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	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Bryn Mawr LLC	275 Penn Avenue North Minneapolis, MN 55405

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow a resident to safely self administer medications for 1 of 1 (R5) resident reviewed who stored medication at their bedside. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE] indicated R5 was independent with making her own decisions, didn't have signs or symptoms of delirium or hallucinations or refused personal cares and medications. R5's Clinical Diagnosis record printed 5/2/24, indicated diagnoses of delusional disorders(one or more firmly held false beliefs that persist for at least one month), epilepsy (brain disorder that causes recurring, unprovoked involuntary movement) , major depressive disorder, mild intellectual disabilities, insomnia, somatization disorder (characterized by an extreme focus on physical symptoms such as pain or fatigue that causes major emotional distress and problems functioning), bradycardia (slow heart rate) , history of falling and thrombocytopenia (a blood disorder that can cause bleeding). R5's Clinical Physician orders printed 5/2/24 lacked orders for the self-administration of medications. R5's electronic medical record reviewed 5/2/24, lacked an assessment for self-administration of medications. During interview on 5/1/24 at 8:21 a.m., R5 stated the nurses put my medications on my tray [on a med cup] and I take them on my own, as I am eating my food. R5 stated she refused to take her medications if the staff didn't leave them (her medications) in her tray. During observation and interview on 5/1/234 at 8:46 a.m., licensed practical nurse (LPN)-C brought R5's breakfast tray and a medication cup containing several medications. LPN-C helped R5 to set up her meal, placed the medication cup next to the plate and left the room. R5 asked to have some peace to eat her breakfast and was left alone. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/1/24 at 8:51 a.m., LPN-C stated I left her medications at bedside, she won't take them right away, she would take them as she eats. Later, I will check and see if she took her meds or not. LPN-C stated, he would know if the medications were administered by asking R5 if she took her medications or not, and by making sure the medication cup was empty. LPN-C didn't know whether R5 had an order or an assessment to self-administer medications. During interview on 5/1/24 at 11:08 a.m., director of nursing (DON) stated R5 had a self-administration assessment done in 2016, which indicated she was unable to safely administer her own medications. Additionally, R5 currently didn't have an order or an assessment to self-administer medications. DON stated they will need to reassess the resident and determine if she is safe to self-administer her medications. R5's 2016 self administration assessment was requested and not received. The facility policy titled Self-Administration of Medications dated 2/2024 indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure maintenance services were provided in a timely manner to address broken window blinds to help provide a private, homelike living space for 2 of 2 residents (R65, R85) reviewed whose window blinds had broken exposing their room to outside public view. Findings include: R65's quarterly Minimum Data Set (MDS), dated [DATE], identified R65 had intact cognition. R85's admission MDS, dated [DATE], identified R85 had intact cognition. On 4/29/24 at 3:38 p.m., R65 was observed lying in bed while in his room. R65's bed was positioned closest to the doorway entering the room and, on the other side of a half-pulled privacy curtain, was R85's bed positioned against the outside wall with a large picture window immediately above it. However, below the window and, in part, underneath R85's bed was a long, white-colored roll-up style curtain on the floor. R65 stated the window shade had been in disrepair for several months and staff still had not repaired it despite R65 and R85 both asking for such many, multiple times, expressing they'd been asking for quite awhile. R85 was seated on his bedside at this time, and expressed he would like to have the window curtains repaired so as to have privacy while in bed as the window opened to the street-level with housing across the road. R85 added, In a perfect world, we'd [R85, R65] have a curtain for privacy. R85 stated someone from maintenance had been in the room about a week prior and measured the window, however, they were unsure what for as, They [maintenance] didn't say much. R85 verified the window is left open to public view at all times, including the night hours, and expressed he would like it fixed. Further, R65 and R85 both verified no attempts to cover the window, including just on a temporary basis (i.e., with paper, other draping), had been offered or attempted to their recall. The following day, on 4/30/24 at 11:13 a.m., R65 and R85's room was again observed. The window curtain remained on the floor below the window rolled up with no visible attempt to provide privacy seen (i.e., paper, other curtain or draping). On 4/30/24 at 11:45 a.m., registered nurse (RN)-D observed R65 and R85's room' window with the surveyor. RN-D verified the curtain was in disrepair and expressed aloud, I think they was supposed to fix it. RN-D stated they recalled the maintenance director (MD) had been down last week and was aware of the window curtains being broken; however, expressed they were unsure what, if any, repairs or actions were being taken with the window curtains. RN-D verified the window opened to the outside, street-level with housing across the road. