D) with a total surface area of 6.79 (cm²). There was no undermining or tunneling noted. - #004 Buttocks; Pressure ulcer/Injury; new wound acquired. The staging recorded as unstageable and wound measured 6.46 (L) X 7.61 (W) X 0.3 (D) with no undermining or tunneling present. The wound bed had 10% granulation tissue and 90% eschar. R4's IWC Follow-Up Progress Note, dated 12/30/25, identified R4 was seen for wound care by an NP who recorded, Patient resting in bed. Having discomfort with position change. Multiple new areas noted today, found when completing routine rounds. Needs air mattress and Foot Boots. Has new area of MASD to scrotum, new diabetic wounds to bilateral feet, left lateral foot and unstageable PU [pressure ulcer] to the right gluteus. The NP recorded R4's pressure ulcer injury as: - #1 Pressure ulcer</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Buttock / Sacrum (right) measuring 8.9 (L) X 5.8 (W) X 0.3 (D) with a total surface area now of 51.62 (cm). The wound now had moderate drainage with a wound bed recorded as 80% granulation, 10% slough, and 10% DTI (deep tissue injury). The treatment was listed to clean the site with wash cloth, pat dry, apply a calcium alginate cut to fit the wound, then apply skin prep to the peri-wound and cover with an absorbent dressing, change every day. - #4 Pressure ulcer Buttock (Right) with no measurements recorded. This wound was recorded with 90% eschar and 10% granulation tissue present in the wound bed. The treatment was listed to be cleaned with a cloth and dried, skin prep applied to the peri-wound, and a hydrocolloid dressing be placed. That was also to be changed daily. R4's SW - Braden Scale, dated 12/30/25, was recorded as a late entry and identified R4 had no sensory perception impairment, having occasional moisture exposure, and being chairfast. This Braden evaluation scored R4 with a score, 16.0 [low risk]. R4's progress note, dated 1/2/26, identified R4 was short of breath and lethargic and was sent to the hospital via EMS. R4 did not return. R4's Pressure Injury Root Cause Analysis, dated 1/7/26, identified an interdisciplinary team (IDT) review of R4's developed unstageable pressure ulcer on his buttocks. The date of injury was 12/30/25. The form contained various items to be discussed and reviewed including Braden score(s), care plan interventions, nutritional risk and interventions, and floor staff interviews about their condition. R4's care plan was updated and the physician consulted about the wound. A section labeled, Actions Taken, identified R4's care plan was changed. R4's medical record was reviewed and lacked evidence R4 was comprehensively assessed by the IDT after the wound on his buttocks was identified on 12/6/25 to determine what interventions were needed to promote healing or reduce the risk for new ulcers; nor after the initial area continued to progress from MASD to a developed pressure ulcer. The record supported treatments were being done to these areas after 12/16/25 when R4 was seen by the PA/NP from IWC. None of their recommendations of dietary evaluation or an APM were acted upon until weeks later and just before R4 was hospitalized. The care plan lacked evidence of new skin interventions until 12/24/25 when the wound had been present for weeks prior. When interviewed on 2/26/26 at 12:24 p.m. nursing assistant (NA)-A stated they recalled working with R4 and explained he had been walking with assist of one until he fell from bed and broke his wrist (on 12/2/25). R4 then needed more help with mobility upon returning from the hospital. NA-A stated they recalled him having a little bit of skin breakdown on his buttocks but expressed it was managed by the nurses mostly. Barrier cream being applied to the area at times but was unsure of the timeline when that started or stopped. NA-A stated they felt staff were repositioning him every few hours during the shift, but this was not recorded in the record. When interviewed on 2/26/26 at 12:52 p.m. registered nurse (RN)-A stated R4 needed more help when he returned from the hospital with a wrist fracture. R4 was typically incontinent of bowel and bladder, and staff had to help him manage that. R4 had some MASD areas and did not know what happened with R4's skin issue. They thought he had always used a regular mattress while at the facility and did not recall an APM ever being placed on the bed. RN-A stated the director of nursing (DON) and assistant director of nursing (ADON) knew more information about R4. When interviewed on 2/26/26 at 1:12 p.m., the ADON and DON stated R4 returned from the hospital on [DATE] with a new wrist fracture and declined in