STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245203	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT BRYN MAWR	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 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide a written room change notice, including the reason for the room change, for 1 of 1 resident (R12) reviewed for room change. Findings include: Family member (FM)-A was interviewed via telephone on 3/12/20, at 10:12 a.m. and verified she was R12's guardian and explained R12 had resided on unit two, an unsecured unit, for a long time without any known issues of wandering and/or elopement. FM-A stated two weeks ago she received a message which indicated R12 was being moved to unit three, the facility locked unit, without any reason and/or explanation. FM-A stated the facility did not provide any notice in writing, offer a meeting or conversation prior to moving R12. FM-A said instead they left her a voice mail that R12 was moving and R12 was moved later that day. R12's quarterly Minimum Data Set ((MDS) dated [DATE], identified R12 had severe cognitive impairment and [DIAGNOSES REDACTED]. The MDS further indicated R12 used a daily wander/elopement alarm. R12's Progress Note dated 2/25/20, indicated Phone call placed to guardian about room move. Guardian did not answer. Voicemail left. R12's medical record lacked evidence of written notification regarding R12's room change. Nursing assistant (NA)-A was interviewed on 3/12/20, at 9:33 a.m. and explained R12 was moved to unit three, two to three weeks ago, due to another resident needing R12's room on unit two. NA-A stated there were two other residents in the facility who had an altercation and one of them had to be moved from unit one to unit two and there was not a bed so they moved R12 to unit three to free a bed on unit two. R12 was interviewed on 3/12/20, at 9:41 a.m. and stated he wanted to move back to unit two. R12 explained he wanted to go for walks and was unable to walk around on his current unit. Licensed Practical Nurse (LPN)-C was interviewed on 3/12/20, at 9:53 a.m. and explained R12 had a wanderguard on his person and LPN-C had worked often with R12 on unit two. LPN-C was unaware R12 attempted to elope and/or leave the facility. LPN-C stated R12 was not fluent in English and would get upset easily when he was unable to communicate with staff. LPN-C stated R12 would calm down easily once someone translated his needs. The Director of Social Services (DSS) was interviewed on 3/12/20, at 12:26 p.m. and stated she was unaware why R12 was moved from unit two to unit three. The DSS stated when she returned to work R12 was moved without reason, however, recalled there was a resident to resident altercation which resulted in the need to move another resident to unit two for safety and that resident now resided in R12's old room. The administrator was interviewed on 3/12/20, at 3:48 p.m. and stated R12 was moved to unit three due to behaviors, she thought the environment and closer supervision in unit three would have been beneficial. The administrator verified R12 had an increase in behaviors following his move to unit three, however was unaware if these behaviors continued. The administrator verified FM-A was left a voicemail and R12 was moved without any conversation. The administrator confirmed the facility ensured residents reside in the least restrictive environment, however was unaware there was no assessment and/or documentation to justify R12's move to unit three. The administrator stated it was her expectation for staff to document in R12's progress notes and/or medical record regarding the justification for R12's move which would include physician notification. The administrator stated it was her expectation for residents from unit three to be included on activities that occurred on unit two which included walks off of the unit. The administrator was unable to provide specifics regarding R12's behaviors which warranted R12 being moved to unit three. The Policy for Secure Unit undated, included when residents admitted to the secured unit would have greater security/ supervision needs when they meet any of the following criteria: confused wanderer, history of behavior management problems that required closed supervision within a confined area, residents who had incident of elopement, and residents who require protection due to risk of abuse. The policy indicated when a resident had been determined to be appropriate for the secured unit the facility would inform the physician and the family/ responsible party.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide adequate supervision to protect residents from resident to resident abuse when 1 of 1 resident (R6) was hit with his television in the head by (R1) following a resident to resident altercation. In addition, the facility failed to identify factors that placed (R6) at risk of further resident to resident altercations. Findings include: R6's Investigative File dated 2/24/20, indicated R1 entered R6's room without knocking while R6 was sleeping. R1 began going through R6's belongings when R6 woke up and asked R1 was he was doing and asked R1 to leave. R1 became agitated and pushed R6's bedside table toward R6 and R1 hit the TV and the TV hit R6 causing a superficial laceration on R6's eyebrow. R1's written statement 2/24/20, indicated I smacked the TV. R1 was educated on knocking on doors. R1's annual Minimum Data Set ((MDS) dated [DATE], identified R1 had