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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure there was reasonable access to private phone use for 1 of 1 residents (R303) reviewed who utilized the facility phone. Findings include: R303's admission Minimum Data Set (MDS) dated [DATE], indicated R303 had moderately impaired cognition and resided in a room on the first floor. During an interview on 3/24/25 at 1:44 p.m., R303 stated staff let him use the phone at the nursing station but could only use it for a few minutes as staff frequently had to use it and occasionally, staff would not let him use the phone at all as staff would need to use it to make other calls. R303 stated he wished he had a more private phone that he could use on a more consistent basis that was not in a shared area with staff. R303 stated this really limited how often he could speak with his family and what he could speak with his family about and this bothered him. During an interview on 3/25/25 at 2:43 p.m., nursing assistant (NA)-A stated most of the residents owned their own phone but if a resident didn't, facility staff would let them use the phone at the nursing station. NA-A stated she was not aware of any other phone a resident could use that was in a more private area. NA-A stated facility staff had to limit how long a resident used the phone and when residents could use the phone as staff also needed to use it. During an interview on 3/26/25 at 8:20 a.m., licensed practical nurse (LPN)-A, the unit care coordinator stated the only phone she knew of to offer residents was the phone at the nursing station. During an observation on 3/26/25 at 9:33 a.m., R303 was sitting in his wheelchair next to the phone at the nursing station. The nursing station was observed at the Y intersection of three hallways. The nurse's station had a tall desk and no walls enclosing it. A medication cart was observed parked in front of the nurse's station immediately to the left of the nurse's station phone with LPN-A and registered nurse (RN)-A standing in front of the medication cart. During an interview on 3/27/25 at 7:46 a.m., the administrator stated if a resident wanted to use a phone, they could use her office or the director of social services office to make those calls. The administrator stated she was not aware of any recent education to staff about ensuring residents were offered these private places to make phone calls. (continued on next page)

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

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy regarding resident access to a private phone was requested and not received.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 49339 Based on observation, interview and document review the facility failed to ensure private and confidential resident information was secure and not visible to residents and visitors when resident care sheets were left out in public view. This had the ability to affect 48 residents on second floor. Findings include: During a continual observation starting at 1:00 p.m. on 3/25/25, a clip board was observed sitting on the top counter of the unit desk (nursing station) with a care sheet 4 NAR Daily Assignment Sheet out in public view which identified 48 resident rooms which included residents full names, with a variety of information with ranged from level of assistance needed with transfers, special programs, if resident has behaviors, if on special precautions, elopement risk, etc. Residents were observed to be standing next to the clip board at the unit next. Multiple residents along with a couple of family members were observed to be walking past the clipboard that contained personal resident information in public view. During interview on 3/25/25 at 1:27 p.m., licensed practical nurse (LPN)-D verified the clip board was sitting on the top counter of the unit desk in public view. LPN-D stated the sheet contained resident information which included resident names and information regarding their care. LPN-D stated this was private information and not everyone should know the information. LPN-D stated the clipboard should be face down so residents and families cannot see the information when they walk by. During interview on 3/27/25 at 8:41 a.m., director of nursing (DON) stated the expectation would be any information with resident information on it would not be sitting out in the open because of HIPAA (Health Insurance Portability and Accountability Act - federal standards protecting sensitive health information from disclosure without the patient's/resident's consent). A policy on HIPAA was requested and not received.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure the quarterly Minimum Data Set (MDS) was completed in a thorough manner to ensure areas of cognition and depressive symptoms were evaluated for 2 of 4 residents (R3, R19) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined a quarterly assessment was a non-comprehensive assessment which was to be completed every 92 days and was used to track a resident' status between comprehensive assessments . to ensure critical indicators of gradual change in a resident's status are monitored. The manual included a section labeled, SECTION C: COGNITIVE PATTERNS, which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, These items are crucial factors in many care-planning decisions; with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, SECTION D: MOOD, which outlined the section would be used to help address mood distress and social isolation adding, Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity, and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R3 R3's quarterly MDS, dated [DATE], identified R3 had several medical conditions or problems including delusional thinking, depression, and schizophrenia. The 'Section C - Cognitive Patterns' was reviewed and the spacing to record a completed Brief Interview for Mental Status (BIMS) was left blank and not completed and, in addition, the subsequent section for the staff assessment (used if the resident is rarely or never understood) was also left blank and not completed. In total, section C0200 to C1000 was left blank and not completed. The 'Section D - Mood' was reviewed and the spacing to record a mood interview, including with symptom presence of frequency of depression, was left blank and not completed and, in addition, the subsequent section for the staff assessment (also used if the resident is rarely or never understood) was left blank and not completed. In total, section D0150 to D0600 was left blank and not completed or addressed. R3's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the quarterly assessment reference date (ARD) to determine what, if any, complications or issues R3 demonstrated with those corresponding areas. R19 (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's quarterly Minimum Data Set (MDS), dated [DATE], indicated R19 was admitted to the care facility on 2/25/25, and had medically complex conditions including seizure disorder, non-Alzheimer's dementia, depression, bi-polar and post-traumatic stress disorder. Section C of the MDS to assess for cognitive patterns was marked as not assessed. The subsequent section for staff assessment, including any long term or short-term memory problems was also marked as not assessed. In addition, section D of the MDS to assess resident mood was also marked throughout as not assessed including the subsequent section for staff assessment to include social isolation. R19's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations had been completed during the quarterly assessment ARD to determine what, if any, complications or issues R3 demonstrated with those corresponding areas. On 3/27/25 at 9:16 a.m., the corporate director of reimbursement (CDR) was interviewed, and verified they had reviewed the medical records of each resident. CDR stated R3 and R19 both had their sections (C and D) dashed and left blank as the corresponding assessments for them to use were not completed within the ARD. As a result, the MDS couldn't use them to record the information. CDR stated they believed the care center had a newer social worker who was likely still learning the role and getting that system down with evaluations to be completed and when. CDR verified the MDS should be completed in a thorough manner adding such helped to give us a more holistic picture of the resident and their needs. A facility' policy on MDS completion was requested, however, none was received.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure a level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 1 of 1 residents (R17) reviewed for PAS. Findings include: R17's admission Minimum Data Set (MDS) dated [DATE], indicated R17 had intact cognition. R17's medical diagnoses list dated 2/24/25, indicated R17 was diagnosed with depression, anxiety, and post-traumatic stress disorder. R17's PAS notice dated 2/21/25, indicated a copy of the PAS was included with this notice but the PAS was not final until the lead agency sent a final determination to the nursing home. R17's entire medical record was reviewed and lacked evidence a final determination had been received. During an interview on 3/25/25 at 11:32 a.m., the senior linkage line representative (SLL) stated she had reviewed the PAS that they had on file for R17 dated 2/21/25, and this was not the final PASARR. SLL stated the facility needed to reach out the lead agency, in this case Hennepin County, to get the facility the final determination. During an interview with receptionist (R)-A and the social services director (SSD) on 3/25/25 at 1:21 p.m., they indicated they shared the responsibility of ensuring the PASARR's were completed and in the medical record. R-A stated they had reached out to senior linkage line today and had received the PAS notice (referenced above) but had not reached out to the county yet. The SSD confirmed the final PASARR was not in the medical record and stated she would have expected to have this on admission to the facility. The facility's Pre-Admission Screening policy dated 6/23, indicated social services will ensure the resident meets the level of care for purposes of medical assistance payment of long-term care prior to the resident being admitted to the facility. The nursing facility is responsible for having a copy of the preadmission form(s) on file in the resident's medical record.