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	06/17/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to immediately report incidents of potential resident-to-resident abuse to the state agency (SA) within two hours, as required for 2 of 2 residents (R64, R116) reviewed for abuse. In addition, the facility failed to ensure allegations of potential abuse were reported to the state agency (SA), within 2 hours, for an injury of unknown cause resulting in a fracture for 1 of 1 residents (R80) whose allegations were reviewed. Further, the facility failed to ensure timely reporting of self-neglect for a missing resident for 1 of 1 resident (R7) reviewed who left the building and did not return and whose whereabouts were unknown. Findings include: R64 R64's quarterly Minimum Data Set (MDS) dated [DATE], indicated R64 had intact cognition, was diagnosed with depression and bipolar disorder, and was independent with all activities of daily living (ADLs). R64's email communication to the administrator dated [DATE] at 1:22 p.m., indicated R64 wrote to the administrator and the substance use disorder services director (SD) that R116 had come up to his unit and was telling other residents that he (R116) intended to fight him (R64). R64 then wrote that given the physical threats made against him, he was increasingly concerned about his safety. The administrator responded at 1:27 p.m. and indicated they would call the nurse back and let them know what was happening. At 2:19 p.m., the administrator advised R64 to stay on his current unit and not go to the substance use disorder unit and let staff at his current unit know if he had any issues. R64's medical record was reviewed and lacked an indication that R64's allegations of resident-to-resident abuse was reported to the SA. R116's admission MDS dated [DATE], indicated R116 had intact cognition, was diagnosed with depression, and was independent with transferring and walking. R116's progress note dated [DATE] at 4:50 p.m., indicated R116 was on 15-minute safety checks related to a verbal altercation with another resident. R116's medical record was reviewed and lacked an indication that R64's allegation of abuse involving R116 was reported to the SA. During an interview on [DATE] at 2:43 p.m., R64 stated that he had a verbal altercation with R116 last Friday. R64 stated that R116 had threatened him and called him vulgar names, but he did not believe any staff had seen the incident. R64 stated that on Friday he had also moved from the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substance use disorder unit to a different unit. R64 stated he had then heard that R116 intended to fight him, so he had emailed the administrator because he feared for his safety. R64 stated that although other residents had talked with R116 over the weekend, he had not seen R116 since Friday. During an interview on [DATE] at 3:24 p.m., the administrator stated that the allegation that R64 had emailed her on [DATE] had not been reported as R64 was very grandiose, but she had put interventions in place to ensure his safety. During an interview on [DATE] at 10:35 a.m., licensed practical nurse (LPN)-C stated that he had been working the substance use disorder unit, that R64 had previously resided in and R116 currently resided in, this Saturday. LPN-C stated R64 was moved off the substance use disorder unit when R64 had been the aggressor in a resident-to-resident verbal altercation. LPN-C stated that as a precaution after the incident, facility staff were to assure R64 and R116 stayed on their respective units. LPN-C stated that if the resident reported abuse or he witnessed it, he would report this to the director of nursing (DON), administrator, or the manager on duty, and they would be in charge of reporting it. LPN-C stated that the administrator had been aware of this altercation between R64 and R116. R80 A submitted SA incident report, dated [DATE] at 6:30 a.m., identified an allegation of unexplained injury and self-neglect was being submitted for R80. An incident dated [DATE] at 7:00 a.m. was listed, which identified resident was in pain and sent out to the hospital and returned with fracture. Further in the report, it identified R80 called 911 himself on [DATE] complaining of pain and was sent to the hospital about 1 p.m. R80's admission Minimum Data Set (MDS) assessment dated [DATE], identified R80 had intact cognition with no hallucinations or delusion, and was dependent on staff for all activities of daily living (ADLs) including bed mobility and transfers. R80's care plan, printed [DATE], identified R80 transferred with assist of full lift (Hoyer lift-mechanical lift used for people who cannot bear weight) and assist of 2 staff. In addition, R80 was identified as a vulnerable adult while residing at the nursing facility and at risk for decreased cognitive and physical ability related to diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis and muscle weakness affecting the left side of the body following a stroke-blood clod in the brain) and aphasia (impairs ability to speak, write and understand both spoken and written language). R80's progress notes, [DATE] to [DATE], were reviewed and identified the following. -[DATE] at 1:34 p.m.: R80 called 911 due to leg pain and requested transportation to hospital -[DATE] at 7:01 a.m.: R80 was sent to the hospital on [DATE]. The note included a diagnosis of closed fracture of proximal end of the left fibula, unspecified fractur morphology and the fibular head is noted to have a fracture. R80 was to wear immobilizer for 6-8 weeks with recommended follow up with ortho in 2 weeks. -[DATE] at 7:02 a.m.: addendum to the note above: R80 returned from the hospital on [DATE] at 7:00 p.m. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] at 2:24 p.m.: R80 returned with documentation that reported a fracture. R80 denied any recent fall, injury or abuse. R80 reported pain to his left leg but denies any injury. Administrator notified. The progress notes lacked an entry of when R80 returned from the hospital and who was notified upon return. During an interview on [DATE] at 12:50 p.m., registered nurse (RN)-F stated they had been working the day after R80 returned from hospital ([DATE]) and had questioned the paperwork the facility had received when he returned from the hospital. RN-F stated she called the hospital to get additional information and was sent the x-ray results. RN-F stated the paperwork from the hospital had been reviewed upon from the hospital as it had passed on in report. Surveyor attempted to reach licensed practical nurse (LPN)-E on called [DATE] at 8:28 a.m. but unable to reach to follow up if they had notified management of fracture of unknown origin upon R80 returning from the hospital. Did not return call. During an interview on [DATE] at 9:12 a.m., licensed practical nurse (LPN)-D stated if a resident returned from the hospital with a fracture with unknown cause would be something that should be reported to the supervisor right away. LPN-D stated they would have to investigate what happened and report it to the state. On [DATE] at 10:18 a.m., director of nursing (DON) stated fractures of unknown causes would be reportable to the state agency. During an interview on [DATE] at 11:12 a.m., administrator reviewed the timelines of the incident and the report. Administrator verified she should have reported the incident to the SA within 2 hours. A facility policy titled Abuse Prohibition/Vulnerable Adult Policy, dated 11/25/, identified the following: -Incidents to be Reported; section e. Injuries of unknown source - an injury should be classified as an injury of unknown source. When both of the following conditions are met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and, b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is in an area not generally vulnerable to trauma), or the number of injuries observed at one point in time or the incidence of injuries overtime. Furthermore, the policy indicated: How and when to report to the Minnesota Department of Health ([NAME])/ Office of Health Facility Complaints (OHFC) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	throughout the time frame that were coded under default PN type for eMAR. A Notice of Resident/Patient Transfer or Discharge indicated the notice was mailed to R7 on [DATE] as R7's 18-day bed hold expired. The progress notes lacked indicated of a missing person report filed after 24 hours of no contact with resident. Furthermore, the progress notes indicated a MAARC report was not filed until [DATE] which was almost a month since last contact with R7. During an interview on [DATE] at 9:12 a.m., licensed practical nurse (LPN)-D stated when a resident doesn't return, they should then notify the supervisor or administrator after searching for the resident. LPN-D stated the local hospitals should be called, and all this was documented in the progress notes. During an interview on [DATE] at 9:28 a.m., social services designee (SS)-D stated if a resident was gone from the facility with no contact, then a missing person's report was filed. SS-D stated if a resident didn't return to the facility, they would hold the resident's bed for 18 days after last contact along with filing a Minnesota Adult Abuse Reporting Center (MAARC) report. SS-D stated R7 was in and out of the facility and sometimes went to his apartment. SS-D was unsure if R7 had signed out of the facility on [DATE]. SS-D stated social services was responsible for ensuring the MAARC report was filed for R7. Surveyor requested copy of sign out sheet for residents for [DATE] along with copy of the MAARC report. A MAARC report was provided for R7 and indicated it had been filed on [DATE] at 10:06 a.m. No copy of the resident sign-out sheet was provided. During an interview on [DATE] at 10:18 a.m., director of nursing (DON) stated if a resident didn't return when they indicated they would be back, the staff should be calling the resident/family and would be expected to put in progress notes regarding this. DON stated social services would follow up if the resident hadn't returned within 24 hours and nursing would provide information needed. During an interview on [DATE] at 11:09 a.m., administrator stated the report was filed late as it should have been filed 24 hours after resident didn't return. Administrator verified it appears the last contact facility had with R7 was on [DATE]. Administrator stated a MAARC report and a missing person report should have been filed so adult protection could get involved and verified that it had not been done until today [DATE]. A facility policy titled Leave of Absence and Discharging Against Medical Advice Process and Acknowledgement Form, updated 10/24, indicated under the leave of absence process:6. If you do not return to the facility within 24 hours from your expected time back and you fail to call the facility to let the staff know when you will be returning, a missing person report will be completed with the local law enforcement.7. If you call the facility and inform the staff that you will not be returning, you will be discharged Against Medical Advice (AMA). The facility protocol for discharges Against Medical Advice will be implemented including contacting adult protective services (MAARC).