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately following, on 4/30/24 at 11:49 a.m., MD entered the unit and observed the curtains in disrepair with the surveyor present. MD stated the administrator was aware of the curtains and, as a result, they had already placed an order for the needed parts to address and resolve it. MD stated they were unaware how long the curtains had been on the floor but expressed it was not the first time they had broken adding, I have fixed it so many times. MD inspected the curtain' mounting brackets and stated one of them was bent and a spring mechanism (which caused them to roll up) was missing but reiterated new parts had been ordered and would be there by weeks' end. MD reiterated they were unsure how long the curtains had been broken but expressed any submitted TELs would have better record of it. MD stated they had not been told or directed, thus far, to place any temporary draping or solutions over the windows to afford the residents' privacy but added, We can get something. A provided Work Order #4459, printed 4/30/24, identified the order was created on 2/26/24 with a title, Station 5 blinds, and listed R65 and R85's respective room number. The order outlined, Blinds in most rooms on station 5 do not open, and listed a due date which read, Mar. 4, 2024, along with a priority level recorded, Medium. The order lacked any further information to demonstrate what, if any, actions had been taken to resolve the issue including on a temporary basis. On 4/30/24 at 1:25 p.m., the administrator was interviewed and verified they were aware of the blinds being in disrepair adding it had been an issue due to them being custom-made. The administrator explained they had emailed other persons, including from the corporate team, to question getting the blinds replaced last on 4/22/24, and they were still determining the cost and scope (i.e., number needed) before the new replacements were ordered as some of the questions on the scope of the order had not been answered yet. The administrator stated they then spoke with MD about it who expressed they needed five blinds to fix all the affected rooms. As a result, the administrator stated they just now ordered them and would pick them up later in the week. The administrator acknowledged the time frame outlined by the provided Work Order and stated they were not sure if the curtains had been in physical disrepair since then or not. However, the administrator acknowledged the delay in getting them fixed and expressed such potentially happened due to only one maintenance person (i. e., MD) being onsite and other day to day things that come up. The administrator stated the care center was going to move the affected residents, including R65 and R85, to a different unit but it had been delayed so now, as a result, the issue would be brought to IDT to determine another temporary solution for the blinds. The administrator stated it was important to ensure window curtains or blinds were fixed timely and provided so residents' had privacy and as it was a basic amenity. A facility' policy on window coverings or maintenance was requested, however, none was received.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 1 residents (R28) who required assistance with personal hygiene. Findings include: R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 had intact cognition and needed extensive assistance with toilet use, personal hygiene, and dressing. R28's diagnostic report dated 8/8/22, indicated R28 was diagnosed with a stroke with resulting right-sided weakness, diabetes, and muscle weakness. R28's care plan dated 4/5/23, indicated R28 required physical assistance with activities of daily living as R28 had limited physical mobility and weakness resulting from the stroke. R28's Weekly Skin Inspections dated 3/1/24- 4/26/24, indicated it was not necessary for R28 to receive fingernail trimming during this period, leaving the box marked refused unchecked. R28's order summary report dated 4/2/24, did not address nail care. During an observation and interview on 4/29/24 at 2:09 p.m., R28 was observed sitting in his wheelchair in his room with his fingernails over 1/4 of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R28 stated he was unable to cut his fingernails by himself and had been asking staff for assistance with clipping his nails for over a week. R28 stated staff would tell him that they would come back with clippers but never did. R28 stated his fingernails had been long for a while and it really bothered him when they looked that way. During an interview on 4/29/24 at 2:40 p.m., nursing assistant (NA)-C stated R28's fingernails looked long and dirty underneath. NA-C stated they do not cut residents' fingernails on a schedule but on resident request but was not sure if R28 had requested his fingernails to be clipped. During an interview on 5/1/24 at 2:41 p.m., registered nurse (RN)-C stated he had completed the weekly skin inspection on 4/26/24 and had noted R28's looked outgrown and after reviewing his documentation, was unsure why R28's nails had not been trimmed. RN-C stated that if R28 had refused fingernail trimming he would have marked it as refused on the weekly skin inspection which he did not. During an interview on 5/2/24 at 11:34 a.m., the director of nursing (DON) stated nail care should have been completed on bath days and as necessary. The DON stated nail care was completed by either the NA or the nurse depending on the residents' diagnoses. The DON stated she thought staff completed a form to indicate whether nail care was completed, offered, or refused but would check and provide any additional documentation. The DON stated completing regular fingernail care was important to decrease the likelihood of infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Nail Care policy dated 11/19, indicated assistance was to be provided to the resident to ensure safe and hygienic nail care was completed but did not indicate the frequency of this care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview, and document review the facility failed to ensure staff provided cares according to standard of practice for gastrostomy tube (stomach insertion feeding tube) care for 2 of 2 residents (R19, R67) reviewed for tube feedings. Findings include: R19's significant change Minimum Data Set (MDS) dated [DATE], identified R19 dependent on helper (staff) for toileting and maximal assistance of staff for transfers, personal hygiene, upper body dressing, lower body dressing, and shower/bath. In addition, R19 diagnoses included hemiplegia/hemiparesis (partial paralysis) affecting left non-dominant side, stroke (cell death to portions of the brain causing loss of functioning), dysphagia (inability to swallow), malnutrition (body not getting enough nutrients), hypertension (high blood pressure), muscle weakness, and had a gastrostomy tube (feeding tube to stomach) for portion of caloric and fluid intake. R19's care