intact cognition. R1's quarterly 2/20/20, MDS identified R1 had [DIAGNOSES REDACTED]. The MDS indicated R1 had physical behavior symptoms directed toward others one to three days, verbal behavior symptoms directed toward others daily and other behavioral symptoms not directed toward others daily. R1's Care Plan dated 2/6/20, identified R1 had a behavior problem related to verbal outbursts/ aggression toward others, threatening behaviors, refusals of care, non-compliance, throws belongings in hall and directed staff to psychology consult, evaluate pain, calm and safe environment, allow to express feelings, areas for decreased stimulation, evaluate sleep, one to one staffing related to altercation with another resident moved to 15 minute checks on 12/5/19, staff to be on the lookout for developing conflicts and intervene one them as quickly as possible to prevent physical aggression, motivational interviewing, administer medications as ordered, anticipate needs, assist to develop coping methods, activities of interest, redirect, reassurance and build trusting connection. R1's Care Plan dated 2/14/20, identified R1 self-reported drug usage and directed staff to allow time to answer questions, monitor and document feelings, offered Rule 25. R1's Care Plan dated 3/5/20, identified R1 had a behavior problem related to cursing at residents and staff, taking staff belongings, throwing things at resident, and putting a butter knife behind bathroom door and directed staff to remove butter knife, remind door cannot be blocked, complete a risk versus benefits, psychological consult as needed, evaluate pain, calm and safe environment, allow to express feelings, area for decreased stimulation, refused Rule 25 on [DATE]. R6's admission MDS dated [DATE], lacked indication of cognitive status, however included [DIAGNOSES REDACTED]. The MDS indicated R6 had no behaviors and indicated R6 received opioids (narcotic) seven days during the reference period. R6's Care Plan dated 8/19/19, identified R6 enjoyed when others participate in banter with him within boundary limits and directed staff psychology consult, calm safe environment, medications as ordered, anticipate needs, offer chemical dependency treatment and give appropriate methods of coping and interacting with others. R6's Progress Note (PN) dated 2/24/20, indicated R6 had a two inch cut on the left eyebrow from an incident with another resident. A

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

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.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) subsequent PN dated 2/24/20, indicated R6 reported R1 threw a TV that hit R6 above the left eye. R1's PN dated 2/24/20, indicated R1 pushed a TV onto R6 after being accused of taking medication off R6's bedside table resulting in a one to two inch cut to R6's left eyebrow. R1's Psychology Note dated 3/2/20, identified R1 was medication seeking and had an altercation with a peer in which he reportedly tipped a TV on top of the peer. R1 noted the incident with the TV was a result of the peer refusing to give R1 his [MEDICATION NAME] (narcotic) which made R1 angry. R6's Order Summary Report dated 3/12/20, included [MEDICATION NAME] three times daily. R1 was interviewed on 3/11/20, at 1:48 p.m. and stated there were residents who resided in the facility who sold drugs and after his pain medications were taken away from him R1 stated I started doing drugs I was not getting my pain meds (medications). R1 verified he would do [MEDICATION NAME] and buy [MEDICATION NAME] either off of the street or from R6. R1 explained R6 was selling his [MEDICATION NAME] to R1 and owed R1 [MEDICATION NAME], however did not give it to R1 as promised which in return R1 smacked his TV down towards R6. R1 indicated he told facility staff R6 had his pill, however indicated no further follow-up occurred. The administrator and director of nursing (DON) were interviewed on 3/12/20, at 4:03 p.m. The administrator stated R6 was sleeping as R1 was going through the items on R6's nightstand; R1 pushed the table which hit R6. The administrator stated she was not aware of a drug deal. The administrator stated social services should have reviewed the incident and would have expected follow-up which would include trying to find the source of the [MEDICATION NAME] and offer treatment. The DON stated she was not aware of the 3/2/20, psychology note. Both the administrator and DON were unaware of [MEDICATION NAME] being sold amongst residents. R6 was interviewed on 3/12/20, at 5:20 p.m. and stated R1 entered his room and threw the TV on R6's bedside table toward him causing the TV to hit R6's head which resulted in a cut above his eyebrow. R6 stated the disagreement was a result of R1 borrowed something from R6, however would not indicated what item was borrowed. The director of social services (DSS) was interviewed on 3/12/20, at 6:00 p.m. and stated she was aware R1 went into R6's room looking for a pill, however DSS indicated she did not follow-up and ask what kind of pill R1 was searching for. DSS stated they were supposed to read the psychology notes, however was unaware if the 3/2/20, note was overlooked. DSS stated she was unaware of [MEDICATION NAME] being sold amongst residents. The facility's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy effective 11/28/17, indicated assessment, care plan and services would be monitored for each resident with behavior needs that might lead to conflict.