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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** Based on observation, interview and record review, the facility failed to maintain the resident room in a safe, clean, and comfortable condition for 2 of 2 residents (R30, R64) by failing to repair or otherwise seal a broken resident room window, leaving an opening to the outside environment that allowed pests to enter the facility. In addition, the facility failed to ensure condition of wall corner trim pieces and baseboards on the second-floor hallways were in a safe condition. Also, the facility further failed to ensure 2 of 2 residents (R10, R100) rooms were maintained in good repair by failing to address missing drawer fronts, missing mirrors, broken wallboard, hanging curtains off their hooks. Findings include: R30's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R30 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and was independent with activities of daily living (ADLs). R64's quarterly MDS assessment dated [DATE] indicated R64 was cognitively intact with a BIMS score of 15 and was independent with ADLs. During an interview and observation on 6/16/26 at 8:12 a.m., R64 stated he had moved into the room the previous week. R64 stated his roommate (R30) had told him the window had been broken for at least four months. Observation revealed an approximately a one-inch gap between the window frame and the windowsill that allowed bugs to enter the room and R64 reported seeing flies in the room over the previous several days. During an interview on 6/16/26 at 8:04 a.m., the Regional Maintenance Director confirmed the window was broken and there was a gap between the window and the frame. He stated the facility had identified an additional issue with the window the previous week and acknowledged there are methods to cover gaps such as this and they should have been implemented. He stated he would have the issue corrected immediately. During an interview on 6/16/26 at 12:06 p.m., the Director of Nursing (DON) agreed with the concern and stated the window should not have been open to the outside environment allowing pests or bugs to enter the facility. R10 R10's admissions Minimum Data Set (MDS) dated [DATE], identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, viral hepatitis, arthritis, osteoporosis, hip fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice. During observation and interview with R10 on 6/14/26 at 11:10 a.m., R10 was lying in bed. There was an empty drawer with a missing drawer front for R10 and a blank space on the wall above the dresser with a silhouette of a mirror. R10 stated she had been in current room since admission to the facility in April of 2026 and the room had always had a missing drawer front and no mirror on the wall. it (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bothers me and my room looks really bad. During interview with R10's family member (FM)-A on 6/15/26 at 4:14 p.m., in R10's room, FM-B stated, condition of the room is not what I expected. I want to move her. RM-B stated missing drawer fronts and cracked wallboard next to the head of her bed was bad and needed repair. I would never live in a place like this. During interview with R10's hospice nurse (RN)-B on 6/16/26 at 1:06 p.m., RN-B stated she visited R10 twice per week and stated, Condition of [R10's] room is filthy. Missing mirror and front drawer. RN-B stated, [R10] deserves better. R100 During observation and interview with R100 on 6/14/26 at 11:00 a.m., a hole in the wallboard was noted near head of bed which was placed twelve inches from the wall. Also, the entire wall had peeling paint with most of it near the head of his bed. R100 stated, [condition of room] looks awful but no one here does anything about it. During observation and interview with nursing assistant (NA)-A on 6/15/26 at 4:30 p.m., NA-A observed R100's window curtain hanging off the hooks on one corner, and missing drawer fronts to the dresser. I don't like the way those drawers look. I would like them fixed and looks like crap. NA-A stated expectation of staff to notify maintenance of repair requests by using the electronic work order (TELS) report. NA-A said she had not submitted a TELS report for maintenance repairs. At 4:32 p.m., NA-A walked into R10's room and pointed to missing drawer front and verified the drawer front was missing. Also, I do not like the condition of the curtains, walls and outlet there. Missing mirror or something (pointing to blank wall with silhouette of mirror). I would hate that in my house. During observation on 6/14/26 at 9:17 a.m., on the second floor of facility a wall corner trim outside elevator was cracked and missing a piece leaving sharp edges. A corner piece on the wall alcove outside the janitor closet across from the elevator and nursing desk was also cracked. A baseboard section across from nursing desk was missing and several cracks were observed. In addition, a broken corner piece of resident door was observed leaving wood visible behind it. During observation and interview with the regional maintenance director (RM)-D and the maintenance operation director (MO)-D on 6/15/26 at 5:26 p.m., MO-D stated expectation of staff to submit an TELS report for anything that is need of repair. Both RM-D and MO-D stated there were no records from staff to repair or replace drawer fronts, mirrors, curtains, holes in walls or corner trim pieces. RM-D and MO-D viewed R10 and R100's rooms and MO-D stated, Definitely not homelike here. MO-D viewed broken corner pieces and stated, it is not safe [for residents] walking by. During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated expectation of staff to submit a TELS report for any maintenance issues or concerns. LPN-B stated she had not submitted any TELS reports in recent memory. During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated, when you hear about or see anything that needs fixing or replacing, we have to let maintenance know by using TELS. TMA-A stated she had not submitted any TELS reports in recent memory. During interview with registered nurse (RN)-C on 6/17/26 at 9:13 a.m., RN-C stated expectation of all (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to submit a TELS report for any maintenance issues or concerns. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated resident dresser drawers, mirrors, curtains, and holes in the wall are not appealing and should be in good repair. Facility policy on safe homelike environment was requested and not received.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. Based on observation and interview, the facility failed to ensure handrails on the second floor were securely attached to the wall. This had the potential to affect all residents, staff, and visitors who had access to the handrails.Findings include: During observation on 6/14/26 at 9:17 a.m., second floor hallway handrails were loosely attached to wall across from the elevator, across from the dining room and nursing desk, between two resident rooms. In addition, one handrail was unattached at one end pulling away from the wall outside a resident room.During review of April, May, and June 2026 electronic work orders (TELS) reports, there was no report of loose handrails.During observation and interview on 6/15/26 at 5:26 p.m., the regional maintenance director (RM)-D and the maintenance operation director (MO)-D reviewed and verified the loose and unattached handrails on the second floor. MO-D stated expectation of staff to submit an electronic work order (TELS) report for anything that is need of repair or replacement including loose and unattached handrails. MO-D and RM-D stated they had reviewed TELS reports for January through June 2026 and they failed to identify any work order report for the loose and unattached handrails.During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated, when you hear about or see anything that needs fixing or replacing, we have to let maintenance know by using TELS. TMA-A stated she had not submitted any TELS reports in recent memory.During interview with registered nurse (RN)-C on 6/17/26 at 9:13 a.m., RN-C stated unattached and loose handrails are a safety concern. RN-C stated expectation of all staff to submit a TELS report for any maintenance issues or concerns.During interview with director of nursing (DON) on 6/17/26 at 10:35 a.m., DON stated unattached and loose handrails, are not safe. DON stated expectation of all staff to submit a TELS report for any maintenance issues or concerns.Undated facility policy titled Safety stated the facility was to provide a safe environment by encouraging and empowering residents/employees to live and work in a manner that fosters personal safety.