plan (CP), printed 5/2/24, identified R19 requires tube feeding r/t [related to] dysphagia and inadequate oral intakes dependent with tube feeding and water flushes, with a start date on the CP of 6/14/23. R19's medication administration record (MAR) and treatment administration record (TAR) for April and May indicated the following orders: -water flush 150 milliliters (mL) QID (four times a day) via G-tube [feeding tube inserted in abdomen], four times a day for water flush document amount infused -place a new syringe daily including date and resident initials. Rinse syringe with water after each use. Every shift. April 2024 MAR/TAR indicated the following: -the water flush order was signed off by a nurse indicating that 150 mL water flush was completed from 4/22/24 to 4/29/24 except for 4/26/24 AM (morning) and noon which was left blank. -the order to place a new syringe daily was signed off by a nurse every shift from 4/22/24 to 4/29/24. During observation on 4/29/24 at 2:29 p.m., R19 was lying in bed. A graduated cylinder with a piston syringe resting inside was noted to be on the table to the left side of the bed along with a piston syringe lying directly on the table. The graduated cylinder and piston syringe inside were dated 4/22 with initials DN. The piston syringe on the table did not have a date or initials. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 4/29/24 at 6:35 p.m., licensed practical nurse (LPN)-B stated that they are familiar with R19 and work with them often. LPN-B stated they are currently not assigned to work with R19 today. LPN-B stated the standard is to change the graduated cylinder and syringe at least daily as it is an infection control issue. LPN-B verified the graduated cylinder and a piston syringe was dated 4/22 with initials DN and the piston syringe on the table did not have a date or initials. R67's annual Minimum Data Set (MDS) dated [DATE], identified R67 dependent on helper (staff) for all effort of activity for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, personal hygiene, and mobility. R67's diagnoses included stroke (cell death to portions of the brain causing loss of functioning), aphasia (inability to speak well), dysphagia (inability to swallow), respiratory failure, hypertension (high blood pressure), muscle weakness, and had a gastrostomy tube (feeding tube to stomach) for nutrition and medication administration. R67's care plan, printed 5/2/24, indicated the resident requires tube feeding r/t [related to] swallowing problem post stroke with inadequate oral intakes the resident is dependent with tube feeding and water flushes which was initiated on 2/3/23. R67's MAR/TAR for April and May included the following orders: -enteral feed order four times a day water flush via gravity 200 mL R67's MAR/TAR lacked orders for placing new graduated cylinder and piston syringe every 24 hours. R67's April's MAR/TAR indicated the following: -the water flush order was signed off by a nurse indicating water flush was completed from 4/22/24 to 4/29/24 except for 1pm on 4/26 which indicated 0 mL of water was administered. During observation on 4/29/24 at 1:39 p.m., R67 was lying in bed looking out the window. It was noted that on table to the left of R67 was a graduated cylinder with a piston syringe resting inside was dated 4.22 with initials D.N. on them. On a subsequent observation at 6:25 p.m., the graduated cylinder with same piston syringe resting inside was observed sitting on the table as it was dated 4.22 with initials D.N. During interview, LPN-B verified the graduated cylinder with piston syringe resting inside both had dates of 4. 22 with initials D.N. LPN-B stated they were not currently working with R67. During interview on 4/29/24 at 6:40 p.m., LPN-A verified they were currently working with R19 and R67 and responsible for their care. LPN-A verified the graduated cylinder and piston syringe inside were dated 4/22 with initials DN and the piston syringe on the table did not have a date or initials. LPN-A verified they had completed a water flush and they had used the graduated cylinder and piston syringe with the date of 4/22 on it. LPN-A stated that the cylinder and syringe should be changed every couple of days or every week and I didn't even look at before I used it on either resident. During interview on 5/01/2024 at 8:20 a.m., LPN-A stated that graduated cylinders and piston syringes are changed to protect from infections. LPN-A stated it is documented in PCC (electronic medical record) in the MAR. LPN-A stated there would be an order put in to change it. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/01/24 at 9:21 a.m., registered nurse (RN)-B stated the expectation is to change the cylinders and syringes for tube feedings at least every 24 hours. RN-B stated they need to be changed to prevent infection as they can become contaminated and don't need them just sitting around. RN-B stated the nurses are responsible for checking the dates prior to using them and changing them out if needed. RN-B stated if the date is more than 24 hours ago, they should be disposed of. During interview on 5/01/24 at 1:52 p.m., director of nursing (DON) who is also facility infection preventionist stated the syringe and cylinder used for tube feedings needed to be discarded at least every 24 hours. DON stated it is an infection control issues as bacteria can get in and increase the risk of infection. She stated it is documented in the treatment order. DON verified the order for R19 and stated the order is not very clear. DON verified the nurses must have been just rinsing out the water as if there is a dated syringe and cylinder of 4/22/24 then they must not have been changing it and just rinsing it out. DON verified there was currently no orders for R67 to change the cylinder/syringe daily. A facility policy Enteral Tube Feeling via Syringe, dated 3/24, was provided. Policy included ensure that syringe has been labeled with resident's name and marked with date and time. If date and time are greater than 24 hours, dispose and obtain new supplies.