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	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to assess, develop, implement interventions and provide supervision for 1 of resident (R1) reviewed for tube feeding. The facility was aware R1 had food seeking behaviors and was on a NPO (nothing by mouth) diet restriction. This resulted in R1 being sent to the emergency department. Once in the emergency department, R1 required intubation and resuscitation by cardio pulmonary resuscitation (CPR) due to cardiac arrest. The immediate jeopardy began on 3/08/26, when the facility failed to assess, develop, implement interventions and provide supervision to R1 when R1 was known to have food seeking behaviors and was on a NPO diet restriction. R1 was sent to the emergency department (ED) on 3/08/26, with decreased responsiveness, temperature of 105 degrees Fahrenheit and was found to have large portions of food materials in R1's oropharynx (upper airway). The immediate jeopardy was removed on 3/13/26, but noncompliance remained at the lower scope and severity level D (isolated, scope and severity level) which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1's diagnoses included malnutrition, anxiety disorder and depression. R1 was severely cognitively impaired, usually understood with unclear speech and had no behaviors. The MDS further indicated R1 required set up to partial assistance with activities of daily living (ADL)'s, occasionally incontinent with urine and frequently incontinent with bowel, and was independent with mobility. In addition, the MDS indicated it was unknown if R1 had weight gain or loss but received nutrition via tube feeding (G-tube) with a weight of 165 pounds (lbs.)R1's care plan dated 2/19/26, indicated R1 self seeks food and fluids while NPO (nothing by mouth), risk versus benefits completed on 2/19/26, required reminders and redirection related to poor cognition.R1's Risk versus Benefit form dated 2/19/26, indicated resident is currently NPO status with tube feeding meeting 100% of nutrition and hydration related to dysphagia (difficulty swallowing) and history of silent aspiration. Therapy staff report resident has been self-seeking food and fluids for ingestion. The form further indicated the risks related to non-compliance would be consuming oral food or fluids could result in aspirating food or fluid into lungs, cause lung infection/pneumonia, loss of airway and inability to breath, return to hospitalization and possible death. The form indicated the provider was updated on 2/19/26 and working with SLP (speech language pathology). SLP planned to assist R1 with improving swallow function and there was a video swallow test to be scheduled for further assessment of R1's swallow ability. A registered dietician (RD) progress note on 2/19/26, indicated R1 was NPO, related to dysphasia with a history of silent aspiration. R1 was self-seeking food and fluids per staff reports. R1 had impaired cognition and required redirection and reminders of diet order. RD reviewed risk versus benefit with R1 related to NPO status. It was difficult to assess R1's understanding, R1 shrugged shoulders and made some facial expressions during education but was unable to repeat back to writer (RD) risks of consuming oral intake.On 2/24/26, record of email exchanges with IDT (interdisciplinary team) related to R1's low slums (St. Louis University Mental Status examination), indicated R1 had a score of (6/30) which indicated dementia. R1's wandering and the need for a memory care bed was discussed. No memory care bed was available. The team determined they would continue to monitor (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1 with no new intervention established.A hospital History of Present Illness (H&P) dated 3/08/26, indicated R1 arrived at the emergency department (ED) and was found with acute hypoxic (lack of sufficient oxygen supply to body tissues) and hypercarbic respiratory failure (low oxygen levels with high carbon dioxide), intubation was complicated by tracheal stenosis (tightening of the trachea) immediately beyond the vocal cords with delayed ETT placement (Endotracheal Tube through the mouth/nose into the trachea to manage the airway) and a brief in-hospital cardiac arrest requiring CPR and was a concern for aspiration at the time of intubation as large food material was suctioned from the oropharynx (the middle part of the throat behind the mouth, comprising the soft palate, base of the tongue, tonsils, and side/back walls, which acts as a passage for air, food, and fluids, assisting in swallowing and speech). The H&P