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 3 of 3 residents (R11, R40, R53) who were seated at the dining room table with other residents who were served meals without being served meals themselves resulting in them waiting for their meals while tablemates dined.Findings include:R11's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R11 had intact cognition and required set up or clean-up assistance from staff for eating.R40's annual MDS assessment dated [DATE], identified R40's short term and long term memory appeared OK and a Brief Interview for Mental Status (BIMS) was not completed indicating R40 was rarely/never understood. Further, the assessment identified R40 was independent with eating.R53's significant change MDS assessment dated [DATE], identified R53 had moderately impaired cognition and required set up or clean-up assistance from staff for eating.On 6/14/26 at 12:09 p.m., the lunch meal service was observed on 2nd floor main dining room. There were residents in the dining room waiting for lunch. The meal cart came up to the floor at 12:13 p.m., and the food was transferred to the steam table. It was observed that R11 and R20 were seated next to each other at the same table on opposite side of the dining room than the steam table along with two other unidentified residents. At 12:30 p.m., R11 was observed to be eating his lunch. At 12:35 p.m., R11 expressed frustration as R11 was still waiting for his lunch. R11 stated it pisses me off as happens all the time [referring to tablemates being served before him]. It was observed that the 2 unidentified residents had finished eating and left the table and R20 was almost done with lunch. At 12:48 p.m. R11 was served lunch (18 minutes after tablemates had been observed eating). At 12:52 p.m., staff delivered desserts to some residents while other residents had not yet been served lunch.On 6/16/26 at 8:14 a.m., the breakfast meal service was observed on the 2nd floor main dining room. There was a table with 2 residents (R82 and R40). At 8:18 a.m., R82 was served a bowl of cold cereal and milk. At 8:30 a.m., R40 was served breakfast (12 minutes after tablemate was served breakfast and eating).During the same observation during the breakfast meal service, another table had 4 residents seated and R53 was seated at the end of the table. Other residents had been served cold cereal in front of them at the start of the observation at 8:14 a.m. At 8:22 a.m., R53 was observed to request oatmeal for breakfast as he did not have any food in front of him despite tablemates having been served. At 8:35 a.m., R53 requested, again, to have some oatmeal which was then provided at 8:37 a.m. (23 minutes after tablemates had been served)During an interview on 6/16/26 at 8:51 a.m., R53 stated he had to wait for breakfast this morning after asking couple of times for oatmeal. During an interview on 6/16/26 at 8:58 am., R40 stated that it happens all the time and stated she frequently had to wait for meals after others at the table are served and added I am used to it.During an interview on 6/16/26 at 10:26 a.m., nursing assistant (NA)-A stated they assist serving residents in the dining room. NA-A stated they served residents as they came into the dining room. NA-A stated if the residents were already in the dining room, they served them as the trays were prepared. NA-A stated they did not serve residents by table. During an interview on 6/17/26 at 9:04 a.m., NA-B stated residents were served by how the trays were prepared and that was determined by the order of the meal tickets. NA-B stated residents were served on a first come first served basis and not by table.During an interview on 6/17/26 at 10:18 a.m., director of nursing (DON) stated that every unit's process for serving food was a little different. DON stated meals should be served table by table. During an interview on 6/17/26 at 11:12 a.m., administrator stated the process for the order of serving residents in the dining room was as the tickets came up from dietary, the residents are served. Administrator verified residents seated at the same table should be served at the same time.A facility policy on dignified dining was requested but not received.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the required Notice of Medicare Non-Coverage (NOMNC) was provided timely to 1 of 3 residents (R39) reviewed for beneficiary notices.Findings include: R39's admission Minimum Data Set (MDS) dated [DATE], indicated R39 had intact cognition. R39's SNF Beneficiary Protection Notification Review form dated 5/28/26, indicated R39's last covered day of Medicare Part A service was on 5/28/26, and the termination was provider-initiated when Part A benefit days were not exhausted. R39's NOMNC form dated 5/28/26, indicated R39's last covered day of Medicare Part A service was on 5/28/26 and was signed by the resident on 5/27/26. R39's medical record was reviewed, and no indication that facility staff had attempted to give R39 the NOMNC form before 5/27/26 was found. During an interview with the administrator on 6/17/26 at 8:12 a.m., the administrator confirmed that she could not find an indication that the NOMNC form was given to R39 before 5/27/26 in R39's medical record. The administrator stated she would have expected this form to be given at least 48 hours before the service end date. The facility's NOMNC policy dated 2/20/23 indicated the NOMNC must be delivered at least two days before Medicare-covered services end.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview and record review, the facility failed to ensure protection of resident property for 2 of 2 residents (R10, R15) reviewed for missing items.Findings include:R10 R10's admissions Minimum Data Set (MDS) dated [DATE], identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, vital hepatitis, arthritis, osteoporosis, hip fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice.R10's admissions Care Area Assessment (CAA) with assessment review date (ARD) of 4/28/26 identified vision problems indicated by Moderately impaired and ability to see in adequate light (with glasses or other visual appliances).R10's MN admission packet dated 4/22/26, identified a Personal Belongings Inventory form with and X marked next to Glasses. The form failed to identify any clothing that was brought in by resident or family at admission.During observation and interview with R10 on 6/14/26 at 11:10 a.m., R10 was lying in bed wearing a nightgown. R10 stated she was missing several nightgowns and a pair of eyeglasses. R10 stated the facility was aware of the missing items and had not investigated.During interview with R10's family member (FM)-A on 6/15/26 at 4:10 p.m., FM-A stated she visited R10 daily and R10 was now missing five nightgowns which were labeled and [R10] is on her third pair of glasses. FM-A stated facility staff were aware but no one from the facility investigated.During interview with hospice nurse (RN)-B on 6/16/26 at 1:06 p.m., RN-B stated she visited R10 twice per week and experienced difficulty working with facility. RN-B stated R10's eyeglasses were missing and had notified facility but nothing was done. RN-B stated R10's nightgowns were missing, Literally everything is missing from [R10's] room. R15 R15's admissions MDS dated [DATE] identified R15 with inability to determine cognition, adequate vision with no corrective lenses, impaired function of one side of upper extremity, utilized a wheelchair for mobility, required substantial assistance with dressing and personal hygiene. In addition, R15 with Encephalopathy (malfunction in the brain causing mental status changes), blood clots, kidney disease, anxiety, depression, and rhabdomyolysis (breakdown of muscle causing kidney damage).R15's MN admission