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review the facility failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 3 of 3 (R18, R34 and R74) residents reviewed who's diagnoses included post-traumatic stress disorder (PTSD). Findings include: R18 R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 admitted to facility on 10/16/20 with impaired cognition, limited mobility due to left below knee amputation, and diagnoses of diabetes, seizure disorder, anxiety, depression, schizophrenia, and post traumatic stress disorder (PTSD). R18's assessment titled Trauma Questionaire dated 7/22/23 indicated, The goal of the questionnaire is to provide each resident with the best person-centered care & customer service while in our facility. We?d [sic] like to ask some questions related to your personal history to obtain awareness of any specific practices or preferences you may have, as well as any past experiences that may cause distress to you during your stay at the skilled nursing facility. You have the right to decline to answer any of the questions, & you may stop the interview at any time if you do not wish to continue. You may also choose to complete the questionnaire independently. This form provided questions regarding past traumatic experiences, triggers, and coping strategies, along with Information from questionnaire should be added to progress notes and care plan. Options to answer the questionnaire was, 1. Yes, 2. No, or 3. Decline. This form was not filled in. R18's care plan focus dated 8/9/23 indicated, Resident is at risk for alterations in behavior related to trauma, including dx of PTSD. The goal associated with teh focus indicated, Resident will develop coping skills to address stated trauma and associated intervention as, Staff will consider past trauma when engaging in work with resident. R18 care plan lacked description of trauma and potential triggers. R18's Kardex (summary of care needs used by nursing assistants) printed 4/30/24, lacked information on his past trauma and potential triggers. During interview with R18 on 4/30/24 at 2:53 p.m., R18 denied being asked about his PTSD from facility. R18 stated, I was in Vietnam. It depends what my triggers are. Loud noises make it worse for me. R34 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's quarterly MDS dated [DATE] indicated R34 was admitted to facility on 8/14/22 and had intact cognition, required assistance with all cares, and had diagnoses of chronic inflammatory demyelinating polyneuritis (slowly developing autoimmune disorder in which the body's immune system attacks the covering of the body's nerves), anxiety, depression, psychotic disorder, PTSD, asthma, lupus (autoimmune disorder in which the body's immune system attacks the body's tissues and cells), and chronic pain. R34's Trauma Questionaire dated 2/5/24, indicated the form was associated with Admission and only one question was answered which was, 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? The answer was, No. The form lacked responses to seven out of the eight questions including, Information from questionnaire should be added to progress notes and care plan. R34's care plan dated 9/7/23 documented, Resident is at risk for alterations in behavior related to trauma, including: Dx [diagnosis] of PTSD and the associated intervention of, Staff will consider past trauma when engaging in work with resident. R34's care plan lacked a description of trauma and the potential triggers. R34's Kardex printed 4/30/24, lacked information on his past trauma and potential triggers. During interview with R34 on 4/30/24 at 3:02 p.m., R34 stated, no one here has directly asked me what my PTSD triggers are which is bringing up my family in a conversation. I am always worrying about my family's safety and health. I can't stop thinking of them. Talking about them makes me anxious and upset. R74 R74's quarterly MDS dated [DATE] indicated R74 was admitted to facility on 12/13/23 and had impaired cognition and diagnoses of anoxic brain damage (damage to brain tissue from lack of oxygen), PTSD, and adjustment disorder with anxiety. R74's Trauma Questionaire dated 2/7/24, indicated the form was associated with Admission and only one question was answered which was, 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? The answer was, No. The form lacked responses to seven out of the eight questions including, Information from questionnaire should be added to progress notes and care plan. R74's Diagnoses List downloaded on 4/30/24 indicated a PTSD start date as 3/5/24. R74's Psychiatric Evaluation dated 3/8/24, documented Significant for PTSD and answer questions appropriately. The Assessment Documented, history of chart reported PTSD, presumably from her brother's [NAME]. R74's care plan printed 5/1/24 indicate R74 is own decision maker and lacked any information regarding PTSD diagnoses and potential triggers. R74's Kardex printed 4/30/24, lacked information on his past trauma and potential triggers. (continued on next page)

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The Villas at Bryn Mawr LLC	275 Penn Avenue North Minneapolis, MN 55405

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with nursing assistant (NA)-A on 4/30/24 at 8:46 a.m., NA-A stated, I don't know if [R74] has it [PTSD] or if there are triggers to make her fly off the handle. NA-A stated expectation of the residents' Kardex to inform him of behaviors or approaches to use or to avoid. NA-A stated R74's Kardex did not inform him or the staff of PTSD diagnosis and triggers. During interview with NA-B on 4/30/24 at 1:05 p.m., NA-B stated she had worked at facility for a year and normally worked full time on the second floor where R18, R34, and R74 resided. NA-B stated expectation of nursing assistants to receive assignment upon starting every shift and to review each residents electronic medical record in the Kardex section to identify what services and assistance each resident requires. NA-B stated, I can't recall if I got any training about PTSD and triggers. But it is important to know what things can cause a person to re-live the painful episode. I don't want to do anything that might make someone break down or freak out. It is not discussed around here. During interview with R74 on 4/30/24 at 3:05 p.m., R74 stated, no one asked me nothing about what trips me off. My trigger is people talking too fast and I feel like they don't take the time to listen to me. I have to be heard and get so mad and frustrated when they rush me. I hate it. They don't need to do that. During interview with registered