status needing more help with cares. ADON stated R4 developed the pressure ulcer on 12/12/25 and it was not concerning at the time, then progressed and got bad several weeks later. DON verified the record lacked evidence that the RD had ever re-evaluated R4 despite the ongoing recommendations from PA-A. DON explained when a new skin issue or ulcer develops, the IDT review is completed using the paper form titled Pressure Injury Root Cause Analysis. This was to be completed with each new ulcer, but it was not done until after R4 had been hospitalized on [DATE] because the nurse manager and ADON</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>were unaware it had to be done. DON stated education had since been completed with them to ensure these wounds were not missed again. ADON and DON reviewed R4's TAR and verified the first documented evidence of an APM being applied was on 12/29/25; and DON stated their Technical Environmental Life Safety (TELS) system supported that same date as when it was asked to be installed by maintenance. DON verified an APM was readily available at the campus to be installed within a day or two of being ordered or recommended. ADON stated they were unsure why they had updated R4's care plan to reflect the air mattress before it had been installed. At 1:33 p.m., RD-A joined the interview. RD-A stated they had not been notified until late December 2025 about R4's wounds needing to be evaluated for nutrition. RD-A stated the nurse managers or ADON should update them when the wound providers are making recommendations for nutritional review, and they would have recorded the review in the record. RD-A stated if they were told about R4 timely, they would have evaluated his calorie needs and started a supplement for him since he was not on one prior. DON and ADON acknowledged the lack of assessment from the IDT of the developed ulcers being done until after he had been hospitalized (nearly a month later) but both reiterated the re-education was provided after they discovered the missed care. When interviewed on 2/26/26 at 1:50 p.m., NP-A stated they were involved with R4's care while he was at the nursing home. NP-A stated R4 had diabetes, and they were actively trying to adjust his insulin several times to better control his blood sugars. R4 needed a mechanical lift for transfers towards the end of his stay at the center but did not have details of his skin condition. NP-A stated if skin issues were identified, they usually would tell the nurses to update the IWC so they could follow them and address it adding a specific referral was not needed for that. NP-A could not identify if R4's pressure ulcers were avoidable or not but stated if interventions and recommendations were acted upon timely then the wounds could have likely been less severe. During an interview on 2/27/26 at 10:02 a.m., PA-A stated R4 needing extensive assistance with bed mobility and transfers. R4 identified as high risk for skin breakdown which is why the recommendations for the IDT to review R4's needs and for RD to evaluate R4 were made. R4's MASD and evolution to a pressure ulcer was multi-factorial. PA-A stated the care center was expected to act on their recommendations for repositioning and wound care, having an APM installed at the start of the wound would have helped slow down the wound progression. PA-A stated it was hard to say whether the wounds were avoidable or not because the recommendations were not followed. A facility Skin Assessment & Wound Management policy, dated 2/2025, identified guidelines for assessing and managing wounds. This included completion of a Braden Scale, implementation of appropriate skin measures, completion of the skin evaluation and risk factors forms, and routine ongoing skin monitoring by the staff. The policy identified a section labeled, Pressure Wounds, which directed steps when a new ulcer was found. This included notifying the provider, completing education with the residents and family, initiating a skin and wound evaluation, referring them to dietary if needed, reviewing and updating the care plan interventions. The past noncompliance harm-level finding was corrected prior to the onsite survey exited on 2/27/26. The facility implemented multiple actions to address the noncompliance which included education provided to the nurse leadership team on expectations with a developed pressure wound, the nurse leadership team on MDS completion, and the nurse leadership on care planning and skin interventions. In addition, a sample of current residents with pressure ulcers were reviewed and identified no additional concerns with the care provided.</p>		