Packet dated 3/19/26 identified a Personal Belongings Inventory form with an X next to Glasses.R15's admissions CAA with assessment review date (ARD) of 4/7/26 identified 03. Visual Function as Not Triggered.R15's orders, care plan and kardex failed to identify visual impairment.R15's Admissions Data Collection assessment dated [DATE] identified R15 as having no to Corrective lenses (contacts, glasses, or magnifying glass)R15's Hearing/Vision Assessment Form dated 3/20/26 and 4/2/26, the forms identified R15 with adequate vision. No corrective lenses.During record review of R15's Hospital DC interagency transfer form dated 4/1/26, identified R15 with uses glasses when prompted regarding any visual impairments.During interview with R15's FM-B on 6/16/26 at 9:23 a.m., FM-B stated R15 wore prescription eyeglasses and when she visited him on 4/9/26 they were bent and dirty and were tucked away in his bedside table. She stated R15 was supposed to have them on. FM-B stated he was missing them entirely on two subsequent visits and staff were unable to locate them. FM-B stated no one from the facility contacted her about the missing eyeglasses. FM-B stated she had to replace R15's eyeglasses.Facility Grievance logs with dates from 1/21/26 to 6/14/26 failed to identify missing items for R10 and R15.During interview with nursing assistant (NA)-A on 6/15/26 at 4:32 p.m., NA-A stated expectation of staff to fill out a grievance form for reported missing items. NA-A stated she was aware of R10's missing eyeglasses and nightgowns yet did not file a grievance because she thought someone else did.During interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of all staff to fill out a grievance form for reported missing items and the social services department would conduct a formal investigation.During interview with licensed practical (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated resident belongings were documented on a personal inventory form which was attached to the admission packet. LPN-B was unaware of who documented it and where it would be located in the electronic medical record (EMR). LPN-B stated social services department was responsible for investigating missing items once staff identify and fill out a grievance form.During interview with trained medication aide (TMA)-A on 6/17/26 at 7:51 a.m., TMA-A stated the facility had a personal inventory form to identify all belonging that are brought in by the resident at admissions but was unaware of where to locate the document or determine if there was one completed for R10 and R15.During interview with social services designee (SS)-D on 6/17/26 at 8:33 a.m., SS-D stated she was responsible for investigating missing items once the staff fill out a grievance form. SS-D stated she was unaware of R10 and R15's missing items. SS-D reviewed the grievance logs and verified they were not reported missing. SS-D stated she believed the mental health technician (MH)-T was responsible for documenting personal inventory of all residents upon admission to the facility. SS-D was unable to locate the form in the EMR for both R10 and R15.During interview with MH-T on 6/17/26 at 8:34 a.m., MH-T stated he was assigned to review personal inventory for all residents upon admission. MH-T stated his role was to complete the personal belonging inventory form electronically which was attached to the admission forms. MH-T verified both R10 and R15 were located in their EMRs with their admissions packets with eyeglasses documented as present on admission.During interview with RN-C on 6/17/26 at 9:31 a.m., RN-C verified she had completed the 3/20/26 Hearing/Vision Assessment form for R15. RN-C stated, I know he wears glasses and do not know why I documented that he did not wear them. RN-C verified the incorrect information she documented failed to trigger a Care Area Assessment (CAA) R15's admissions MDS which failed to create a care plan and kardex for R15 with regard to eyeglasses.During interview with the facility's MDS Coordinator (M)-C on 6/17/26 at 9:59 a.m., M-C stated she was responsible for submitting all MDS information to Centers of Medicare and Medicaid. M-C reviewed the vision section of R15's admissions MDS and stated it was not filled out correctly. I think he wears eyeglasses. M-C stated R15's inaccurate MDS resulted in the CAA section to not be triggered for vision therefore causing R15's care plan and kardex to not include his prescription eyeglasses. M-C stated, the ball got dropped.During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of staff to fill out a personal inventory form for anything that the resident brought with them upon admission. DON was unaware of who was assigned to complete the form and download it in the EMR. For missing items, the DON stated expectation of staff to fill out a grievance form and social services department could then investigate. DON verified the grievance logs failed to identify missing eyeglasses for R10 and R15. DON stated the staff had failed to document and follow up on missing items.Facility policy on missing items was requested and not received.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure ongoing, adequate monitoring for side effects with psychotropic medication use to promote continuity of care for 1 of 5 residents (R15) reviewed for unnecessary medication use. In addition, the facility failed to ensure psychotropic medication had identified target behaviors/symptoms, and therefore failed to monitor for target behavior/symptoms for 1 of 5 residents (R15) reviewed for unnecessary medication use.Findings include: R15's admission Minimum Data Set (MDS) dated [DATE], indicated R15 had some difficulty making decisions regarding tasks in daily life in new situations and demonstrated no delusional thinking during the review period. The MDS indicated R15 used antidepressant medication and was diagnosed with depression and anxiety. R15's care plan dated 5/20/26, indicated R15 had an alteration in mood and behavior related to anxiety, depression, ADHD (attention deficit/ hyperactivity disorder), and mild cognitive impairment and was enrolled in mental health services per recommendation. The care plan did not include target behaviors or side effect monitoring for duloxetine. R15's order summary dated 6/13/26, included an order dated 5/22/26 for 60 milligrams (mg) of duloxetine (an antidepressant medication) daily for depression. R15's medical record, including the treatment administration record, was reviewed and did not indicate that duloxetine target behaviors were identified or being monitored. Side effect monitoring for duloxetine use was also not found after reviewing R15's medical record. During an interview on 6/17/26 at 9:11 a.m., licensed practical nurse (LPN)-C stated R15 received duloxetine for depression. LPN-C stated that usually target behavior monitoring and side effect monitoring were added to the treatment administration record (TAR), but he did not see that it had been added. LPN-C stated he was unsure what target behaviors related to his duloxetine but did not think R15 had been having any side effects from the medication. During an interview on 6/17/26 at 9:17 a.m., LPN-A, the nurse manager for the unit, confirmed she had reviewed R15's medical record and stated that she did not see that target behaviors were identified or monitoring was in place for his duloxetine. LPN-A stated that she also did not see that side effect monitoring for the duloxetine was in place and would have to add it. During an interview on 6/17/26 at 9:22 a.m. with the director of nursing (DON) and regional nurse consultant (RNC)-A (a registered nurse), RNC-A stated that residents taking psychotropic medications should have target behavior monitoring and side effect monitoring in place. The DON stated this monitoring would be documented in the TAR. The facility's Psychotropic Medication Use policy dated 5/2025, indicated that identified target behaviors would be monitored along with individualized interventions as well as supporting documentation in the clinical record. The policy indicated that ongoing documentation must include behavioral indicators or symptoms, monitoring for effectiveness, and potential for adverse consequences.