nurse (RN)-A on 4/30/24 at 3:11 p.m., RN-A stated [trauma responses] comes when it is triggered. Could show up as confusion too so we try to re-direct them if they are acting out. RN-A stated each person has different experiences and we can't really help them if we do not know what triggers to avoid. Also, the resident care plan and Kardex is where that information should be found. During interview with administrator on 5/1/24 at 9:18 a.m., the administrator stated, we have an opportunity for trauma informed care education and review for all of our staff. I believe they are doing it but it is not written down on the care plan for staff to follow. It should be written down in the care plan and electronic medical record (EMR) about possible triggers and ways to address or treat the residents. During interview with social serviced director (SS)-D on 4/30/24 at 1:41 p.m., SS-D stated her role is to interview and fill out the trauma questionnaire on all admissions. I have a designee and me both do it. In addition, SS-D stated, It is important to understand and ask what the triggers are for our residents wo we can collaboratively address with all the disciplines to care plan effectively. This is not being done at this time. It should be. I am not aware of staff education on trauma informed care. Staff who directly interact and work with the residents should know what strategies to use for taking care of these residents. Staff should know what the specific triggers are that stress out and re-traumatize the resident. Everyone is unique and the care plan should address that. During interview with nurse manager (RN-B) on 5/1/24 at 10:57 a.m., RN-B stated he had worked at facility for several years and was nurse manager of second floor of facility which includes R18, R34, and R74. RN-B stated, I don't think [R74] has any trauma history. I don't know if [R74] has PTSD. RN-B looked in R74's EMR diagnoses list and and stated, [R74] has PTSD. RN-B stated, [R74] has PTSD so the staff can individualize our approaches to the residents and ensure safety for both the resident and staff. To build trust with these residents. I do not see any individualized interventions [in the care plans] for [R34, R74, and R17]. The ones in there are very general. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Trauma Informed Care, revised 2/24/23, direct policy philosophy as, Staff are aware of individualized strategies to help eliminate, mitigate or sensitively address a resident's triggers. In addition, Resident-Care Strategies include: 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.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure required nurse staffing information was posted on a daily basis including over the weekend. This had potential to affect all 87 residents, staff, and visitors who could wish to review this information. Findings include: On 4/29/24 at 11:47 a.m., the survey team entered the nursing home for the recertification survey through the main entrance. Inside, a reception desk was present and on the wall adjacent a clear-glass container was attached to the wall which had a single white-colored posting titled, Daily Nurse Staffing Form Villa at [NAME] Mawr. The posting had the total and actual hours of the licensed staff, however, the posting was dated, Friday, April 26, 2024. There was no posted information visible for 4/27/24, 4/28/24, or 4/29/24 (the current date). When interviewed on 4/29/24 at 11:49 a.m., the receptionist (RCP)-A stated the staffing coordinator was responsible to post the information. RCP-A verified the posting was dated 4/26/24 and stated they would alert the staffing coordinator to get today's information posted. On 4/30/24 at 9:19 a.m., the administrator was interviewed. They verified the staffing coordinator should be posting the information during the week and, on weekends, the receptionist or overnight nurse should ensure it gets done. The administrator stated they followed up with the staffing coordinator who expressed the postings had been printed but were accidentally left in the printer and not posted. The administrator verified the information should be posted daily and stated the facility had identified this same issue on a mock survey a few months prior so they were working on it. The administrator verified the front display case, as seen on 4/29/24, was the only location in the care center the information was typically posted and stated it was important to ensure such postings were done so people can see what we're staffing for the day. A facility' Nursing Hours Posting policy, dated 10/2022, identified the care center would post the nurse staffing data on a daily basis at the beginning of each shift. This was required per Federal law.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to ensure dishware was cleaned and sanitized in a manner to reduce the risk of cross-contamination and/or foodborne illness. This had the potential to affect all 88 residents residing in the facility at the time of the survey. Findings include: During observation and interview during the initial kitchen tour with dietary manager (DD) on 4/29/24 at 12:07 p.m., DD demonstrated the low temp machine use and chlorine testing for sanitization for the Ecolab ES-2000 low temperature commercial dishwasher. DD pointed to a container with chlorine test strips and a three ring binder on a shelf in the dishwasher area and stated the kitchen staff were required to document the wash temperature using a mechanical temperature indicator and obtain a chlorine measurement result following every meal each day when operating the machine. Observation of dishmachine testing by the DD indicated a temperature of 118 degrees Fahrenheit which the DD stated, It must be at least 120 degrees. Also, the chlorine sanitizing strips result was inconclusive indicating the sanitizing properties were not functioning properly per the DD. DD stated this was the first time she was aware of any issues with the functioning of the dishwasher. DD and surveyor then reviewed the April 2024 Low Temperature Dish Machine Temperature Log and identified the missing entries for the following dates and mealtime: 4/24/24: Supper 4/25/24: Breakfast, Lunch, Supper 4/26/24: Breakfast, Lunch, Supper 4/27/24: Breakfast, Lunch, Supper 4/28/24: Breakfast, Lunch, Supper 4/29/24: Breakfast, and Lunch