further indicated R1 had been G-tube dependent since January and was not supposed to be taking food or fluid orally. Nurse practitioner (NP) visit note on 2/25/26, indicated R1 was seen and had aspiration, coughing, resident continues strict NPO with staff reports she continues to seek out food and fluids. Resident reports she has been eating and coughs with swallowing. And a chest Xray was ordered to rule out aspiration pneumonia.R1's medical record indicated Chest Xray results dated 2/27/26, indicated no fluid/massed noted.On 2/27/26, a progress note indicated facility contacted R1's daughter to discuss guardianship due to extreme confusion, daughter agreed to discuss.NP visit note on 3/4/2026 indicated R1 presented with silent aspiration, cough, coarse lung sounds, R1 continued to report food and fluid intake by mouth despite strict NPO. Order placed for another chest x-ray. Results were read on 3/5/2026 with no negative results.A progress note dated 3/09/26 at 1:45 a.m., indicated resident sent to hospital unresponsive pulse 151 all other vitals were stable. 911 arrived O2 (oxygen) sats declined family notified.Email dated 3/11/26, related to the ongoing concerns with R1, interim Administrator indicated, When IDT was made aware resident was food seeking, IDT met and implemented intervention of monitoring order that entered on 02/19/2026.During interview on 3/09/2026 at 4:35 p.m., paramedic who responded to the call on 3/8/26 stated, the call came in at 12:40 a.m., and paramedics arrived at 1:00 a.m. R1 had heavy breathing and was unresponsive. R1's temp was 105 degrees Fahrenheit, BS (blood sugar) was in the 200s. When R1 arrived at the hospital, R1 was found to in acute hypoxic and hypercarbic respiratory failure. Intubation in the ER was complicated by large food particles from the oropharynx and a diagnosis of aspiration pneumonia. R1 had a brief cardiac arrest, requiring CPR and was admitted to the ICU with placement on a mechanical ventilation.During interview on 3/11/26 at 11:49 a.m., NP stated she was informed by the staff of R1's food seeking behaviors on 2/19/26, and when she saw R1 on 2/25/26, R1 nodded her head yes when she asked R1 if she was eating or drinking food. NP ordered chest xray, results were normal. In addition, the NP stated she saw R1 on 3/4/26, NP ordered another chest xray over concerns of her eating and the results were normal. During interview on 3/11/26 at 2:06 p.m., RD stated she was informed on 2/19/26, R1 was seeking food and was found drinking soda. RD stated on 2/19/26, she completed the risk vs. benefits form with R1 although her cognition was not good and was unable to repeat back her understanding, she felt education needed to be completed and R1 was her own person. In addition, an order was added to R1's treatment administration record (TAR), to observe for self-seeking food and fluids as needed and provide re-education as needed due to poor cognition. During interview and document review on 3/11/26 at 3:58 p.m., employee (E)-A stated two weeks ago she had observed R1 eating a gummy jolly rancher that another resident on R1's floor had given to R1. E-A stated she informed a registered nurse and was told he [E-A] could not give R1 candy due to her NPO status. In addition, E-A stated within the past couple of weeks, she had observed R1 wandering into other residents' rooms and had to stop her twice before she would try to eat food on the left-over room trays. (E)-A also stated she had seen R1 wandering all over the unit and had seen her in the dining room during and after meals. Review of R1's record lacked evidence of any action taken in response to these events.During interview on 3/11/26 at 4:08 p.m., facility SLP-A stated R1 had severe cognitive deficits, and wandered all around the unit. SLP-A stated R1 did not understand what NPO meant. SLP-A stated if (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1 were to eat regular food or fluids, she was at high risk for aspiration which her swallow evaluation at the hospital indicated on 2/09/2026. R1's video swallow, completed at the hospital, indicated R1 had silent aspiration with thin liquids and deep penetration with all other trials and was recommended NPO.During interview on 3/11/26 at 8:15 a.m., licensed practical nurse (LPN)-A stated he worked the night shift on 3/07/26 to 3/08/26, and shift started at 10:30 p.m. LPN-A received report from the evening shift, R1 was now receiving bolus (large, intermittent doses) tube feedings. LPN-A stated he did his rounds at the start of the shift checking on his residents and R1 was sleeping. LPN-A then stated at 12:00 