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide a written bed hold (BH) for 3 of 3 residents (R9, R15, R100) reviewed for hospitalization. Findings Include: R15 R15's admissions MDS dated [DATE] identified R15 with inability to determine cognition, adequate vision with no corrective lenses, impaired function of one side of upper extremity, utilized a wheelchair for mobility, required substantial assistance with dressing and personal hygiene. In addition, R15 had diagnoses of Encephalopathy (malfunction in the brain causing mental status changes), blood clots, ischemic colitis requiring colostomy (bag outside body to collect stool), kidney disease, anxiety, depression, and rhabdomyolysis (breakdown of muscle causing kidney damage). R15's progress notes for 3/19/26 and 3/20/26 identified R15 with admission to facility on 3/19/26 and suffered a fall with head strike on 3/20/26 with return to the hospital. R15's progress note dated 4/1/26, stated R15 had readmitted to the facility. Also, R15's progress note dated 5/23/26 identified hospitalization and subsequent return on that date. R15's Care Conference form dated 4/8/26 identified R15 had admitted to facility on 3/19/26 and had a fall with a head strike and was admitted to the hospital. Also, R15 was readmitted to facility on 4/1/26. R15's Hospital Transfer form dated 5/23/26 documented by registered nurse (RN)-A identified R15 had another fall with a head strike and was sent to the hospital. The assessment form failed to mark section of 7. Bed hold form with indication of sending a signed bedhold form with R15 to the hospital. Form stated daughter, family member (FM)-B was notified. During interview with R15's FM-B on 6/16/26 at 9:23 a.m., FM-B stated she and the rest of R15's family were never notified or informed regarding a bedhold or transfer form with both hospitalizations on 3/19/26 and 5/23/26. FM-B stated she called the facility on 3/19/26 to follow up on R15's hospitalization because the hospital contacted her and not the facility. During interview with social services designee (SS)-D on 6/14/26 at 1:14 p.m., SS-D stated R15 was competent to make his own decision and reviewed R15's electronic medical record (EMR) and verified hospitalizations on 3/20/26 with return to facility on 4/1/26, and 5/23/26. SS-D stated nursing was responsible for ensuring a written and signed bedhold form was completed and scanned into the EMR. If form was not signed then a progress note would have to be done in the EMR and social services would have to follow up. SS-D stated this was not done for R15 for both his hospitalizations on 3/19/26 and 5/23/26. R100 R100's quarterly MDS dated [DATE] identified R100 with intact cognition, substantial assistance needed for dressing, and toileting hygiene and had diagnoses of schizoaffective disorder, cancer, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heart disease, diabetes, seizures, anxiety, depression, bipolar, and lung disease. R100's EMR identified hospitalizations on 1/28/26, 2/25/26, 3/15/26, 5/19/26, 5/22/26, and 6/11/26 from the Hospital Transfer form assessments. All assessments failed to identify a signed bedhold form was offered and signed. During interview on 6/14/26 at 3:14 p.m., R100 stated he had never been asked to sign a bedhold form prior to any of his hospitalizations. Review of Ombudsman notices from facility to the Office of the State Long-Term Care Ombudsman for January to May 2026 failed to identify R4, R15, and R100's hospital transfers. During interview with social services director (S)-D on 6/17/26 at 11:15 a.m., S-D stated there was staff turnover and verified notices to the Office of the State Long-Term Care Ombudsman failed to include residents who transferred to the hospital and that bedholds were not documented in the EMR and should be. During interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of staff to start a Hospital Transfer form in the EMR for every incident of transferring a resident to the hospital. RN-A verified he documented R15's 5/23/26 Hospital Transfer form and also R100's 1/28/26, 2/25/26, 3/15/26, 5/19/26 ,5/22/26,and 6/11/26 Hospital Transfer forms. RN-A stated, I do not know anything about a bedhold form. I have never been told that I have to have a resident sign [that]. I only fill out the hospital transfer form in the EMR and mark the sections that I complete. During interview with licensed practical nurse (LPN)-B on 6/17/26 at 7:40 a.m., LPN-B stated expectation of nursing staff to document bed hold conversations in the Hospital Transfer form when sending resident to the hospital. Also, staff were supposed to document whether they obtained the signed form or not and to inform social services to follow up if form was not signed. During interview with RN-C on 6/17/26 at 9:05 a.m., RN-C stated expectation of nursing staff to create a document in the EMR titled Hospital Transfer form for each episode of transferring a resident to the hospital. RN-C stated the form identified what paperwork needed to accompany resident to the hospital and a signed bedhold form was included. RN-C reviewed R15's EMR and verified he was admitted to hospital on [DATE] with no Hospital Transfer form documented and no indication or scanned bed hold in the EMR. She also verified R15 was sent to the hospital on 5/23/26 and the EMR identified a Hospital Transfer form but no bed hold was offered or signed. RN-C reviewed R100's EMR and verified hospitalizations on 1/28/26, 2/25/26, 3/15/26, 5/19/26, 5/22/26, and 6/11/26. RN-C also verified bedhold were never offered and signed. RN-C stated, the EMR does not have bedholds uploaded and not done, it should be. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of nursing staff to create a Hospital Transfer form in the EMR for each resident sent to the hospital. DON also stated expectation of staff to offer and have resident or guardian sign the form and if they were unable to, then document that in the EMR and have social services follow up. DON verified the process was not being done and it is on the radar to educate [staff] further for the bedhold process. R9's quarterly Minimum Data Set (MDS) dated [DATE] indicated R9 was cognitively intact, had no delusions, and did not refuse personal cares. R9's MDS indicated diagnoses of hypertension, diabetes, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bipolar disorder, anxiety disorder, and chronic pulmonary disease. R9's progress notes indicated he was hospitalized on [DATE] and 1/30/26. R9's progress notes lacked evidence of a BH being discussed with the resident or representative at time of transfer for the 1/7/26 or the 1/30/26 hospitalizations or during either hospitalization. Facility's forms titled Hospital Transfer forms dated 1/7/26 and 1/30/26 lacked documentation about the BH. During review of R9's entire electronic medical record (EMR) lacked documentation whether a written BH form was sent to the hospital during R9's hospital stays on 1/7/26 and/or 1/30/26. During interview on 6/14/26 at 12:04 p.m., R9 stated he was very sick and was hospitalized twice in January. R9 said he was very sick with pneumonia at the beginning of January and later in the same month he returned to the hospital due to increase weakness in his right arm. During interview on 6/15/26 at 4:11 p.m., registered nurse (RN)-D stated when a resident was sick the nurse assessed the resident, updated the primary doctor, and the doctor decided if a sick resident needed to be sent to the hospital. RN-D stated the nurse sent a copy of the resident's face sheet, POLST (code status) form, medication record, treatment record, and hospital transfer form. When asked about the BH form, RN-D stated, sometimes the residents could sign the BH form before they are transferred to the hospital. RN-D stated there was a section on the Hospital Transfer form where the nurse would check if a BH form was sent with the resident or not. RN-D added they also wrote a progress note indicating what forms were sent to the hospital and whether a resident wanted to hold their bed or not. RN-D stated if a resident was unable to sign the BH before leaving the facility or the family/guardian could not be contacted, then the nurse working the following shift needed to follow up. RN-D verified there were no BH forms in R9's EMR for his two hospitalizations in the month of January. During interview on 6/16/26 at 10:45 a.m., the medical records manager (MRM) verified R9's EMR did not contain any BH forms. MRM stated the BHs were scanned into the miscellaneous section, and if they were not scanned, the forms were never completed or signed. Facility's policy titled Bed-Holds and Returns dated 2/2026, indicated prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. The policy also indicated: Prior to the transfer, written information will be given to the residents and the residents' representatives that explains in detail: The rights and limitations of the resident regarding bed holds. The reserve bed payment policy as indicated by the state plan (Medicaid residents). The facility per diem rate requires to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and The details of the transfer (per the Notice of Transfer).