DD stated, we have some holes in that. It should be filled out every day for each meal time. Manufacturer instructions for the Hydrion Chlorine pH and sanitizer test kit directions indicated, Tear off a strip of test paper from the dispenser: immerse it in the solution and compare the resultant color with the color chart [provided]. During interview with DD on 4/29/24 at 6:44 p.m., DD stated, the dishwasher is not working. The test strips are not registering. In addition DD stated, it is a concern with the dishwasher not working because we can't guarantee or be certain that they [dishes, etc] are being washed and sanitized appropriately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with DD on 5/1/24 at 7:32 a.m., DD stated the facility did not have a user manual for the ES-2000 dishwasher. If there are issues [with the] dishwasher, they [staff] should call Ecolab. DD stated, I expect staff to tell me right away if there is a problem with the dishwasher. I was not aware that the dishwasher was not working. During interview with dishwasher representative (ER) on 5/1/24 at 8:46 a.m., ER stated, I am familiar with the ES-2000 dishwasher. Very familiar. ER stated the ES-2000 uses a chlorine based sanitizer to sanitize dishes through the wash cycle. ER stated, [facility] should be testing at least once per day. ER stated, if the machine results were, not in spec [specifications], it can leave the door open to infection because the dishes are not sanitized. During interview with dietary aide (D)-A on 5/1/24 at 7:39 a.m., D-A stated she had worked for facility in her role for over [AGE] years. DA stated, We test [using] the strips [chlorine sanitizer] every day. Hydrion [name brand of chlorine test strips] chlorine test every meal time when running the dishes through the washer here. If the results were off, then I would do it [test] a couple times to [sic] making sure I ain't tripping [forgetting]. If [DD] was not here I would call Ecolab to fix the machine. I have not had to call Ecolab. We had training on using it. If there is no documentation in the log here then there are open slots and we don't know if it is safe to use. It is important to test every meal so we make sure the residents don't get sick. People can get sick if we don't test and make sure the dishes and all are really clean. During interview with D-A on 5/1/24 at 2:18 p.m., D-A stated, I was scheduled on some of those days but did not use the dishwasher. Nobody told me that there was a problem with that thing or not testing the water and temp. We know what to do [with testing]. During interview with D-B on 5/1/24 2:15 p.m., D-B stated, we know we need to write it down in the book there and if there is something not right then we let our supervisor know. I don't recall hearing about anything wrong with that dishwasher. During interview with D-C on 5/1/24 at 22:20 p.m., D-C stated, Oh yeah, I did not work the dishwasher on those days. I didn't hear about any problems with that dishwasher. We got to test the water with those strips there and run the temp thing through it at every meal time when we do dishes. We should write it down in the book there and if there is a problem I would tell my supervisor or someone. During interview with D-E on 5/2/24 at 9:48 a.m., D-E stated, we got to write down the result of the test each mealtime. If chlorine is bad we tell [DD] and use paper plates. During interview with maintenance director (MA) on 5/1/24 at 7:52 a.m., MA stated, Ecolab will come and look at dishwasher if there is issues. I make sure the temp is right and Ecolab manages the chemicals. During interview with registered dietician (RD) on 5/1/24 at 10:32 a.m., RD stated, [lack of daily testing for sanitization is] worse case scenario is that the dishes and utensils are not sanitized correctly and could cause illness. Facility policy titled Dishwasher dated 09/2012 direct staff to, Record temperature per policy of facility. The policy failed to mention how and when to use sanitizing strips.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure transmission-based precautions (TBP) were assessed for and implemented for 1 of 1 residents (R11) with symptoms of a respiratory illness with the potential to affect 23 residents residing on the unit. In addition, the facility failed to ensure resident education was provided and smoking infection control practices were followed for 2 of 2 residents (R22, R61) assessed for smoking. Findings include: TBP The Centers for Disease Control and Prevention (CDC) guideline titled Transmission-Based Precautions dated 1/7/16, indicated droplet precautions should be used for residents with known or suspected infections of pathogens transmitted by respiratory droplets that are generated by coughing, sneezing, or talking. The guideline indicated the resident should wear a mask, put in a single room if possible and a staff should wear a mask when entering the resident room or are in the resident space. The facility should limit the transportation or movement of the resident outside of the room as much as possible and ask the resident to follow respiratory hygiene/cough etiquette. The CDC guideline titled Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated 11/29/22, indicated TBP should be implemented based on the resident's clinical presentation and possible infection diagnoses as soon as possible and then discontinued when more clinical information was available such as confirmatory laboratory results. The guideline indicated that to the extent possible, a resident should be placed in a single room when awaiting clinical assessment. R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 had intact cognition and was diagnosed with chronic obstructive pulmonary disease (COPD- incurable lung disease causing breathlessness, frequent coughing, and chest tightness), anxiety, and depression. R11 required substantial assistance with dressing and personal hygiene and required set-up help with oral hygiene. R11's care plan dated 4/23/23, indicated R11 had an altered respiratory status related to COPD with a goal of maintaining a normal breathing pattern. The care plan included interventions such as administering medications as ordered, monitoring for symptoms of respiratory distress, and documenting abnormal breathing patterns. The care plan did not include the use of