F 0603 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess and provide supporting, objective clinical justification to have 1 of 1 resident (R12) reside in the locked memory care unit resulting in seclusion from activities of interest. Findings include: Family member (FM)-A was interviewed via telephone on 3/12/20, at 10:12 a.m. and verified she was R12's guardian and explained R12 had resided on unit two, an unsecure unit, for a long time without any known issues of wandering and/or elopement. FM-A stated two weeks ago she received a message which indicated R12 was being moved to unit three, the facility locked unit, without any reason and/or explanation. FM-A indicated R12 was not happy due to not liking the locked unit and stated R12 told her they locked me down and I cannot walk around. FM-A indicated I know he yells but he needs his freedom he's saying I have no freedom. FM-A stated the facility did not offer a meeting or conversation prior to moving R12. FM-A said instead they left her a voice mail that R12 was moving and R12 was moved later that day. R12's care plan initiated 11/12/19, identified R12 was an elopement risk/wanderer related to [MEDICAL CONDITION] and directed staff to provide recreational activities, staff were aware of wander risk, wanderguard on right wrist, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, monitor for fatigue and weight loss, and provide escort to outside appointments. R12's care plan initiated 2/11/20, identified R12 had behavioral problem related to history of reaching out to others and grabbing at them, refuses dressing change, limited communication ability secondary to limited English, communicates with gestures, calls others names at times, inappropriate behavior towards staff, screaming, yelling and hitting objects. The care plan directed staff to psychology consult as indicated, provide calm and safe environment, allow to express feelings, provide area for decreased stimulation for negative behaviors, walker for mobility, positive interaction, attention, stop and talk to R12 when passing by, explain what was not acceptable behavior, remove away from others, complete a risk vs benefits, medication adjustment and medication review by pharmacist, medications per orders, provide activities of interest and accommodate status, redirect behavior and remove from others when becomes intrusive or aggressive, educate and remind not to swear names to others, not allowed to smoke with other residents, and hourly checks. R12's quarterly Minimum Data Set ((MDS) dated [DATE], identified R12 had severe cognitive impairment and [DIAGNOSES REDACTED]. The MDS further indicated R12 used a daily wander/ elopement alarm. R12's Wander/Elopement Risk Evaluation dated 12/31/19, identified R12 had no history of elopement/wandering off or getting lost and indicated R12 was at risk to wander/elope. Directed staff to offer recreational activities and wanderguard on right wrist. R12's Wander/ Elopement Risk Evaluation dated 1/23/20, identified R12 had a history of [REDACTED]. The summary included R12 made repetitive statement about going home or leaving the facility, however indicated R12's behavior was de-escalated. R12's provider note dated 1/13/20, indicated R12 adjusted well to moving off of the secured unit. R12's behaviors included inappropriate advances toward females, shouting loudly at others and being resistive to cares at times. R12's provider note dated 2/3/20, indicated R12 had increased shouting loudly, touching females inappropriately, and grabbed out at others. R12 would benefit from a calm environment. R12's Progress Note dated 2/25/20, indicated Phone call placed to guardian about room move. Guardian did not answer. Voicemail left. R12's medical record lacked evidence of involvement from R12's representative including care planning and decision for placement. In addition, R12's record lacked documentation of clinical criteria met for placement in the locked area, indication regarding the least restrictive approach for R12, reaction of R12 regarding placement on the unit, and revision of R12's care plan. Nursing assistant (NA)-A was interviewed on 3/12/20, at 9:33 a.m. and explained R12 was moved to unit three, two to three weeks ago due to another resident needing R12's room on unit two. NA-A stated there were two other residents in the facility who had an altercation and one of them had to be moved from unit one to unit two and there was not a bed so they moved R12 to unit three to free a bed on unit two. NA-A stated R12 had been upset since he moved to unit three and explained he would repeat himself wanting to go back to unit two. NA-A indicated R12 would take a chair to sit by the door that lead to unit two and at times would pound on the door with his fits wanting to leave. NA-A further explained R12's behaviors had increased since moving to unit three which included pounding on items, hitting out at staff and yelling. NA-A stated R12 enjoyed to walk around on unit two and now was limited to his ability to ambulate around unit three. NA-A was unaware of R12 attempting to elope from the facility while residing