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect vision status for 1 of 1 residents (R15) reviewed for MDS accuracy.Findings include: R15's Admissions Minimum Data Set (MDS) dated [DATE], identified R15 with adequate vision and no corrective lenses. In addition, R15 required assistance with hygiene and had an ostomy (abdominal opening for stool to drain out of). Also, diagnoses include encephalopathy (brain disorder which can lead to mental status issues, memory loss, personality changes and in some cases, coma), kidney disease, anxiety, depression, blood clots, and rhabdomyolysis (muscle breakdown). The Care Area Assessment (CAA) for Visual Function was not triggered. R15's Hospital DC Interagency Transfer form dated 4/1/26 identified R15 with uses glasses.R15's admission CONTRACT dated 3/19/26 with a form titled Personal Belongings Inventory identified R15 with eyeglasses.R15's care plan and kardex failed to indicate R15 wore eyeglasses.R15's Hearing/Vision Form assessment dated [DATE] completed by registered nurse (RN)-C identified R15 with adequate vision and no corrective lenses.During observation on 6/14/26 at 2:00 p.m., R15 sat in wheelchair out at dining room and was wearing eyeglasses.During interview with family member (FM)-B on 6/16/26 at 9:23 a.m., FM-B stated R15 wear[s] prescription eyeglasses.During interview with mental health technician (MH)-T on 6/17/26 at 8:34 a.m., MH-T stated he was the staff responsible for filling out the Personal Belongings Inventory section of the Admissions Packet. MH-T stated the admissions packet was electronic and he reviewed with resident and family the personal items that were brought in. This form was then filled out and imbedded into the admissions packet and downloaded into the electronic medical record (EMR).During interview with registered nurse (RN)-C on 6/17/26 at 9:28 a.m., RN-C verified she was the nurse manager on R15's unit and was familiar with R15. RN-C looked at the 4/1/26 Hospital DC Interagency Transfer form and verified it stated R15 had eyeglasses. RN-C then reviewed the Hearing/Vision Form assessment dated [DATE] completed by her and stated, I know he wears glasses and do not know why I documented that he did not wear them. RN-C reviewed R15's 4/7/26 MDS and verified it was coded incorrectly and the CAA did not trigger a care plan or kardex section regarding visual function.During interview with facility coordinator (M)-C on 6/17/26 at 9:59 a.m., M-C stated she was responsible for submitting the MDS information to Centers for Medicare and Medicaid (CMS) when the nurse managers complete the assessments. M-C stated, I think [R15] wears glasses and observed the EMR banner for R15 which had a photo of him wearing eyeglasses. M-C agreed R15's MDS was incorrectly filled out and the ball got dropped. M-C verified the CAA was not triggered which meant his care plan and kardex were not triggered. During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of MDS's to be completed accurately. DON stated R15 did wear eyeglasses and verified the EMR failed to have a care plan and kardex mentioning visual function. In addition, DON verified the 4/7/26 MDS did not trigger a CAA for visual function.Facility policy on MDS accuracy requested and not received.

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	245203	A. Building B. Wing	06/17/2026

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure timeliness of person-centered care conferences for 1 of 1 residents (R100) and to include periodic review and revision by an interdisciplinary team along with the resident in adjusting their care plan and making decisions about their care.Findings include:R100's quarterly MDS dated [DATE] identified R100 with intact cognition, substantial assistance needed for dressing, and toileting hygiene and had diagnoses of schizoaffective disorder, cancer, heart disease, diabetes, seizures, anxiety, depression, bipolar, and lung disease.Additional MDS assessments were completed as follows:7/15/25 Quarterly,8/5/25 Annual,10/22/25 Quarterly,1/15/26 QuarterlyR100's MHM IDT Care Conference Forms dated 10/6/25, and 3/26/26, indicated R100 had a guardian and family was involved in care, but did not include whether R100 was invited or attended.Review of R100 electronic medical record (EMR) revealed no other care conference forms to coincide with the MDS assessment schedule, including the most recent MDS dated [DATE].During interview on 6/15/26 at 4:57 p.m., R100 stated, I do not remember having a meeting to talk about my care here.During interview with social services designee (SS)-D on 6/17/26 at 8:24 a.m., SS-D stated she was responsible for scheduling and documenting care conferences in the EMR. SS-D stated the facility had originally scheduled and documented care conferences every three months regardless of the MDS cycle. SS-D reviewed R100's care conferences and MDS cycle and stated the care conferences were not done for the 7/15/25, 8/5/25, and 1/15/26 MDS cycle.During interview with registered nurse (RN)-C on 6/17/26 at 9:12 a.m., RN-C stated expectation of care conferences to be performed around the MDS schedule and the social services designee was responsible for scheduling and documenting them in the resident EMR.During interview with director of nursing (DON) on 6/17/26 at 10:30 a.m., DON stated expectation of care conferences to be completed with the MDS cycle by the SS-D. DON verified R100's MDS assessments were completed for 7/15/25, 8/5/25, and 1/15/26 and facility failed to conduct care conferences for R100 at those times.Facility policy on care conferences was requested and not received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to consistently and comprehensively assess a non-pressure skin condition to ensure skin condition changes could be adequately monitored and acted upon promptly to promote healing and reduce the risk of complications (i.e., infection, worsening) for 1 of 2 residents (R22) reviewed who had skin impairments. In addition the facility failed to ensure services were coordinated with the hospice agency of 1 of 1 residents (R10) reviewed who received hospice services. Findings include: R22's annual Minimum Data Set (MDS) dated [DATE], indicated R51 had moderately impaired cognition and was diagnosed with dementia and schizophrenia. The MDS indicated R22 was independent with toileting hygiene, required supervision or touching assistance with bathing/showering, and set up or clean up assistance for lower body dressing. R22's Weekly Skin Inspection dated 3/11/26, indicated R22 had ongoing red rashes on the perineal area, that a cream was applied per order, and included no further description such as if open areas were present on the skin. R22's provider note dated 3/16/26 at 12 a.m., indicated R22 had fungal dermatitis to her buttocks that was unresolved, open areas to her bottom, and the provider was ordering a new treatment. R22's Weekly Skin Inspection dated 3/18/26, indicated R22 had ongoing fungal rashes on the groin/perineal area, that R22 was receiving an oral medication, and included no further description such as if open areas were present on the skin. R22's order summary dated 4/29/26, indicated R22 had an order dated 4/29/26 for Nystatin-Triamcinolone (a combination antifungal/steroid) cream twice a day to her bilateral legs, back, abdomen, and perineal area for skin condition. R22's care plan dated 5/1/26, indicated R22 had a risk for alteration in skin integrity related to dementia and schizophrenia. The care plan indicated R22 had a history of picking at skin and had a rash on the trunk/buttock/groin area with a goal of the rash resolving by the review date of 7/30/26. The care plan indicated staff were to monitor skin integrity daily during care, and the nurse was to complete weekly skin inspections. The care plan indicated nursing staff were to document on R22's skin condition and keep the provider informed of changes. R22's progress notes dated 5/15/26 to 6/14/26 were reviewed with the following referencing skin status: - 5/15/26 at 12 a.m., the provider note indicated that on exam of R22, the rash to her bottom continued to improve and was nearly healed with one small scab to her right buttock, no open areas noted, and mild redness to her bottom and groin. - Dated 6/12/26 at 12 a.m., the provider note indicated that on exam of R22's rash to bottom, it was stable with a few light scratch marks, no open areas, and mild redness to the groin and bottom. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No further progress notes indicating R22's skin status during this period were found. R22's Weekly Skin Inspection dated: - 5/20/26, indicated a cream was applied to R22's fungal rashes on her perineal area, abdomen, lower back, and bilateral legs. - 5/27/26, indicated a cream was applied to R22's fungal rashes on her perineal area, abdomen, buttocks, and bilateral upper legs. - 6/3/26, indicated a cream was applied to R22's fungal rashes on her perineal area, lower back, buttocks, and bilateral upper legs. - 6/10/26, indicated a cream was applied to R22's fungal rashes on her lower back and legs, perineal area, and buttocks. - The inspections did not include further description of the skin alteration, such as if open areas were present or what color the skin alteration was. During an observation and interview on 6/16/26 at 7:47 a.m., licensed practical nurse (LPN)-B was observed entering R22's room and escorting her to the bathroom. A small, thin (slightly thicker than a fingernail) scab that was about an inch long on her right buttock, with dark pink skin observed in the gluteal cleft expanding out to her bilateral buttocks. Slight redness was observed extending down a couple inches down the inner thighs. The skin was observed with no open areas. LPN-B stated that nursing staff were supposed to document on R22's skin alteration on her shower days in the weekly skin checks. LPN-B stated they were supposed to document whether the alteration was healing, moist or dried, if there was any odor or not, what the color of the wound was, and if it was open or closed. LPN-B was observed reviewing the 6/10/26 Weekly Skin Inspection and stated she did not see that nursing staff were including these things in their assessment, so she was unsure if the wound had changed since then or not based on this assessment. During an interview on 6/16/26 at 10:47 a.m., LPN-A, the nurse manager for the unit, stated that all residents had a weekly skin check after their shower to ensure their skin was intact. LPN-A stated that if the resident had a skin alteration, she would expect nursing staff to document a description of this alteration, including the color, if the area had any open areas or if it was closed, and if the wound was improving or not. LPN-A stated that R22 had a fungal rash that nursing staff applied a cream to as treatment. LPN-A stated she would expect assessments of this rash to be completed in the weekly skin checks. During an interview on 6/16/26 at 12:32 p.m., the director of nursing (DON) stated that nursing staff would complete weekly skin assessments that would be documented in the weekly skin assessment form. The DON stated she wouldn't expect staff to document if a rash was closed or its color, but would expect staff to document if the area had changed or if the rash had opened up. During an interview on 6/16/26 at 12:52 p.m., nurse practitioner (NP)-A stated R15 had a fungal rash since around February, and they had tried a variety of treatments, but the wound now seemed to be improving. NP-A stated there had been scabs from R22 itching the area in the past. NP-A stated she would expect nursing staff to document if there were any open areas or not, any worsening redness, or if the patient reported worsening symptoms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Skin Assessment and Wound Management policy dated 2/2025, indicated that staff would perform daily skin inspections with daily care, and a weekly skin inspection would be completed by licensed staff. The policy indicated if a significant alteration, that is When large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers occurred, staff would notify the provider and the resident representative, complete education, initiate skin and wound evaluation, notify the nurse manager/wound nurse, refer to dietary and therapies as appropriate, review and update the care plan and resident care lists, and update the care plan to identify risks for skin break down. R10's R10's admissions Minimum Data Set (MDS) dated [DATE], identified R10 with intact cognition, moderately impaired vision with corrective lenses, impairment of one side of lower extremity, required substantial to maximal assistance with dressing and personal hygiene. In addition, R10 with diagnoses of anemia, viral hepatitis, arthritis, osteoporosis, hip fracture, anxiety, depression, chronic lung disease, respiratory failure, cataracts, and was on hospice. During review and interview of R10's hospice binder at nursing desk on 6/14/26 at 1:14 p.m., with social services designee (SS)-D the binder contained no calendar of visits and no home health aide visit notes. SS-D stated, looks like we do not have [them] and missing information from the binder was necessary for all staff to provide needed care. During observation and interview with RN-A on 6/15/26 at 5:18 p.m., RN-A stated expectation of R10's hospice binder should have updated calendar for who is coming and when from hospice. If it is not in there then we will not know who is doing what and when for [R10]. RN-A pointed to R10's hospice binder at the nursing station and stated, it did not have a calendar in it before today so we could not find out when the aide comes. Communication is not ideal if we do not know who is coming and when. During interview with hospice nurse (RN)-B at 6/16/26 at 1:06 p.m., RN-B stated she was R10's case manager and visited twice per week. RN-B stated the hospice binder was supposed to have the visit monthly calendar and the written visit notes by each hospice service including home health aides, nursing, social worker, and chaplain. RN-B stated working with the facility has not been easy and communication is a problem. RN-B stated, I have had to replace that binder several times because [facility] keep losing it, although I do not know how. RN-B stated the facility did not have information needed to provide care for R10 with missing visit notes and calendars. In addition, RN-B stated facility did not reach out to her with concerns about missing calendars and visit notes. During interview with nursing assistant (NA)-A on 6/16/26 at 11:05 a.m., NA-A stated expectation of facility staff to review R10's hospice binder to receive needed information which included visit notes from all services. if no calendar or visit notes [then] we do not know who is coming out and when and what happened. During interview with staffing coordinator (S)-C on 6/16/26 at 11:09 a.m., S-C stated she also filled in as nursing assistant and trained medication aide when staffing is needed. S-C stated expectation of facility staff to review R10's hospice binder to determine when hospice staff were visiting and what happened at each visit. It is important to have a streamlined system in place to have us, hospice and family on the same page. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with family member (FM)-A on 6/15/26 at 4:14 p.m., FM-A stated she was primary emergency contact and daughter for R10. FM-A stated the hospice provider communicated frequently with changes and updates, however communication and updates from the facility were lacking and was not happy with facility. During interview with registered nurse (RN)-C on 6/17/26 at 9:13 a.m., RN-C stated expectation of facility staff to review R10's hospice binder to determine when hospice staff were visiting and what happened at each visit. RN-C stated she was unaware of facility reaching out to R10's hospice provider to communicate or collaborate on visits and updates. RN-C stated, there is a failure to communicate with us and hospice. If the calendar and visit notes are missing then we are unable to know what is going on and when. The process [here] is not therapeutic at this time for [R10]. During interview with director of nursing (DON) on 6/17/26 at 10:36 a.m., DON stated expectation to provide quality care to R10 is for facility staff to review R10's hospice binder to determine when hospice staff were visiting and what happened at each visit. DON stated, [There] should be better collaboration [with hospice] schedules and visit notes for everyone. Policy on communicating and collaborating with outside providers was requested and not received.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review, the facility failed to failed to ensure medications were stored in a secure manner when staff left a medication cart unattended and unlocked, resulting in unauthorized individuals having potential access to medications, including controlled substances. This had the potential to affect medications accessible in that cart by allowing unauthorized access and creating the potential for medication diversion or resident harm. Findings include:During continuous observation on 6/16/26 from 9:01 a.m. through 9:21 a.m., an unlocked medication cart remained unattended at the nurses' station while the assigned nurse was away from the cart. During the observation, four ambulatory residents walked past the medication cart, staff members came and went from behind the nurses' station, and the nurse manager also walked past the unattended cart. The cart was out of sight of staff intermittently throughout the observation. Because the medication cart remained unlocked, medications, including controlled substances stored within the cart, were no longer maintained in a double-locked manner.On 6/16/26 at 9:22 a.m., registered nurse (RN)-E acknowledged the medication cart had been left unlocked. RN-E stated, I always lock it, I should have. Someone was going on break and called me over and I left without locking it.During an interview on 6/17/26 at 11:35 a.m., the Director of Nursing (DON) stated staff were expected to lock the medication cart whenever they walked away from it for resident safety.A facility policy titled Medication Storage in the Facility, dated August 2019, indicated controlled substances were to remain double locked at all times.

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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** Based on observation, interview and document review, the facility failed to follow infection control standards of practice for cleaning a urinal for 1 of 1 resident (R2) reviewed for infection control. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE] indicated, R2 had severe cognitive impairment, didn't have delusions, didn't refuse cares, was continent of bladder, was independent with activities of daily living, was independent with transfers, and used a wheelchair for mobility. R2's MDS indicated diagnoses of anemia, coronary disease, heart failure, hypertension, and chronic lung disease. R2's care plan indicated he had a risk for alteration in elimination related to impaired mobility. Care plan indicated R2 was continent of bladder, and he kept a plastic urinal on his wheelchair. R2's care plan also indicated the staff had to clean or replace the urinal as needed. During observation and interview on 6/14/26 at 12:32 p.m., R2 was in his room, and on top of his bedside table there were two plastic urinals with black matter around the rims, numerous black spots inside the vessels, and 6-8 flies standing on the urinals. Additionally, there were little black insects flying throughout the room. R2 stated he used a urinal throughout the day and sometimes the staff emptied the urinals in the room's bathroom, but he also used the toilet in the spa room to empty his urinals. R2 said the staff never rinsed or washed his urinals, R2 said the staff had not replaced the urinals for a long time. During observation and interview on 6/15/26 at 3:57 p.m., trained medication aide (TMA)-B stated she emptied R2's urinal once to twice during her shift but has never washed or changed his urinals. During observation on 6/15/26 at 4:00 pm, R2's urinals were on top of his bedside table and within 20 centimeters there was a mug with water. The urinals were partially filled; one was closed with a lid, and the other had no lid. During interview on 6/15/26 at 4:04 p.m., TMA-B verified the urinals had black matter around the rims and black spots inside the vessel. TMA-B stated they were dirty, and she would replace them. During interview on 6/15/26 at 4:06 p.m., nurse manager/licensed practical nurse (LPN)-A observed the urinal on top of the bedside table and stated, They [urinals] should not be near food. They need to be emptied. They are dirty, this in an infection control issue. LPN-A also verified insects were standing in the urinals and flying in the room. During interview on 6/17/26 at 12:36 p.m., director of nursing (DON) stated she was informed about the urinals and said it was an infection control issue. Facility's policy titled Infection Prevention and Control Program dated 11/2024, indicated the primary mission of Monarch Healthcare Management is to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP is a facility wide effort involving all disciplines and is part of the quality assurance and performance improvement program.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the emergency call system remained accessible and functional for 4 of 4 residents (R9, R30, R52, and R64) who used the shared bathroom by failing to ensure the bathroom emergency call light pull cord was long enough to be reached by a resident from the floor creating the potential for delayed staff response during an emergency.Findings include:R9's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R9 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, was independent with personal hygiene and toileting, and had experienced one fall with minor injury.R52's quarterly MDS assessment dated [DATE] indicated R52 had severe cognitive impairment with a BIMS score of 4 and was independent with activities of daily living.R30's quarterly MDS assessment dated [DATE] indicated R30 was cognitively intact with a BIMS score of 15, was independent with activities of daily living, and had diagnoses that included unsteadiness on feet and unspecified dementia.R64's quarterly MDS assessment dated [DATE] indicated R64 was cognitively intact with a BIMS score of 15, was independent with activities of daily living, and had a diagnosis that included a history of falling.Observation on 6/14/26 at 9:48 a.m. revealed the emergency bathroom call light pull cord shared by R9, R30, R52, and R64 was broken off, leaving approximately one inch of cord hanging from the wall connection approximately half-way up the wall. The remaining cord was not long enough to be reached by a resident from the bathroom floor in the event of a fall, preventing residents from activating the emergency call system to summon assistance.During an interview on 6/16/26 at 12:06 p.m., the Director of Nursing (DON) confirmed the short emergency pull cord in the bathroom and stated the bathroom emergency pull cords should be long enough to be reached if a resident fell to the floor. The DON stated a maintenance work order would be submitted to repair the call light and add a longer chain to ensure the cord was reachable from the floor.A facility policy titled Call Light Policy, dated 5/16/23, indicated, A nurse call must be provided for each resident bathroom, facility bathroom (if the resident is able to access it), and in all areas used for resident bathing. If a pull cord is provided it must extend to within six inches above the floor, so it is accessible to a resident lying on the floor.