TBP. R11's progress note dated 4/25/24 at 1:42 a.m., indicated R11 was coughing throughout the shift and given medication for symptom relief. R11's Change of Condition progress note dated 4/25/24 at 11:48 a.m., indicated R11 was coughing throughout the previous night. The writer noted R11's lungs were assessed and were clear, a COVID-19 test was administered and was negative, and the provider was notified. R11's progress note dated 4/27/24 at 11:27 p.m., indicated R11 had been coughing throughout the shift and was given medication for symptom relief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's progress note dated 4/29/24 at 1:52 a.m., indicated R11 had been coughing throughout the shift and was given medication for symptom relief which was not effective as she continued to cough all night. R11's Change of Condition progress note dated 4/29/24 at 1:26 p.m., indicated R11 had been coughing a lot so a COVID-19 test was completed and which was negative. The provider was notified and ordered a chest x-ray. R11's progress note dated 4/29/24 at 3:06 p.m., indicated R11 had been coughing a lot so the provider was notified and a chest x-ray and antibiotics were ordered for pneumonia. R11's progress note dated 4/30/24 at 7:59 a.m., indicated R11's chest x-ray results were received, and no disease process was noted. The results were faxed to the provider. R11's progress note dated 4/30/24 at 2:52 p.m., indicated R11's chest x-ray was negative but it was too early for the x-ray to show pneumonia per the provider report. R11's Order Summary Report dated 4/30/24, indicated R11 was receiving one 875-125 milligram (mg) tablet of Augmentin (an antibiotic) orally two times a day for pneumonia. The order summary did not include an order for TBP. During an observation and an interview on 4/29/24 at 5:24 p.m., R11 was observed in her room lying in bed without a mask on. No TBP sign or cart was observed by the room door. Licensed practical nurse (LPN)-A was observed entering R11's shared room without donning personal protectice equipment (PPE) and assisting R11 with repositioning. R11 was observed with a wet-sounding cough during repositioning. R11 stated she felt shorter of breath than she normally did, and her cough had also been a lot worse. R11 stated overall she had not been feeling well and it had been a lot worse that day. During an observation on 4/29/24 at 6:01 p.m., R11 was observed repeatedly coughing while sitting at a dining table in the common area about one foot from another resident. Both residents were observed not wearing masks. Nursing assistant (NA)-D was observed not wearing PPE, squatting down next to R11 with a hand on R11's right armrest with her face about a foot away from R11 talking with her. During an interview on 4/29/24 at 6:06 p.m., LPN-A stated he was the nurse in charge of R11's care and had noted R11 had not been feeling well lately with increasing coughing, a decreased appetite, and tiredness. LPN-A stated he had tested R11 for COVID-19 today and it had come back negative. LPN-A stated a chest x-ray and antibiotics had been ordered for possible pneumonia, but they had not tested for any other viruses. LPN-A stated R11 was not and had not been on any TBP today. LPN-A stated he had not been wearing a mask during her cares since she was not on TBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/24 at 6:26 p.m., registered nurse (RN)-B, the nurse manager, stated nursing staff had first noted R11's symptoms of a possible respiratory illness on 4/25/24. RN-B stated R11 usually had a cough but it was much worse recently. RN-B stated R11 also had additional symptoms including fatigue and a low appetite. RN-B stated nursing staff had let the provider know of R11's symptoms today and the provider ordered a chest x-ray to rule out pneumonia as a cause. RN-B stated the nursing team had tested R11 for COVID-19 and she was negative but R11 had not been tested for any additional viral illnesses. RN-B stated R11 had not been on any sort of TBP during the past week. RN-B stated the clinical team as a whole decided together if a resident needed TBP. RN-B stated he could have initially started these precautions when symptoms of a respiratory illness began, but that had not occurred. RN-B stated he would base the decision on whether to utilize TBP on the facility policy. During an interview on 4/29/24 at 6:35 p.m., the director of nursing DON/ infection preventionist (IP) stated, given R11's symptoms of a respiratory illness without a laboratory result confirming what the illness was, she would have expected R11 to have been put on TBP such as droplet or airborne depending on the case, to decrease the likelihood of the respiratory illness spreading to other residents. The DON stated she was not aware of TBP being utilized for R11. The DON stated that R11 should have been advised to eat in her room while displaying symptoms of a respiratory illness to decrease the risk of spreading the unknown illness to another resident. During an interview on 5/2/24 at 11:32 a.m., the DON stated if R11 was on TBP, staff were expected to add this to the care plan and the orders and put a TBP sign on the door of the resident's room. The facility Infection Prevention and Control: TBP policy dated 7/31/23, indicated the facility would follow CDC guidance regarding TBP. The policy indicated droplet precautions would be utilized to prevent respiratory droplets containing viruses or bacteria from spreading to another individual through coughing, sneezing, or talking. The policy indicated droplet precautions consisted of the use of a face mask when entering the resident room, as well as providing a private room or cohorting the resident with other residents with the same infectious agents when a private room was not available. Smoking R22's significant change MDS dated [DATE], indicated R22 was diagnosed with heart failure, diabetes, and COPD. R22 required substantial assistance with eating, oral hygiene, and dressing. R22's care plan dated 4/16/24, indicated the facility would hold R22's smoking materials while not in use however R22 was assessed as safe to independently smoke. R22's Brief Interview for Mental Status (BIMS) assessment dated [DATE], R22 scored 15/15, indicating intact cognition. R22's Smoking Evaluation dated 4/22/24, indicated the facility would hold R22's