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to provide assistance and/or equipment to complete personal hygiene cares (i.e., nail care) for 1 of 5 residents (R59) reviewed who needed set-up assistance with nail care. Findings include: R59's annual Minimum Data Set (MDS), dated [DATE], identified R59 had moderate cognitive impairment and demonstrated no rejection of care behavior. R59's care plan, dated 3/26/25, identified R59 had a self-care deficit due to his cognitive impairment and listed a goal, Resident will be accept [sic] assistance with self cares. The care plan directed, Independent with grooming, provide set up as needed. However, the care plan lacked information on what, if any, preference R59 had about his fingernail length preference (i.e., short or longer). On 3/24/25 at 2:35 p.m., R59 was observed seated in his room reading a Bible. R59 was dressed in a winter coat and stated he had received a shower earlier that same day (3/24/25). However, R59 had multiple fingernails, including both thumb nails, which were long with the nail plate being several millimeters (mm) long from the end of the finger. R59 stated he needed to find someone to clip them. R59 looked at his nails and verified he wanted them clipped shorter adding it had been quite awhile since those nails were last clipped. Further, R59 stated he used to clip them himself but his clippers had gone missing. On 3/26/25 (two days later) at 7:50 a.m., R59 was again observed while in his room. R59's fingernails remained long as had been observed days prior. R59 reiterated wanting them clipped then abruptly added, I prayed for you. R59's record identified a series of MHM (Monarch Healthcare Management) Weekly Skin Inspection V-5(s) had been completed. These included: On 3/17/25, R59 was recorded as having received a shower. A series of questions to be answered by the staff with a corresponding radio-style button included, Fingernails trimmed? This was answered as, C. Not Necessary. On 3/25/25, R59 was recorded as having received a shower. A series of questions to be answered by the staff with a corresponding radio-style button included, Fingernails trimmed? However, again, this was recorded with a response, C. Not Necessary. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 7:52 a.m., nursing assistant (NA)-D was interviewed. NA-D verified they had worked with R59 prior and stated he didn't require much physical assistance for cares, rather staff just re-direct him a little bit. NA-D stated nail care should be completed with bathing and the nurse was responsible to chart it (i.e., Weekly Skin Inspection). NA-D stated they thought R59 would require assistance to complete his nail care adding aloud, I haven't seen him do that. NA-D then observed R59's fingernails at the request of the surveyor and verified their length adding, A few of them [nails] are high up [long]. NA-D stated they would let the nurse know and try to get them clipped. At 7:57 a.m., licensed practical nurse (LPN)-C joined the interview. LPN-C stated R59 was very limited in what he'd allow staff to do for him adding R59 had off and on cognitive issues. LPN-C stated staff should be helping R59 with nail care but felt he'd often refuse it. LPN-C verified a pair of clippers was available for staff to use or offer R59 and stated nail care, including offers and refusals, should be documented in the record. LPN-C reviewed R59's Weekly Skin Inspection(s) in the record and verified nail care had been marked as 'not necessary.' LPN-C stated they were unsure why the inspections had been marked like that as there was nothing in the record explaining it despite R59 having long nails still. R59's medical record was reviewed and lacked evidence R59 had been offered, refused or had his fingernails clipped within the past week despite having visibly long nails; nor was there evidence to explain why some nails were clipped but others (such as observed) were long. However, a subsequent note, dated 3/26/25 at 9:46 a.m., was authored by LPN-C which outlined, Writer offers to trim res[ident] fingernails, but res refused stated 'I can trim my own nails.['] Writer gives res the fingernails clipper. Res trimmed his nails and give [sic] writer back the fingernails clipper. On 3/26/25 at 8:31 a.m., licensed practical nurse manager (LPN)-A was interviewed. LPN-A stated nail care was typically recorded on the Weekly Skin Inspection adding they were unaware of what, if any, other places were used to record it adding aloud, None that I know of. LPN-A stated nail care should be completed on scheduled bathing days or as needed and verified any refusals should also be recorded in the medical record. LPN-A stated R59 was typically pretty accepting of cares adding, He doesn't refuse much. LPN-A verified the medical record lacked evidence why some of R59's fingernails were not clipped or trimmed, and they expressed nails should be kept short for sanitary reasons and to reduce the risk of R59 scratching himself. A facility' provided Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/2023, identified the facility would ensure each resident was provided with appropriate treatment and services to maintain their abilities to carry out ADLs. The policy outlined, 3. The facility will provide care and services for the following activities of daily living: a. Hygiene - bathing, dressing, grooming, and oral care .

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47495 Based on observation, interview and document the facility failed to provide activities of daily living (ADLs) including nail care and routine bathing to 2 of 3 residents (R19, R31) reviewed for ADLs who were observed to be disheveled with long, dirty fingernails and greasy appearing hair. Findings include: R19 R19's quarterly Minimum Data Set (MDS), dated [DATE], indicated R19 was admitted to the care facility on 2/25/25 and was dependent on staff for most ADLs including toileting, bathing, dressing and personal hygiene (to include nail care). R19's care plan, dated 6/23/23, indicated R19 had a self-care deficit related to a cerebral vascular accident (stroke) with residual left sided weakness and required assist of one staff member with personal hygiene. During observation on 3/24/25 at 2:47 p.m., R19 was laying in bed, asleep, and was observed to have long fingernails approximately 1/4 inch in length with dark matter under the nail beds. During interview and observation on 3/26/24 at 7:59 a.m., R19 was laying in bed and observed to continue to have a dark matter under her fingernails. R19 lifted her right hand, stating I probably need help to clean my nails, they [facility staff] should probably keep them shorter. Nursing assistant (NA)-C observed R19's nails, stating nail care should be done when a resident received a shower or bath. A second unnamed NA entered R19's room to assist with putting a brace on R19's left hand and to assist with transferring R19 to her wheelchair. R19 was brought out to the dining room for breakfast without receiving nail care. During an interview on 3/27/25 at 7:50 a.m., nurse manager and registered nurse (RN)-B stated nail care was expected to be done at least weekly during a resident shower or bath, but that for human decency nails should be kept clean and trim in between bathing as needed. RN-B stated the NAs should be checking resident for clean hands/nails and faces at mealtime. 48065 R31 R31's quarterly Minimum Data Set (MDS) dated [DATE], indicated R31 was cognitively impaired, had no hallucinations, delusions or behaviors, and didn't refused cares. R31's MDS indicated she was independent with eating and ambulation, and needed set up or cleanup assistance with oral hygiene, toileting, dressing and personal hygiene. R31's MDS indicated she needed moderate assistance with bathing and had diagnoses of non-traumatic brain dysfunction (brain damage caused by internal factors rather than external trauma), Alzheimer's disease, psychotic disorder (a mental disorder characterized by a disconnection from reality, also known as psychosis), anxiety and depression. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's care plan for activities of daily living (ADLs) printed on 3/27/25, indicated R31 had potential for an ADL self-care performance deficit related to Alzheimer's. ADLs care plan indicated R31 often refused showers; encourage and reapproach as needed. Sponge bath: Avoid scrubbing and pat dry sensitive skin. R31's mood and behavior care plan did not include interventions to encourage her to shower or bathe. R31's weekly skin inspection reports dated 3/24/25, 3/17/25, 3/10/25, 3/3/25, 2/25/25, 2/21/25, 2/14/25, 2/10/25, 2/7/25 and 2/3/25 indicated resident refused bathing. Bathing option included shower, sponge bath, and tub bath. During observation on 3/25/25 at 2:00 p.m., R31 was sitting at a table in the dining room, and her hair was dull, greasy and separated in locks starting on her scalp. During interview on 3/25/25 at 2:09 p.m., licensed practical nurse (LPN)-C stated it was hard to provide cares for R31. LPN-C stated R31's hair was dirty. During interview on 3/25/25 at 3:46 p.m., nursing assistant (NA)-F stated R31 sometimes agreed to take a shower but then she refused. NA-F stated sometimes she let them wash her with wash clothes, but she hit them throughout the whole process. During observation on 3/26/25 at 9:00 a.m., R31 was sitting at the dining room table, her hair was dull, greasy and separated in locks starting on her scalp. During interview on 3/26/25 at 10:15 a.m., nurse manager-LPN-A stated she knew R31 refused cares, and staff needed to redirect and reapproach her. LPN-A verified R31's hair was dirty. LPN-A verified there were not other interventions in place to wash R31's hair. LPN-A stated she was unsure if a dry shampoo caps had been tried. During interview on 3/26/25 at 10:38 a.m., LPN-C stated the facility had not tried to use a dry shampoo cap with R31. LPN-C added we [facility] have dry shampoo caps available. During interview on 3/27/25 at 10:05 a.m., director of nursing (DON) verified R31's care plan directed staff to reapproach resident but did not include any other interventions. DON stated obviously the residents had the right to refuse cares, but the facility needed to determine if residents had preferences, offer options, get creative, and maybe offer a reward program to encourage R31 to bathe and wash her hair. DON stated good hygiene was important for R31 personal appearance and dignity. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Activities of Daily Living dated 3/21/23, indicated It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. The policy further indicated, It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review, the facility failed to assess and care plan for a resident's social and emotional well-being for 1 of 1 resident (R20) who wished to help in the dining area. Additionally, did not adequately assess for food preferences or find ways to encourage resident to adhere to dietary recommendations, and neglected to follow up with an order for a video swallow study for 1 of 1 residents (R23) reviewed who frequently refused a modified diet and requested regular-textured foods. Additionally, the facility failed to assess, care plan, and implement interventions for 1 of 1 resident (R90) reviewed for skin assessment. The facility also failed to coordinate care for a resident who was consistently out of the building for scheduled appointments and not receiving treatments/medications as ordered for 1 of 1 resident (R52) reviewed for dialysis. Findings include: R20 R20's quarterly Minimum Data Set (MDS) indicated R20 was admitted to the care facility on 6/19/24, had severe cognitive impairment but was independent with activities of daily living (ADLs). R20's Diagnoses List, dated 6/19/24, indicated had multiple diagnoses including other symptoms and signs involving cognitive functions and awareness and obsessive compulsive disorder. R20's care plan, printed 3/27/25, indicated R20 had an intervention, dated 12/2/24, resident likes to help others. Another intervention, added to R20's care plan during survey on 3/27/24, indicated resident 'assists' in the dining room with clearing and sweeping. IDT [interdisciplinary team] determined it is therapeutic for resident to allow a feeling of purpose. During observation on 3/25/25 at 1:27 p.m., R20 was in the dining room, attempting to help clear lunch plates from the tables after the residents had finished eating lunch. Two unnamed staff members were repeatedly telling R20 to Stop! and Don't touch that! in stern sounds tones, stating We tell you this every day! No attempts were made to distract R20 with another activity during this time. R20 stated, this is like a prison before walking out of the dining room. During an interview and observation on 3/26/25 at 9:05 a.m., nursing assistant (NA)-E state staff do not want to allow R20 to help in the dining room because they think state would not like it, so staff tell her to stop when she tries to help. NA-E stated when she works, she would put gloves on R20 and let her help, even though it was not care planned, stating other staff were afraid to let R20 help. R20 was observed walking around the dining room, with gloves on, helping to clear plates from the dining room tables. During an interview on 3/27/25 at 7:50 a.m., nurse manager and registered nurse (RN)-B stated R20's care plan does include helping with mealtimes (added that same day, 3/27/25), but it doesn't give a detailed explanation of what clear means. It just says clear. RN-B stated that R20 attempting to help in the dining room has been an ongoing issue and that when R20 gets upset, staff should be assisting R20 with putting gloves on. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 9:10 am, the director of nursing (DON) confirmed she was aware that R20 liked to help in the dining room and that education was needed to ensure direction to staff was clear and consistent to allow R20 to assist in the dining room for her wellbeing. R23 R23's significant change Minimum Data Set (MDS), dated [DATE], indicated R23 had a diagnosis of cerebral vascular accident (stroke) and was dependent on staff for all activities of daily (ADLs). The MDS further indicated R23 had mild cognitive impairment. R23's Orders indicated an order for soft and bite sized textured foods with mildly thick liquids, dated 1/23/25. The Orders also indicated an order for a dysphagia 1 routine video swallow study, which provides a real-time X-ray view of how food and liquids move through the mouth, throat, and esophagus, dated 2/12/25. R23's Care Conference Note, dated 2/14/25, indicated R23 expressed a desire to return to a regular textured diet, and a referral had been placed to Hennepin County Medical Center for a video swallow study. R23's most recent Clinical Nutrition Evaluation, dated 2/11/25, indicated R23 would get upset easily regarding his diet and would often use refusing to eat as leverage to get what he wants. The evaluation lacked any assessment of what foods R23 would or would not eat under his modified diet or how they could ensure R23 was receiving foods he would enjoy. R23's Care plan, printed 3/27/25, indicated R23 refused to eat at times due to not getting his diet of choice. The care plan indicated R23 had a risk versus benefit completed due to his refusal to eat his suggested diet or eat at all. R23's electronic medical record (EMR) lacked any evidence a follow up swallow study was scheduled or completed as requested by resident and indicated in R23's Orders. The EMR further lacked a comprehensive assessment of how staff could meet R23's needs such as cutting up food table side or meeting with resident daily (or weekly) to assess what foods on the menu he would want for each meal. During an interview on 3/26/25 at 10:15 a.m., the therapy program manager (TPM) stated R23's last video swallow study was done in the hospital around October 2024. The TPM stated speech therapy had done an evaluation in December 2024 for diet recommendation, and it was recommended for a soft, bite sized diet with mildly thick liquids due to his history of aspiration pneumonia. During observation and interview on 3/26/25 at 12:34 p.m., R23 was in the dining room, raising his voice about not wanting to eat his grilled cheese sandwich but that he wanted regular food. NA-E stated R23 did this all the time. The dietician was present, telling R23 she would talk with him after lunch, and that she recognized soft and bite sized foods was not his wishes but was the diet the guardian wanted R23 on. R23 and the dietician compromised on a burger that would be cut into small pieces for lunch. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/26/25 at 12:44 p.m., dietician stated that although a risk versus benefit has been signed, R23's guardian refused to allow R23 to have a regular diet but that she would call and speak with his guardian again. The dietician stated R23 would go on food strikes to have his food of choice, but the facility had to stick to his prescribed diet. The dietician stated no other interventions were in place to prevent R23 from going on food strikes. During an interview on 3/27/25 at 7:50 a.m., nurse manager and registered nurse (RN)-B stated she spoke with the dietician yesterday and that R23 would get upset that his food did not look like his tablemates Stating he looked at his table mate's food and did not understand why his food did not look like theirs. RN-B confirmed she had not assessed R23 for what specific foods he would or would not eat based on his prescribed diet. RN-B also confirmed she had not assessed for other interventions that might improve R23's quality during mealtime such as educating the NAs to cut up R23's food table side so that food arrives looking like his table mates, or sitting him near residents who received the same type of diet. RN-B stated R23 caused disruption a lot about food in the dining room. During an interview on 3/27/25 the director of nursing (DON) stated the dietician had spoke with her yesterday about R23 and the DON was going to speak with the team about getting a care conference scheduled for R23 to address his dietary needs and wants. The DON confirmed a swallow study had not been completed or scheduled. 48065 Resident #90 R90's admission Minimum Data Set (MDS) dated [DATE], indicated R90 was cognitively intact, had no behaviors, didn ' t not refuse cares, and was dependent with all activities of daily living. MDS identified diagnoses of atrial fibrillation, anemia, Gastroesophageal reflux disorder, pneumonia, diabetes, malnutrition, and schizophrenia. R90's MDS indicated he was at risk for skin breakdown. R90's Profile record printed on 3/31/25, indicated R90 was admitted to facility on 2/5/25. R90's Clinical Orders printed on 3/31/25 included an order for Weekly skin inspection by licensed nurse every Wednesday. R90's care plan printed on 3/26/25 indicated, R90 was at risk for skin integrity related to methamphetamine use, homelessness, MSSA pneumonia (methicillin-susceptible staphylococcus aureus), low grade bacteremia, and type 2 diabetes. R90's care plan interventions directed staff to monitor R90's skin daily during cares, and weekly skin inspection by nurse. R90's progress noted lacked documentation of concerns related R90's feet. R90 had weekly Skin Inspections performed by licensed nurses between 2/12/25 and 3/26/25. The weekly skin inspections failed to document R90's dry yellowish patches of thick and scaly skin on his feet. The documentation on the weekly skin inspections was as follow: - 2/12/25: bed bath. No new issues noted. IV PICC line is clean and patent - 2/19/25: bed bath. Red groin, intact IV PICC line dressing. Rest of skin intact. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/26/25: bed bath. Noted redness to groin. IV PICC line dressing intact. No other skin issues. - 3/12/25: bed bath. Ongoing PICC line on left arm, dressing intact. Skin clean dry and intact. - 3/19/25: resident refused shower, skin clean and intact. - 3/26/25: resident refused shower; visible skin intact. During observation and interview on 3/26/25 at 8:20 a.m., R90 was in bed covered with a top sheet, but his feet were exposed. The bottom of R90's bottom feet were covered with patches of dry thick yellowish scaly skin. R90 stated his feet have been like that for a long time, even before coming to the facility. R52 stated the staff had not said or do anything about his feet. During interview on 3/26/25 at 8:48 a.m., R90 stated he groomed by himself, and had not have a shower since he was admitted to the facility. R90 stated he got up 2-3 a week and when works with occupational and physical therapists. During interview on 3/26/25 at 9:37 a.m., nursing assistant (NA)-C stated R90 accepted assistance with personal cares but refused to shower. NA-C stated once, he refused a shower and sponge bath because he wanted to sleep. During interview on 3/27/25 at 9:00 a.m., nurse manager, registered nurse (RN)-B stated the expectation was for staff to apply lotion to R90's feet to keep the skin moist and prevent skin breakdown. During interview on 3/27/25 at 9:21 a.m., NA-F stated she noticed R90's feet dry skin about two weeks ago, and she reported to the nurse on duty, but did not remember who she reported to. NA-F stated she had not applied any lotion to R90's feet. NA-F stated, We should apply lotion to his feet, maybe twice a day. During interview on 3/27/25 at 9:25 a.m., RN-C verified the bottoms of R90's feet were covered with patches of dry scaly skin. RN-C stated the staff were supposed to apply lotion to keep them moist and prevent skin breakdown. During interview on 3/27/25 at 9:56 a.m., director of nursing (DON) verified lack of documentation about R90's feet skin status. DON stated the nurses should document about skin concerns on the weekly skin inspection, and the primary physician should be notified. The facility policy titled Care Planning dated 11/2024, indicated the interdisciplinary team in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purpose of providing care or services to the resident. 49339 (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R52'S quarterly Minimum Data Set (MDS) assessment, dated 10/2/24, identified R52 had intact cognition with no hallucinations or delusions, no behaviors or rejection of care. Section O: special treatments and programs identified R52 received dialysis. Section N-medications identified R52 received insulin injection and indicated R52 received R52 received insulin injections 7 days out of the last 7 days. R52's admission record, printed 3/27/25, identified the following relevant diagnoses: end stage renal disease (final, permanent stage of chronic kidney disease where kidney function can no longer function properly on their own), and type 2 diabetes mellitus without complications (disease in which your blood sugar levels are too high). During interview on 3/24/25 at 4:30 p.m., R52 stated he went to dialysis three times a week. R52 stated on the days he went to dialysis that he brought a bag lunch with him to eat while at dialysis as he left about 10:00 a.m. and got back late afternoon. R52 stated he did not get his noon dose of insulin or get his blood sugar checks while at dialysis. R52 stated he did get high blood sugars sometimes. R52's March medication administration record (MAR), printed 3/27/25, identified the following information: -Humalog Kwikpen 100 unit/milliliter(ml) solution pen injector (a fast-acting insulin used to treat diabetes) inject as per sliding scale: if 70-149=0; 150-199=2; 200-249=3; 250-299=4; 300-349=5; 350-399=6; 400 or greater give 7 units, if >(greater) x2 call MD/NP, give subcutaneously three times day for type 2 diabetes mellitus without complications give with meals started 6/15/24 -Monday 3/3/25, indicated NA for blood sugar and 3 indicating absent from home -Wednesday 3/5/25, indicated NA for blood sugar and 3 indicating absent from home -Friday 3/7/25, indicated NA for blood sugar and 3 indicating absent from home -Monday 3/10/25, left blank -Wednesday 3/12/25, indicated blood sugar was 169 and insulin dose given was 2 units. -Friday 3/14/25, indicated NA for blood sugar and 3 indicating absent from home -Monday 3/17/25, indicated NA for blood sugar and 3 indicating absent from home -Wednesday 3/19/25, indicated NA for blood sugar and 3 indicating absent from home -Friday 3/21/25, left blank -Monday 3/24/25, indicated NA for blood sugar and 3 indicating absent from home -Wednesday 3/26/25, indicated NA for blood sugar and 3 indicating absent from home (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Blood sugars on the remaining days remained from 109 to 289 which required 0 units of insulin to 4 units of insulin. -Renvela (a medication given to people receiving dialysis to lower the amount of phosphorus in the blood) Oral tablet 800 milligrams (mg) three times a day every Mon, Wed, Fri related to gastro-esophageal reflux disease with esophagitis started on 4/24/24 -3/14/25 charted as 3 indicating away from home -3/21/25 charted as 6 indicating hospitalized -3/24/25 charted as 3 indicating away from home -3/26/25 charted as 3 indicated away from home R52's progress notes dated 3/1/25 to 3/27/25, were reviewed and lacked evidence of coordination with provider or dialysis regarding insulin during dialysis. R52's care plan, printed 3/27/25, identified R52 received dialysis, placement of fistula (a permanent connection placed between the artery and vein that allows for the removal of waste products from the blood during hemodialysis), location of clinic, days of dialysis, and post dialysis assessment. Furthermore, the care plan indicated bag lunches were provided on dialysis days. R52's care plan indicated R52 had diabetes with interventions including diabetes medications and fasting blood sugars as ordered by provider. R52's care plan lacked evidence of coordination with the provider of not completing 12:00 p.m. blood sugar checks or insulin doses (if needed) while at dialysis. Furthermore, lacked evidence of coordination with dialysis center regarding need to monitor blood sugars or need for insulin. During an interview on 3/26/25 at 9:02 a.m., licensed practical nurse (LPN)-D stated they were familiar with R52 and worked with him often. LPN-D stated they took vital signs and got paperwork ready to go prior to R52 leaving for dialysis. LPN-D stated they did not send any medications with R52 to dialysis. LPN-D stated R52 has dialysis on Monday, Wednesday and Friday every week, left the facility about 10:00 a.m., and returned to the facility between 3:00 p.m. and 4:00 p.m. LPN-D reviewed current orders and verified R52's orders included an order for Humalog TID with meals. LPN-D stated R52 did not have his blood sugars checked at noon on dialysis days or get his noon dose of insulin. LPN-D stated dialysis did not check R52 blood sugars or provide insulin. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/26/25 at 9:29 a.m., LPN-E stated they were familiar with R52 and worked with him often. LPN-E stated they often prepared his items needed for dialysis which included preparing the packet to send with one medication (Renvela), along with taking vital signs and sending a bag lunch with R52. LPN-E stated R52's blood sugar got checked in the morning prior to leaving for dialysis and upon returning to the facility in the afternoon, about 4:00 p.m. LPN-E verified R52's orders which included blood sugar checks three times a day with meals and Humalog three times a day with meals. LPN-E stated the facility could not give the noon dose of insulin as R52 was not in the facility. LPN-E stated he did not believe the dialysis clinic checked R52's blood sugars and stated the dialysis clinic did not administer insulin to R52 while he was at dialysis. LPN-E was unsure if the provider was notified that R52 did not receive the noon dose of insulin or noon blood sugar checks on dialysis days. During an interview on 3/26/25 at 9:43 a.m., registered nurse manager (RN)-D stated the expectation would be if a medication was not given or was scheduled to be given during dialysis, there would be coordination with the provider regarding this. RN-D reviewed R52 electronic medical record (EMR) and stated R52 had not received the noon dose of insulin on any dialysis days in the month of March. RN-D verified R52's blood sugars were not completed at noon on dialysis days and upon return from dialysis, they tended to be higher than on days he was not at dialysis. RN-D stated the expectation would be there had been communication with the provider. RN-D stated she was going to update the provider now. During an interview on 3/27/25 at 8:05 a.m., nurse practitioner (NP)-A stated the facility updated them yesterday (3/26/25) regarding (R52) not receiving his noon insulin doses while at dialysis. NP-A stated she was told that the facility would check (R52) blood sugars upon returning to the facility after dialysis and I was told his blood sugars were running higher when he returns when he gets back from dialysis. NP-A stated she was not sure how long (R52) was not receiving his insulin dose when out at dialysis. NP-A stated, Ideally, I would expect to be notified the first day it happens but as soon as possible. During an interview on 3/27/25 at 8:42 a.m. director of nursing (DON) stated she would expect to see communication with the nurse practitioner if a medication was not being administered. A facility policy titled Notification of Changes Policy, dated 3/2024, indicated it is the policy of this facility that changes in a resident' condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure cataract surgery was coordinated with an appointed guardian to facilitate attendance and successful surgery for 1 of 1 resident (R3) reviewed who complained about their poor vision. In addition, the facility failed to act on reports of missing hearing devices and/or seek a replacement for 1 of 1 residents (R28) reviewed who was reported to have had lost their hearing aids. Findings include: R3 R3's quarterly Minimum Data Set (MDS), dated [DATE], identified R3 had impaired vision (sees large print, but not regular print in newspapers/books) and did not use corrective lenses. However, the spaces to record R3's cognition were dashed and not completed (see F638). On 3/24/25 at 12:51 p.m., R3 was observed lying in bed while in her room. R3 did not have any glasses on at this time. R3 stated repeatedly aloud, I have trouble with my eyes. R3 stated she was unable to see fine things and, again, then voiced, I'm having difficulty seeing with my eyes. R3 stated she didn't have a pair of glasses right now and voiced they had been destroyed years prior. When interviewed on 3/25/25 at 8:53 a.m., R3's appointed guardian (G)-A stated R3 needed to have cataract surgery which had been expressed to the care center multiple times. However, G-A stated then G-A never heard back from them. G-A stated they had been told some consents were needed, however, again, then never received them to sign. G-A stated R3 had a history of paranoia and needed to be accompanied to the appointment, however, reiterated the surgery consult should proceed as R3 often complained about her vision adding she (R3) would, at times, have to bring items up to her nose to read them. G-A stated they had repeatedly tried to follow-up with the care center about this, however, often when they call just get a fax-machine noise on the line and were unable to reach people. R3's progress note, dated 1/14/25, identified a nursing note which read, Guardian notified SS [social services] that they would like cataract surgery set up . optometrist documentation on 12/1 notes that resident declining this to be set up . Called guardian to discuss and left message, awaiting reply. R3's most recent MHM (Monarch Healthcare Management) IDT Care Conference Form V-5, dated 1/6/25 (locked 3/11/25), identified a quarterly review was held. A section labeled, Exams, was included which recorded spaces to write the date(s) of R3's last dental and eye exams. These spaces were left blank, however, dictation was written below for each which read, in the last quarter. A subsequent note, dated 1/24/25, identified the staff had spoken with the guardian who was willing to go with R3 to her appointment . to help resident to be agreeable to go if it can be scheduled on a day she [guardian] is available. Message sent to huc [health information manager]. However, the medical record lacked any further information on this. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 12:31 p.m., health information manager (HIM)-A was interviewed, and verified they helped arrange both onsite and offsite appointments for the campus. HIM-A recalled R3 being scheduled for a cataract surgery consult at HCMC and believed R3's appointed guardian had been notified of it. However, then on the day of the appointment R3 refused to go adding this had just happened like last week. HIM-A stated they never heard back from R3's guardian so they just scheduled it when able. HIM-A verified they never talked with G-A prior to scheduling the appointment to determine what day would work to have G-A attend the appointment, too, adding aloud, I never actually spoke to her on the phone. HIM-A stated they were aware of there being a problem with the phone system as people had told them they were unable to leave messages even. Further, HIM-A stated they didn't wait to make an appointment until consulting with G-A first as they were told the appointment was an emergency, adding they had not followed up with G-A about the missed appointment from last week yet, either, but it was on my follow-up list to get it done. When interviewed on 3/25/25 at 1:07 p.m., licensed practical nurse manager (LPN)-A stated they were aware of the cataract consult which had been missed and verified HIM-A should have contacted and consulted with R3's appointed guardian prior to setting it up. LPN-A stated they were aware of R3 having poor vision as it had been raised at a care conferences a couple months ago. LPN-A acknowledged if the appointment had been coordinated with G-A, then R3 likely would have been more willing to go and have the consult. LPN-A stated it was important to coordinate appointments so everybody's on the same page otherwise things may fall through the cracks. Further, LPN-A stated they also had been told the phone system was potentially malfunctioning adding aloud, There is a problem with the line I think. On 3/25/25 at 2:49 p.m., the interim director of nursing (DON) was interviewed. DON stated the consult appointment should have been coordinated with the appointed guardian to see would any of these days [available] work for you. A facility policy on vision appointments was requested, however, none was received. 49034 R28 R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 had moderate cognitive impairment, adequate hearing (no difficulty in normal conversation), and did not use hearing aids. R28's audiology note dated 10/12/23, indicated the audiology provider had completed an initial fitting for R28's hearing aids and the resident had reported hearing well from the hearing aids. The note indicated the charger/box was to be kept at the nursing station and staff were to assist the resident with insertion and removal and keeping the hearing aids charged. R28's audiology note dated 11/22/23, indicated the audiology provider had visited the resident, and his hearing aids could not be located. The note indicated the resident did not know where they were, and the facility staff did not see them at the nursing staff. The note indicated the provider wanted the staff to continue looking for the hearing aids before requesting a replacement. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's medical record was reviewed and lacked evidence that R28's hearing aids had been further searched for and/or addressed with a replacement solution despite being identified as potentially missing. During an interview on 3/24/25 at 2:05 p.m., R28 stated his hearing aids had gotten lost about a year and a half ago and didn't think anyone had offered to help him get new ones. R28 said that he had repeatedly asked staff in the past but will need to ask more firmly as no one had helped him. R28 stated he wanted new ones because he had problems talking with other residents and staff members and had to ask people to repeatedly, repeat themselves. During an interview on 3/26/25 at 10:48 a.m., licensed practical nurse (LPN)-A stated she had been working at the facility for about six months as the care coordinator for R28's unit. LPN-A stated she had not been aware that R28 had ever had hearing aids or that these had been lost. LPN-A stated after reviewing R28's medical record it looked like a ball was dropped as she did not see that anyone had attempted to get him new hearing aids. During an interview on 3/26/25 at 11:02 a.m., the health information manager (HIM) stated the last time she could find that the resident was seen by audiology was 11/22/23. The HIM stated she oversaw making resident appointments and R28 did not have any outstanding appointments with audiology as she did not recall being notified that he needed one. During an interview on 3/27/25 at 7:43 a.m., the director of nursing (DON) stated she was not aware that R28 needed hearing aids but would have expected facility staff to follow up when the hearing aids had gone missing. A facility policy regarding hearing aid replacement was requested and not received.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure long, hard toenails (i.e., dystrophic) were appropriately referred to the onsite contracted podiatry service in a timely manner for 1 of 1 resident (R3) reviewed who needed professional management of their nails due to a medical condition. Findings include: R3's quarterly Minimum Data Set (MDS), dated [DATE], identified R3 had delusional thinking and demonstrated no rejection of care behaviors during the review period. Further, the MDS recorded R3 required supervision or touching assistance to complete personal hygiene. However, the spaces to record R3's cognition were dashed and not completed (see F638). On 3/24/25 at 12:51 p.m., R3 was observed in her room on the locked unit. R3 had on a pair of flip-flop shoes on with no socks, which exposed both of her feet and toes. R3's toenails were all long with the nail plate being several millimeters (mm) in length, and R3 having visible hallux valgus (inward bend of the big toe) present on both feet. R3 was asked about her toenails and if they had been clipped or trimmed recently to which R3 responded aloud, I'd like to see the foot doctor again. R3 stated she was unsure when they were last clipped or she had been seen by the podiatrist adding, I'm just losing track of time. R3 stated she couldn't clip them herself, either, as she had poor balance. When interviewed on 3/25/25 at 8:46 a.m., R3's guardian (G)-A verified they were R3's current guardian. G-A stated they had noticed R3 to have long, thick toenails during their visits and had asked the care center to get R3 into the onsite podiatry clinics, however, nobody from the care center ever knew when they'd (Podiatry) be onsite saying aloud, We don't know, we don't know. G-A stated R3 needed to be seen for her toenails but there just seemed to always be quite a delay in that. Further, G-A stated R3 having long toenails was probably why she has the flip-flops on [versus covered shoes]. R3's care plan, dated 7/2023, identified R3 had potential for skin breakdown due to several medical conditions including hallux valgus. The care plan listed interventions which included, Resident seen by podiatry (Often refuses visits). R3's progress note, dated 11/11/24, identified R3 was seen by podiatry. The corresponding Healthdrive Podiatry Group note, dated 11/11/24, identified R3 as the patient and listed her as non-diabetic. The note recorded R3 as having moderate bunion deformity along with elongated, dystrophic and discolored nails on both feet. A section was listed labeled, Progress Note, which included dictation, Advised more frequent podiatry visits to reduce accumulation or hyperkeratotic tissue . Patient tolerated procedure well . Non-professional treatment is hazardous to the patient. The note concluded with no new orders and a note which read, Recall: As medically necessary but no sooner than 60 days. This was the last time R3 had been seen by the podiatry clinic as recorded within her medical record. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 3/25/25 at 12:17 p.m., nursing assistant (NA)-B stated they had worked with R3 multiple times prior, and described her (R3) as accepting of most cares. NA-B stated they believed R3 had been, at one time, seen by podiatry but was unsure when this had been. NA-B stated the onsite podiatry group had just been there at the care center like three weeks ago but, again, was unsure if R3 had been seen or not. NA-B stated R3 needed her toenails clipped though still adding they looked kind of scary being so long. NA-B stated R3 had just told them earlier that day (3/25) podiatry was going to do adding some guy [surveyor] was helping her arrange it. NA-B stated the health information manager (HIM)-A helped arrange appointments and would be the person to talk with about podiatry visits. On 3/25/25 at 12:31 p.m., HIM-A was interviewed, and verified they helped arrange the podiatry visits to the care center. HIM-A explained the podiatry services were done by an outside group who came to the care center. They would provide a list of patients to be seen to HIM-A who then also sent it to the nursing department. HIM-A stated they were aware R3 needed to be seen by the podiatry group and expressed the group was last onsite on 2/13/25. However, at that time, R3 was off the list and they were not sure if R3 had been seen or not. HIM-A provided the contact person for the group' information and verified there was no record, at least which they could find, to show R3 had been seen, offered or refused podiatry services on 2/13/25. HIM-A verified R3 had signed consents for the service and, again, expressed they were not sure why R3 had been removed from the list to be seen. HIM-A verified if the service had been offered and refused, then an entry into the medical record should have been done. The provided Healthdrive Facsimile Cover Page, dated 1/24/25, identified the listing of patients to be seen via podiatry on 2/13/25. The page directed to inform the group if any add-on requests or priority patients were identified, and 20 patient names were listed. However, R3's name was not included. On 3/25/25, an email was placed to the offsite podiatry group contact person, as provided by HIM-A, with a request to call. A response was received on 3/25/25, which outlined the email and request was forwarded to their supervisor adding, I am not sure when they will reach out to you. However, a return call was never received. R3's medical record was reviewed and lacked evidence R3 had been offered or seen by podiatry on 2/13/25, despite the previous podiatry note calling for more visits and R3 having long nails which needed to be addressed. Further, the record lacked evidence on what, if any, rationale or explanation for R3 not being listed on the roster of patients to be treated. When interviewed on 3/25/25 at 1:07 p.m., licensed practical nurse manager (LPN)-A stated HIM-A would be the person who managed podiatry appointments for the care center. LPN-A stated floor staff should be reporting to HIM-A if anyone needed to be added to the list, and expressed nobody had told them (LPN-A) R3 needed to be seen. LPN-A verified someone should have ensure R3's nails were addressed adding having long, unkept nails could cause cuts in the skin or all kinds of issues. On 3/25/25 at 2:49 p.m., the interim director of nursing (DON) was interviewed. DON stated they hadn't delved into the podiatry stuff since I've been here yet but acknowledged HIM-A helped managed it adding, Usually the HUC [HIM-A] is setting all that stuff up. DON stated nobody had reported, at least to her recall, R3's long toenails to her. A facility policy on podiatry appointments and services was requested, however, none was received.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to provide routine range of motion (ROM) for 1 of 1 resident (R63) reviewed for ROM who was dependent on staff for all activities of daily living (ADLs). Findings include: R63's annual Minimum Data Set (MDS) dated [DATE], identified R63 had severe cognitive impairment and diagnoses of aphasia (brain disorder which affects how one speaks and understands language), stroke (occurs when blood vessel is blocked or bursts), and hemiplegia or hemiparesis (loss of muscle function on one side of body or partial weakness on one side of body). R63 had impairment on one side of both upper and lower extremities and was dependent on staff for all activities of daily living, such as dressing, bed mobility, and transfers. R63's care plan intervention initiated 2/14/24, directed staff to provide gentle range of motion as tolerated with daily care. R63's Occupational Therapy Evaluation and Plan of Treatment dated 2/20/24, indicated R63 had impaired ROM to right upper extremity and a goal to improve standing tolerance and transfer status. R63's Physical Therapy Evaluation and Plan of Treatment document dated 2/21/24, indicated R63 had no movement in right lower extremity and a goal to improve transfer status. The document indicated nursing managed R63's contracture impairment. R63's Physical Therapy Discharge Summary dated 3/25/24, indicated therapy discussed stretching to decrease contractures, and R63's daughter demonstrated understanding. The document indicated R63's prognosis to maintain current level of function was good with consistent staff follow-through. R63's Summary of Daily Skilled Services dated 8/28/24, indicated R63's family member was aware of discharge from skilled therapy and plan to have R63 on functional maintenance program with skilled therapy to maintain and not worsen R63's contractures. R63's Physical Therapy Discharge Summary dated 8/28/24, indicated R63 would be picked back up on functional maintenance program to maintain contractures and recommended a hoyer lift for transfers. The document stated the prognosis to maintain current level of function was good with consistent staff follow-through. R63's Summary of Daily Skilled Services dated 10/11/24, indicated R63's family member was educated to complete functional maintenance program. R63's Summary of Daily Skilled Services dated 11/14/24, indicated R63's family member was not comfortable stretching R63 at that time. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R63's Physical Therapy Discharge Summary dated 11/21/24, indicated discharge recommendations to use a hoyer lift for transfers and maximum assistance to propel wheelchair. The document stated the prognosis to maintain current level of function was good with consistent staff follow-through. R63's Therapy Screen document dated 11/27/24, indicated R63 was recently discharged from therapy, and R63's family member was educated on how to stretch patient. R63's medication and treatment administration record printed 3/26/25, lacked documentation of nursing staff providing ROM to R63. R63's Follow Up Question Report, dated 3/1/25 to 3/26/25, lacked documentation of the nursing assistants providing ROM to R63. During interview on 3/24/25 at 5:42 p.m., R63's family member (FM)-K stated the facility did not provide R63 with continuous range of motion or exercises, so FM-K stretched R63 when they visited. During observation on 3/26/25 at 7:47 a.m., nursing assistant (NA)-C and NA-G assisted R63 to put on a sweater over R63's clothes. R63 had a hoyer sling underneath them, and NA-C and NA-G transferred R63 from bed to wheelchair. R63's right hand was limp, and R63 used their left hand to move their right hand. During interview on 3/26/25 at 7:59 a.m., NA-G stated R63 was dependent on staff for all ADLs. NA-G stated R63's morning cares included dressing, peri-cares, personal hygiene, and transferring into wheelchair. NA-G stated nursing and therapy notified nursing assistants about which residents required ROM and other exercises and charted exercises performed in point-of-care (program used to record and document resident information). NA-G stated they were not notified to complete exercises with R63. During interview on 3/26/25 at 8:21 a.m., NA-C stated R63's morning routine included dressing, peri-cares, personal hygiene, and transferring into wheelchair for breakfast. NA-C stated they looked at resident care plan to know who needed assistance with exercises, and R63 did not require assistance with exercises. During interview on 3/26/25 at 11:01 a.m., licensed practical nurse (LPN)-D stated therapy knew who needed exercises and had their own program and charting. LPN-D stated therapy worked with R63 previously and did not know of any ROM nursing staff were to provide for R63. During interview on 3/27/25 at 10:54 a.m., registered nurse (RN)-B stated therapy gave nursing communication forms for exercises staff should complete with residents. RN-B placed orders for the exercises communicated to them and updated nursing staff. RN-B reviewed R63's care plan and stated they would need to discuss with therapy. RN-B stated range of motion helped residents maintain strength and movement and prevented stiffness. During interview on 3/27/25 at 12:11 p.m., the director of nursing (DON) expected staff to follow resident care plan and kardex (document to reference resident information from the care plan). DON verified R63's care plan and kardex directed R63 to receive daily range of motion, and R63's medical record lacked documentation of ROM. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/27/25 at 12:27 p.m., the therapy program manager (TPM) stated therapy worked with R63 in October to mid-November 2024 for range of motion and stretching. Therapy educated FM-K to provide range of motion for R63. TPM stated FM-K was frequently with R63 and thought FM-K's schedule may have changed since then. TPM stated R63's care plan for range of motion was in place before they were in their current role. The facility did not have a range of motion policy.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to comprehensively assess and implement behavioral interventions for 1 of 1 resident (R46) reviewed for behavior of throwing dining ware. Findings include: R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 had severe cognitive impairment, hallucinations, delusions, and no other behavioral symptoms or rejection of care. R46 was independent with activities of daily living. R46's Medical Diagnosis list printed 3/27/25, included mild cognitive impairment of uncertain or unknown etiology, hypertension (high blood pressure), and schizophrenia (chronic mental illness characterized by a combination of symptoms which significantly impair a person's thinking, feeling, and behavior). R46's care plan printed 3/27/25, indicated a focus area of potential nutritional problem and identified R46 had a history of throwing plates and breaking china dishes. The care plan indicated an intervention to offer plastic plates prn (as needed) to prevent injury to self or others. The care plan indicated a focus area of mood/behavior, which specified resident has a history of behaviors in the dining room, such as throwing food from tray and sliding tray across the floor. Interventions directed staff to monitor and document on mood state/behaviors upon occurrence. R46's Behavior/Mood Record printed 3/27/25, did not have target behavior monitoring prior to 3/27/25. R46's Follow Up Question Report dated 3/1/25 to 3/27/25, indicated R46's behavior, number of times behavior occurred during the shift, behavioral approaches, and trend as Not Applicable besides one entry on 3/24/25. The entry dated 3/24/25 indicated R46's behavior as None noted, number of times behavior occurred during the shift as 0, behavior approaches as Offer food/snack, and trend as Stayed the same. R46's progress notes were reviewed dated 8/1/24 to 3/27/25. A note on 9/4/24 at 9:51 a.m., indicated R46 picked up breakfast tray from dining room and threw their cereal over their head behind them on the way back to their room. Resident returned to room and slammed the door. ACP and social services to follow up as needed. No other progress notes were noted related to R46 throwing food or dining ware. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 3/24/25 at 7:06 p.m., a plate rolled from down the hallway, which aligned with the dining room where residents were seated and eating their meal. Staff and visitor moved to avoid contact with the rolling plate. R46 wheeled self down the hallway, and staff directed for R46 to place their room tray and dishes in the designated dirty dish area. R46 forcefully dumped the dishes and tray into the dirty dish container. Multiple staff and culinary director in the dining area confirmed the observed behavior happened often. The culinary director shrugged and stated mental health as the reason why R46 threw dining ware, and the other staff did not reply. During interview on 3/25/25 at 1:17 p.m., dietary aide (DA)-D stated R46 threw dining ware all the time and was not sure why. DA-D stated staff tried to have R46 use paper plates and were told the use of paper plates was a dignity issue. On 3/26/25 at 9:00 a.m., R46 opened their door, declined interview, and shut their door. R46's progress notes lacked documentation of R46 throwing dining ware on 3/24/25. During interview on 3/27/25 at 10:46 a.m., licensed practical nurse (LPN)-D stated R46 received food in the dining area but ate in their room. R46 was provided regular dining ware, was known to randomly throw dining ware, and could go weeks without throwing dining ware. During interview on 3/27/25 at 11:04 a.m., registered nurse (RN)-B stated R46 ate in their room and in the dining area. RN-B was aware of R46 throwing dining ware a couple days ago and was not aware before then. RN-B reviewed R46's care plan and stated staff could look at R46's triggers and monitor R46's mood to know when to give R46 a plastic plate. During interview on 3/27/25 at 11:12 a.m., nursing assistant (NA)-H stated R46 broke plates all the time and threw food. NA-H stated nobody knew why R46 threw dining ware and usually provided R46 with regular plates besides today, in which R46 received a gray colored type of plate. During interview on 3/27/25 at 12:19 p.m., the director of nursing (DON) stated they had not heard of R46 throwing dining ware until recently and questioned if staff were documenting on R46. DON reviewed R46's care plan intervention and stated there were no clear parameters and would rely on nursing judgement for when to give R46 a plastic plate. DON stated there were safety concerns of others getting hit by R46 throwing dining ware. Via email correspondence on 3/28/25, the administrator indicated they did not have a policy specific to behavioral management and tracking.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48299 Based on observation, interview, and documentation, the facility failed to ensure opened food items were wrapped, labeled, dated, and disposed of by use by dates. The facility failed to ensure personal staff items were not stored next to resident food items. Further, the facility failed to ensure facial hair restraints were worn during meal service and hair nets were worn in the kitchen. In addition, the facility failed to ensure the kitchen's dish machine reached adequate temperature and pans and utensils were completely dry before storage to prevent bacterial growth. This had potential to affect all 98 residents who resided in the facility, staff, and visitors who consumed food from the main production kitchen, and specifically residents on station two who consumed food from the steam table. Findings include: During the initial kitchen tour on [DATE] at 12:26 p.m., a few culinary staff were in the kitchen area without hair nets or facial hair covers. The dry storage area had two jackets which hung on racks with food items. One shelf had an opened container of Hormel nectar consistency thickened cranberry juice cocktail. The container was approximately three fourths full and was labeled ,d+[DATE]. The container label indicated to refrigerate unused portion and discard if not used within ten days after opening. The freezer near the dry food storage had multiple items in plastic bags with the opening knotted closed without a label or date. Meat patties in their original container with a bratwurst label was opened and not wrapped or secured shut and did not have a date label. The walk-in cooler in the kitchen labeled B had two fans. One fan had thin grayish colored, fuzzy matter throughout approximately half of the fan blades. The other fan had four areas of brownish grayish colored fuzzy matter which were sticking out of the fan. The area above the fans had brownish grayish colored fuzzy matter to the area above the fans approximately a foot and a half by a quarter to half an inch. Two large containers were labeled marinara sauce with a written label to use by [DATE]. One sandwich with cheese was wrapped in plastic without a label and not dated. The bread felt hard. One opened container of sour cream had a printed best by date of [DATE] and no opened date, and an opened container of cottage cheese had a printed best by date of [DATE] and dated ,d+[DATE]. All staff then had hair nets on in the kitchen, however two staff with facial hair were not wearing beard nets. A refrigerator labeled C had a plastic water bottle with a name written on it and more than twelve pitchers of orange and other juice without a label and date. In the freezer across from refrigerator C, there was a plastic water bottle, two opened containers of carrot rolls without a date, and pastries in a plastic bag which were unlabeled and undated. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on [DATE] at 1:03 p.m., the culinary director (CD) stated food and drink items should have a label and date and they generally kept opened refrigerated products for three to five days. CD stated the cooks usually rotated food supplies, and CD also reviewed supplies on Mondays. CD confirmed the jackets hanging on the dry storage racks and expected staff to hang their jackets in the kitchen closet. CD confirmed observation of the opened thickened liquid and stated they would toss the container. CD confirmed the observations on unlabeled and unwrapped and/or opened items in the freezer by the dry storage. CD identified the products as brats, pork, chicken, cheese ravioli, and egg rolls. In the walk-in cooler labeled B, CD stated the marinara sauces and other items which were unlabeled or past their use by dates should not be used. CD stated opened dairy products were kept for five to seven days. CD confirmed observations in refrigerator C and stated staff made juice from concentrate and stated there was usually a label with the date the juices were prepared on the shelf. CD confirmed observations in the freezer across from refrigerator C. During continued interview, CD stated they had issues with staff not wearing hair nets and facial hair nets and confirmed the previous observations of staff not wearing hair nets or facial hair nets when in the kitchen area where food was prepared. During continued observation and interview of the kitchen, dietary aide (DA)-A and DA-B washed dishes through the dish machine. The DAs stated they tested the temperature and sanitizer level of the dish machine to ensure the dish machine worked appropriately. DA-B stated they checked the temperature and sanitizer level earlier in the shift and believed the machine was a low temperature dish machine. DA-A ran the dish machine to wash plastic pitchers, and the temperature gauge read 102 degrees Fahrenheit (F). DA-A tested the sanitizer level with the test strip a few times after restarting the dish machine, and the strip did not change color. The sanitizer container was empty, and DA-A stated they needed to change the bucket. The [DATE] temperature and sanitizer level record was reviewed. The form had a blank area for when to report temperature and sanitizer levels. DA-B stated the sanitizer level was adequate this morning during breakfast, and the dish machine temperature dropped at times and had to have maintenance check. DA-B stated a dish machine temperature of 115 degrees F or below was not safe. During interview on [DATE] at 1:42 p.m., the corporate culinary director (CCD) confirmed the observation of the fans and above the fans in the walk-in refrigerator and stated the fans and area above needed to be cleaned. During observation and interview on [DATE] at 1:51 p.m., DA-A stated the sanitizer level was 100 ppm (parts per million) this morning and was not sure when the sanitizer solution ran out. The plastic pitchers were not rewashed as DA-A tested the sanitizer level after more sanitizing solution was placed. The test strip turned purple, and DA-A confirmed was an adequate level per the products' instructions and the dish machine temperature was 120 to 125 degrees F. Observation of further cycles, identified a temperature level of 110 degrees F. During observation and interview on [DATE] at 1:57 p.m., DA-A placed clean utensils in drawers which had visible condensation. DA-A stacked clean pans with condensation. DA-A observed a couple pans stacked and stated the dish machine should dry them and returned to the dish machine room. DA-A stated the temperature of the dish machine, which continued to be used, was 110 degrees F. The temperature gauge read 102 degrees F. DA-A placed a square yellow thermometer into the dish machine, which identified a temperature of 101 degrees F. The dish machine continued to be used. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The American Dish Service dish machine with model number AFC3DS had a label, which indicated a minimum temperature of 120 degrees F and 50 ppm. During observation of meal service on [DATE] at 12:15 p.m., DA-A was behind the steam table and took the foods' temperature and dished up multiple plates for residents. DA-A had a facial hair on their chin approximately a quarter inch to half an inch long and did not wear a facial hair restraint. During observation and interview on [DATE] at 1:38 p.m., DA-A and DA-C washed dishes through the dish machine. They stated the temperature earlier was 105 degrees F. During subsequent interview, DA-C stated the dish machine temperature was supposed to get to 120 to 130 degrees F, and the dish machine temperature fluctuated. DA-C stated left over food was dated and labeled and kept for five days to a week. DA-C stated food out of original packaging should be labeled and dated. DA-C stated it was important to label and date food so other shifts knew when items needed to be used by. DA-C stated their jackets were stored in the closet and stored food brought from home in a refrigerator on station four. DA-C stated they were supposed to wear hair and facial hair restraints during meal service. DA-C stated they let dishes dry before stacking or dried with a towel if needed to dry faster. During interview on [DATE] at 1:56 p.m., DA-A confirmed they did not have a facial hair restraint on and stated they forgot. During joint interview on [DATE] at 11:21 a.m., the floating maintenance director (MD) and the regional maintenance director (RDOM) stated they were notified the dish machine temperature was not adequate. They stated the temperature of the dish machine should be 140 to 160 degrees F and was 86 degrees F. The dish machine needed to reach appropriate temperature to sanitize the dishes. There was a monthly cleaning schedule for the fans in the walk-in refrigerator. The fans had been cleaned in the past month and was cleaned again this week. The fans would have been cleaned the first week of April per their cleaning schedule. They expected staff to notify them if fans needed to be cleaned sooner than their monthly schedule. Fans were important to keep clean for sanitary reasons and longevity of the machine. During interview on [DATE] at 11:32 a.m., CD stated they did not know the fans in the walk-in refrigerator needed to be cleaned and maintenance knew more. CD expected dishes to dry on the rack before stacking. CD stated they had a low temperature dish machine, and the minimum temperature was 120 degrees F. CD stated they had maintenance looking at the dish machine and adequate function of the dish machine was important to make sure dishes were sanitized and germs killed. During interview on [DATE], the administrator expected food items to be labeled and dated to avoid serving residents expired food. The administrator stated jackets and personal plastic water bottles needed to be stored away from resident food items for sanitary purposes. The administrator expected dishes to dry before stacking for sanitary reasons. The facility policy Dishwashing Machine Use dated [DATE], directed dishes to air-dry. The policy directed the operator to check temperatures with each dishwashing machine cycle and frequently during dishwashing machine cycle and to report inadequate temperatures immediately to the supervisor. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Food Storage - Non Perishable dated ,d+[DATE], indicated personal belongings or other non-food items would not be stored with food. The facility policy Food Receiving and Storage dated [DATE], indicated all foods stored in the refrigerator or freezer will be covered, labeled, and dated with use by date. The facility policy Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices dated [DATE], directed staff to wear hair nets or caps and/or beard restraints to keep hair from contacting exposed food, clean equipment, utensils, and linens.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was used for 1 of 1 resident (R63) who received cares and was on enhanced barrier precautions. Findings include: R63's annual Minimum Data Set (MDS) dated [DATE], identified R63 had severe cognitive impairment and diagnoses of aphasia (brain disorder which affects how one speaks and understands language), stroke (occurs when blood vessel is blocked or bursts), and hemiplegia or hemiparesis (loss of muscle function on one side of body or partial weakness on one side of body). R63 had impairment on one side of both upper and lower extremities and was dependent on staff for all activities of daily living, such as dressing, bed mobility, and transfers. R63's care plan printed 3/25/25, indicated R63 was on enhanced barrier precautions (EBP) related to presence of tube feeding. During observation on 3/26/25 at 7:47 a.m., nursing assistant (NA)-C and -G assisted R63 to put on a sweater. One NA wore gloves and no gown, and the other NA did not wear gloves or gown. The scrubs of both NAs touched R63's bed. Both NAs had gloves on and no gowns to transfer R63 from the bed to wheelchair using a hoyer lift. NA-C and -G boosted R63 up in the wheelchair. During interview on 3/26/25 at 7:59 a.m., NA-G stated R63 required total assistance and wore gloves to assist R63. NA-G stated nurses wore gloves and gowns to assist R63 with their feeding tube. NA-G verified R63's door had a sign which indicated enhanced barrier precautions. The sign directed staff to wear gloves and gowns for high-contact resident care activities, which included dressing and transfers. During interview on 3/26/25 at 8:21 a.m., NA-C stated they were supposed to wear gloves and a gown whenever they worked with R63 and verified they did not wear a gown when R63 was assisted. During interview on 3/26/25 at 11:01 a.m., licensed practical nurse (LPN)-D stated residents who required enhanced barrier precautions had a sign on their room. LPN-D stated staff needed to wear a gown when they worked with R63's feeding tube but not with transfers or personal cares. During interview on 3/27/25 at 10:54 a.m., registered nurse (RN)-B stated nurses were trained on enhanced barrier precautions and expected staff to follow the enhanced barrier precautions sign on R63's door. RN-B stated staff followed enhanced barrier precautions to prevent infections and for the protection of residents and staff. During interview on 3/27/25 at 12:11 p.m., the director of nursing (DON) expected staff to wear a gown and gloves during transfers and close cares for residents with enhanced barrier precautions. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy Enhanced Barrier Precautions dated 4/1/24, directed staff to follow enhanced barrier precautions for residents with indwelling medical devices, which included feeding tubes. The policy identified enhanced barrier precautions referred to the use of gown and gloves during high-contact resident care activities, and high-contact resident care activities, which included transferring, dressing, and device care.

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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure the first-floor shower room was maintained in a clean, sanitary manner when the shower ceiling was observed with brown staining. This had the potential to affect 26 residents (including R28, R73, and R304) who resided on the first floor and utilized the shower room on a routine basis. Findings include: R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 had moderate cognitive impairment and resided on the first floor. R73's annual MDS dated [DATE], indicated R73 had intact cognition. R73's banner printed on 3/24/25, indicated R73 resided on the first floor. R304's admission MDS dated [DATE], indicated R304 had intact cognition, was admitted to the facility on [DATE], and resided on the first floor. During an interview on 3/24/25 at 12:48 p.m., R73 stated she believed the facility had black mold growing in the shower room and felt unsafe using the shower related to this and felt it was a serious issue. R73 stated she was unsure when she had told staff but thought they were aware of the black mold. During an observation and interview on 3/24/25 at 1:33 p.m., the ceiling above and to the right of the shower head when facing it, had an approximately one-foot by one-and-a-half-foot area of small, various spaced and sized, black/brown stains. Licensed practical nurse (LPN)-B stated he had not seen the stain before but thought it looked like mold and he would need to have maintenance look at it. During an interview on 3/24/25 at 1:58 p.m., R28 stated he had noticed the black stuff on the ceiling of the shower room for months. R28 stated he had notified staff of the black stuff when he had first noticed it, but was told it was fine and did not receive any follow-up on if it was going to be fixed. During an interview on 3/24/25 at 5:56 p.m., R73 stated the ceiling in the shower room was gross. R304 stated he had first noticed the black spots on the ceiling about two days after he was admitted and had used the shower for the first time. During an interview on 3/26/25 at 9:30 a.m., nursing assistant (NA)-A stated she would clean the shower room after each resident use, but housekeeping would be in charge of cleaning the black stain on the ceiling as it required a deeper cleaning. NA-A stated she had seen the stain before but was unsure how long it had been there. At 11:27 a.m., NA-A confirmed that they only had one shower for the floor and all 26 residents on the unit used it. (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	03/27/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with housekeeping aide (HA)-A and the director of housekeeping (DOH) on 3/26/25 at 10:36 a.m., HA-A stated he had worked at the facility for about a year and the stain on the ceiling had been there since he started. HA-A stated he had attempted to clean the stain previously but was unable to remove it so he had notified maintenance prior to the director of maintenance leaving in February, but it had never been fixed. The DOH stated he did not believe that the stain was mold but given its appearance could understand why residents would think that. HA-A followed up by stating, he wouldn't like that in my shower either. During an interview on 3/26/25 at 11:11 a.m., the regional director of maintenance (RDOM) stated he was filling in as the last maintenance director had left in February of this year. The RDOM stated he had not been made aware of the first-floor shower room ceiling staining until the being of this week. The RDOM acknowledged that he thought communication may have been an issue with the last maintenance director and may have led to the ceiling stain in the shower room not being addressed. The RDOM stated they would have to tear down that part of the wall/ceiling to address the issue and redo it in case this issue was related to moisture, although he did not think the staining was mold. A policy regarding maintenance requests was made and a TELS Masters procedure dated 2019 was received. The procedure did not address an expected timeline for completing maintenance requests.