on unit two. R12 was interviewed on 3/12/20, at 9:41 a.m. and stated he wanted to move back to unit two. R12 explained he wanted to go for walks and was unable to walk around on his current unit. Licensed Practical Nurse (LPN)-C was interviewed on 3/12/20, at 9:53 a.m. and explained R12 had a wanderguard on his person and had worked often with R12 on unit two. LPN-C was unaware R12 attempted to elope and/ or leave the facility. LPN-C stated R12 was not fluent in English and would get upset easily when he was unable to communicate with staff. LPN-C stated R12 would calm down easily once someone translated his needs. The Director of Social Services (DSS) was interviewed on 3/12/20, at 12:26 p.m. and stated she was unaware why R12 was moved from unit two to unit three. The DSS stated when she returned to work R12 was moved without reason, however recalled there was a resident to resident altercation which resulted in the need to move another resident to unit two for safety and that resident now resided in R12's old room. The Therapeutic Recreation Director (TRD) was interviewed on 3/12/20, at 2:36 p.m. and stated he was aware R12 enjoyed walking around unit two, however due to not having enough staff R12 was only taken for a walk once on 3/2/20, since moving to unit three. The TRD indicated if there were enough recreation staff R12 should have been walked one to two times weekly. The administrator was interviewed on 3/12/20, at 3:48 p.m. and stated R12 was moved to unit three due to behaviors, she thought the environment and closer supervision in unit three would have been beneficial. The administrator verified R12 had an increase in behaviors following his move to unit three, however was unaware if these behaviors continued. The administrator verified R12's FM-A was left a voicemail and later R12 was moved without FM-A response. The administrator confirmed the facility ensured residents reside in the least restrictive environment, however was unaware there was no assessment and/or documentation to justify R12's move to unit three. The administrator stated it was her expectation for staff to document in R12's progress notes and/or medical record regarding the justification for R12's move which would include physician notification. The administrator stated it was her expectation for residents from unit three

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F 0603 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) to be included on activities that occurred on unit two which included walks off of the unit. The administrator was unable to provide specifics regarding R12's behaviors which warranted R12 being moved to unit three. The Facility Assessment Tool dated 10/2019, lacked indication of a locked/secured unit and criteria for admission. The tool further lacked specialized training and/or services regarding the secured unit. The Policy for Secure Unit undated, included when residents admitted to the secured unit would have greater security/ supervision needs when they meet any of the following criteria: confused wanderer, history of behavior management problems that required closed supervision within a confined area, residents who had incident of elopement, and residents who require protection due to risk of abuse. The policy indicated when a resident had been determined to be appropriate for the secured unit the facility would inform the physician and the family/responsible party.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 timely report to the State Agency (SA) and administrator for 4 of 4 residents (R15, R16, R12, R13) reviewed for two separate resident to resident altercations. Findings include: R15's discharge assessment Minimum Data Set ((MDS) dated [DATE], identified R15 had intact cognition and [DIAGNOSES REDACTED]. R16 was told to block R15's from text messages. R16 wanted staff to be made aware, however did not want the police called. A subsequent PN dated 3/9/20, indicated R16 was upset that nothing was done regarding the incident with R15 and the text message. R16 declined filing a police report. R15's PN dated 3/9/20, indicated R15 was mad at R16 and sent the messenger message to get her point across but not to hurt her. R15 was informed by the director of social services (DSS) that the written threat was unacceptable and could have been deemed as cyber bullying. R15 and R16's medical records lacked evidence of timely reporting to the SA. Licensed practical nurse (LPN)-A was interviewed on 3/12/20, at 10:01 a.m. and stated R15 was out of the facility on a leave of absence (LOA) and would not be returning until tomorrow. LPN-A was unaware of R15 threatening R16 via text message. R16 was interviewed on 3/11/20, at 2:45 p.m. and explained R15 gave R16 six dollars to purchase R15 a bottle of alcohol. R16 stated when R15 returned from a LOA she texted R16 and threatened to harm me. R16 stated R15 texted she was going to break my jaw due to R16 not having R15's six dollars or the promised bottle of alcohol. R16 indicated R15 texted her you better have my[***]or when I come back I will f**k you up then she (R15) said watch I will break your