smoking materials while not in use however R22 was assessed as safe to independently smoke. R22's medical record was reviewed and did not indicate education had been given regarding infection control practices while smoking and/or refusal to follow these practices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R61's quarterly MDS dated [DATE], indicated R61 had severely impaired cognition and was diagnosed with a traumatic brain injury (TBI) and a seizure disorder. The MDS indicated R61 was independent with eating, oral hygiene, and dressing. R61's Smoking Evaluation dated 3/12/24, indicated the facility would hold R61's smoking materials while not in use however R61 was assessed as safe to independently smoke. R61's care plan dated 3/14/24, indicated the facility would hold R61's smoking materials while not in use however R61 was assessed as safe to independently smoke. The care plan indicated R61's guardian approved one cigarette per smoking time. R61's Kardex dated 5/2/24, indicated R61 was on a staff one-to-one related to a high fall risk. R61's medical record was reviewed and did not indicate education had been given to the resident or guardian regarding infection control practices while smoking and/or refusal to follow these practices. During an observation on 4/30/24 at 1:46 p.m., R22 and R61 were observed sitting on the smoking patio with nursing assistant (NA)-E within arm's reach, facing both residents. R61 was observed to pass the lit cigarette he had been smoking to R22. R22 was observed to smoke from the cigarette and then pass the cigarette back to R22. During an observation on 4/30/24 at 1:51 p.m., NA-E assisted R22 in lighting a cigarette and then sat back down across from the two residents. R22 smoked from the cigarette and then passed it to R61. The cigarette was observed passed between the residents and used by both multiple times. The cigarette was noted to be smoked down to almost the filter when NA-E assisted the residents with extinguishing it. During an interview on 4/30/24 at 2:20 p.m., NA-E stated this was the first time she had assisted residents with smoking, so she had not seen the residents share cigarettes previously. NA-E stated she had not received training on what to look for when assisting residents with smoking but now realized she would be worried about the residents spreading a virus or other kind of infection when sharing a cigarette. During an interview on 4/30/24 at 2:41 p.m., R22 stated he was friends with R61, so they frequently shared the same cigarette, but no one had ever talked to him about any risks associated with this practice. During an interview on 5/1/24 at 1:42 p.m., R61 stated he frequently shared cigarettes with R22, but he did not recall any staff members ever telling him there was any infection risk related to him doing this. During an interview on 5/2/24 at 11:33 a.m., the DON/IP stated she would have expected the NA to redirect the residents from sharing cigarettes due to the risk of spreading infections. The DON stated she was not aware of education being provided to the residents regarding infection control practices while smoking but she would investigate it and provide any additional documentation. (continued on next page)

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	05/02/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Policy and Procedure for Safe Smoking dated 4/3/23, indicated the smoking area would be supervised by staff during the designated smoking times. The policy indicated that residents were not allowed to give/borrow cigarettes to other residents but did not address infection risks related to residents smoking the same cigarette.

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	05/02/2024

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on interview and document review, the facility failed to offer or provide the recommended pneumococcal vaccine to 1 of 5 residents (R74) reviewed for immunizations. Finding include: The National Center for Immunization and Respiratory Diseases feature, dated 9/22/23, indicated adults 19 through [AGE] years old with certain risk conditions including i.e., chronic heart disease, congestive heart failure and cardiomyopathies should receive the pneumococcal vaccine. Individuals who had never received any pneumococcal vaccine, regardless of risk condition the recommendation is to give 1 dose of PCV15 or PCV20. When PCV15 is used, it should be followed by a dose of PPSV23 at least 1 year later. The minimum interval (8 weeks) can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will be then complete. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete. R74's quarterly Minimum Data Set (MDS) dated [DATE], indicated R74 had moderate cognitive impairment, had no behaviors or hallucinations, was independent with activities of daily living and needed supervision with showers. R74's Clinical Diagnosis report printed 5/2/24, indicated diagnoses of anoxic brain damage (lack of oxygen to the brain), adjusting disorder, other cardiomyopathies (a condition that prevents the heart to effectively pump blood to the rest of the body), dysphagia (difficulty swallowing), cardiac arrest (unexpected loss of heart function, breathing, and consciousness), and psychoactive substance abuse. R74's medical record and the immunization record printed 5/2/24, lacked documentation of whether the pneumococcal vaccine was declined or offered to the resident or rationale for the vaccine not being offered. During interview on 5/2/24 at 9:44 a.m., R74 stated she wasn't sure if the staff talked to her about receiving a pneumococcal vaccine. During interview on 5/2/24 at 10:30 a.m., director of nursing (DON) stated the pneumococcal vaccine was offered [AGE] years old and older and for residents younger than [AGE] years old per providers recommendations. Facility's Pneumococcal Policy dated 2/2024 indicated It is the practice of the Health Care Facility to offer all residents the pneumococcal vaccines to aid in the prevention of pneumococcal/pneumonia infections. To follow recommendations of the Advisory Committee on Immunizations Practices (ACIP), Centers for Disease Control (CDC) and/or the state Department of Health for prevention of Pneumococcal disease by identifying those residents at risk for Pneumococcal disease and offering Pneumococcal vaccination.