a.m., he was notified by nursing assistant (NA)-B resident was unresponsive. LPN-A called the charge nurse, registered nurse (RN)-A, to come to his floor while he checked R1's POLST (Physician Orders for Life-Sustaining Treatment) and R1 was full code (all necessary measure taken to sustain life) status. LPN-A stated, NA-A took R1's vital signs and was unaware R1's vitals indicated a temperature of 97.8 degrees Fahrenheit and the arriving paramedics received a temperature of 105 degrees Fahrenheit. During interview on 3/12/26 at 3:50 p.m., employee (E)-B stated she had seen R1 wandering all over the unit and had seen her in the dining room during and after meals. On 3/12/26 at 8:30 a.m., NP stated she was never informed R1 had eaten jolly rancher gummies and would expect to be immediately notified so a chest x-ray could be ordered and increased monitoring of R1's respiratory status, especially with the risk of eating food could cause aspiration and choking. During interview on 3/12/26 at 3:30 p.m., regional nurse consultant stated after 2/19/26, there had been no documentation of resident food seeking or wandering into rooms for food. Also, interviews with residents and staff show that no one had seen her attempting to get food or have food. Therefore, there was no need for the facility to implement stricter interventions since she wasn't demonstrating any further food seeking behaviors after the first intervention was implemented.Interview on 3/12/26 at 3:43 p.m., with medical doctor (MD)-A stated he is currently responsible for the care of [R1] and in reading [R1's] hospital note on 3/08/26, if she would have had food lodged in her oropharyngeal for a long period of time she would have been coughing constantly at all times and it would have been noticed, and her fever upon arrival at the emergency department of 105 is consistent with acute aspiration.The immediate jeopardy that began on 3/08/26, was removed on 3/13/26, when the facility completed a full house audit with residents who had modified diets. They audited care plans for those with modified diets and provided training to staff on modified diets and any changes made to care plans.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to assess and develop a plan to ensure tube feeding needs were met for 1 of 1 resident (R1) reviewed who had a behavior of disconnecting her feeding and sustained over 13 pounds (lbs.) of weight loss in less than 30 days as a result. Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1's diagnoses included malnutrition, anxiety disorder and depression and was severely cognitively impaired, usually understood with unclear speech and had no behaviors. The MDS further indicated she required set up to partial assistance with activities of daily living (ADL)'s and was independent with mobility. In addition, the MDS indicated it was unknown if R1 had a weight gain or loss but received a tube feeding with a weight of 165 pounds (lbs.).R1's care plan (CP) dated 2/19/26, indicated R1 self seeks food and fluids while NPO (nothing by mouth), risk versus (vs) benefits completed on 2/19/26, and required reminders and redirection related to poor cognition. The CP further indicated she had actual alteration in nutrition and had weight loss over 30 days related to inadequate caloric intake as evidenced by disconnects feeding prior to end time. Risk vs benefit form completed on 3/02/26. R1's Risk vs. Benefits form dated 3/02/26, completed by the facility's registered dietician (RD) indicated resident was NPO status with tube feeding meeting 100% of R1's nutrition and hydration need. The risks related included: it was important that you [R1] keep your tube connected to the pump during this time to allow your body to obtain the adequate calories and protein and fluids/nutrients your body needs to stay healthy and maintain weight. Disconnecting your feeding tube prior to 9:00 a.m. could result in continued weight loss, malnutrition, dehydration, return to hospitalization or possible death. The form indicated the RD placed a call to primary family member (FM)-A to update and review. FM-A was in agreement with attempting bolus feeding (gravity used to slowly give the tube feedings over a 15-to-20-minute time period). Dietary progress note dated 3/02/26 at 4:41 p.m., indicated R1, exhibits significant weight loss over <30days [less than 30 days] weight series: 2/16/26 168lbs. to 3/2/26 155lbs. and confirmed with reweight. Down 13lbs/7.7%/<30days. Staff report res. [R1] often disconnects feeding prior to end time in morning thus resulting in inadequate calories via tube to support stable weight. Staff report res. often has high movement in bed, moving back and forth and tube at risk of being tugged or pulled on. Res. may tolerate and be more compliant w/ [with] bolus tube feeding regimen during day by gravity. Reviewed risk vs. benefits w/ res. Res. w/ poor cognition and difficult to assess understanding. Call placed to res. primary contact [family member (FM)-A]. Reviewed weight loss and risk vs. benefits. [FM-A] in agreement w/ bolus schedule. Re-estimated needs d/t [due to] wt [weight] loss: 155lbs actual wt 25-35cal/kg [calories per kilogram], 1-1.3g [grams] pro/kg [substance per kilogram], 30cc [cubic centimeters] fluid/kg: 1760-2450cal/day, 70-91g pro/day and 2100 cc fluid/day. I would recommend Osmolite (a therapeutic, fiber-free, ready-to-use enteral formula suitable for bolus feeding)1.5 bolus 1.5 cartons or 355cc QID (four times a day) via gravity. Flush 125 ml (milliliters) before and after each bolus feeding QID. New regimen would offer total of 2130cals, 89g pro/day and 2086cc fluid/day. Cont. w/ ok for ice chips per order, however not a significant source of fluids. Provider notified of wt loss r/t inadequate calories r/t res. Ill compliance to feeding regimen. Requested bolus schedule change and awaiting reply. RD to follow up as needed w/any changes to meal intakes or weights. Provider updated re: risk vs benefits education. RD to follow up as needed. Awaiting orders. An additional note on 3/03/26, completed by RD indicated, provider rec. [recommends] start bolus tube feeding schedule. New orders for Osmolite 1.5 355ml (1 and a half cartons) QID bolus by gravity w/ 125ml water pre and post bolus. Rec. weekly weights for observation of weight trends. RD to follow up as needed. R1's weights listed in point click care (PCC) (facilities computerized documentation system) indicated the following weights since admission on [DATE]:-2/16/2026- weight was 168.0 lbs.-2/18/2026- weight was 165.0 lbs.-2/28/26- a weight was documented as 166.8 lbs. (although the RD struck out the weight on 3/02/26 and wrote (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Incorrect Documentation.)-3/01/26- a weight was documented as 155.5 lbs.-3/02/26- weight was documented as 155.0 lbs.-3/07/26- weight was documented as 155.0 lbs. During interview on 3/10/26 at 5:32 p.m., family member (FM)-A stated she visited R1 on 2/27/26 noticed a brown colored substance on her bed sheets. When FM-A asked the staff, she was informed it was due to R1 disconnecting her tube feeding. FM-A stated the RD informed her of the weight loss on 3/02/26, when her feedings were changed to bolus feedings. During interview on 3/11/26 at 6:40 a.m., licensed practical nurse (LPN)-C stated he had been informed R1 was disconnecting her tube feeding but was unsure how long this occurred before she switched to bolus feedings on 3/02/36. During interview on 3/11/26 at 2:06 p.m., RD stated on 3/02/26, she discovered R1's weight loss and did strike out the weight listed on 2/28/26 in PCC since she knew it was an error after getting a second weight on 3/02/26 which showed R1's weight to be 155.0 lbs. RD found out, from talking to staff, R1 was disconnecting her tube feeding. RD stated R1 was on weekly weights due to being a new admission and had a new tube feeding. RD stated she then completed with Risk vs Benefit for disconnecting the tube feeding and received an order to start bolus feeding from R1's physician to decrease the amount of time the tube feeding is running. RD stated the order was changed to bolus feeding four times a day. During an additional interview on 3/13/26 at 12:44 p.m., RD indicated she was unsure when R1 started to disconnect her tube feeding. RD was made aware R1 was disconnecting the tube feeding, prior to the end time, the same day as the progress note (3/2/26). RD stated she did not talk to registered nurse (RN)-C about the incorrect weight and staff were not re-educated on incorrect weights and what they should do. During interview on 3/13/26 at 2:03 p.m., nursing assistant (NA)-C stated she has never seen R1 disconnect her tube feedings when she worked with her. Weight Policy dated 10/2012, indicated it is the policy of Monarch Healthcare Management to obtain accurate weights and provide monitoring to ensure each residents nutrition parameters are maintained within acceptable parameters to prevent avoidable decline in nutritional status, unless their clinical condition demonstrates that this is not possible. The policy indicated at the discretion of the interdisciplinary team and/or physician residents at high risk maybe continued more frequents weight monitoring.