jaw. R16 stated she notified the facility staff on Monday morning. The DSS was interviewed on 3/12/20, at 12:21 p.m. and verified R15 texted R16 a verbal threat to break her jaw over six dollars. The DSS indicated she explained to R15 cyber bullying threats were not acceptable. The DSS verified she saw the text message threat between R15 and R16, however, still considered this cyber bullying. The administrator was interviewed on 3/12/20, at 4:00 p.m. and stated she was unable to confirm the text message occurred between R15 and R16 and did not feel the text message was reportable. The facility Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy effective 11/28/17, indicated abuse included verbal abuse which was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents. Examples of verbal abuse included threats of harm. The facility would ensure all alleged violations involving abuse were to be reported to immediately but not later than two hours to the SA. R12's quarterly MDS dated [DATE], identified R12 had severe cognitive impairment and [DIAGNOSES REDACTED]. R12's Progress Note (PN) dated 2/28/20, identified R12 held onto her left hand tight tiring (trying) to get her personal belonging from her at the end of the hallway. Resident had skin discoloration; two spots. R13's PN dated 2/28/20, identified R13 reported being held so tight to her left wrist at the end of the hallway by R12. The PN indicated R12 was trying to get what .didn't belong to him forcefully. R13 was noted to have had two spots of discoloration to her left hand on the back by her thumb and finger. R12 and R13's medical record lacked evidence of timely reporting to the SA. Licensed practical nurse (LPN)-B was interviewed on 3/12/20, at 9:15 a.m. and stated R12 attempted to get the light out of R13's hand and grabbed her hand when doing so. LPN-B explained when R12 wanted something he would get forceful and demanding and try to take things while yelling give me give me. R13 was interviewed on 3/12/20, at 9:28 a.m. and explained R12 grabbed her arm/hand and twisted it when he was trying to get her lighter. R13 stated it hurt and she had a slight bruise following the incident. R12 was interviewed on 3/12/20, at 9:41 a.m. and did not recall incident. The administrator was interviewed on 3/12/20, at 3:48 p.m. and stated she did not feel the situation between R12 and R13 was reportable due to lack of intent for R12. The administrator stated she was unaware R13 complained her hand hurt after R12 grabbed her. The facility's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy effective 11/28/17, indicated abuse when the willful infliction of injury resulting in physical harm, pain or mental anguish. Physical abuse included hitting, slapping, pinching, and kicking. The facility would ensure all alleged violations involving abuse were to be reported immediately but not later than two hours to the SA.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to thoroughly investigate and protect an allegation of verbal abuse for 2 of 2 residents (R15, R16) reviewed for resident to resident altercation. Findings include: R15's discharge assessment Minimum Data Set ((MDS) dated [DATE], identified R15 had intact cognition and [DIAGNOSES REDACTED]. R16 was told to block R15's from text messages. R16 wanted staff to be made aware; however, did not want the police called. A subsequent PN dated 3/9/20, indicated R16 was upset that nothing was done regarding the incident with R15 and the text message. R16 declined filing a police report. R15's PN dated 3/9/20, indicated R15 was mad at R16 and sent the messenger message to get her point across but not to hurt her. R15 was informed by the director of social services (DSS) that the written threat was unacceptable and could have been deemed as cyber bullying. R15 and R16's medical records lacked evidence of observations and/or monitoring of interactions and relationships between resident to other residents. Licensed practical nurse (LPN)-A was interviewed on 3/12/20, at 10:01 a.m. and stated R15 was out of the facility on a leave of absence (LOA) and would not be returning until tomorrow. LPN-A was unaware of R15 threatening R16 via text message. R16 was interviewed on 3/11/20, at 2:45 p.m. and explained R15 gave R16 six dollars to purchase R15 a bottle of alcohol. R16 stated when R15 returned from a LOA she text R16 and threatened to harm me. R16 stated R15 text she was going to break my jaw due to R16 not having R15's six dollars and/or the promised bottle of alcohol. R16 indicated R15 text her you better have my[***]or when I come back I will f**k you up then she (R15) said watch I will break your jaw. R16 stated she notified the facility staff on Monday morning, however felt as if staff did not care. The DSS was interviewed on 3/12/20, at 12:21 p.m. and verified R15 text R16 a verbal threat to break her jaw over six dollars. The DSS indicated she explained to R15 cyber bullying threats were not acceptable. The DSS verified she saw the text message threat between R15 and R16, however still considered this cyber bullying. The administrator was interviewed on 3/12/20, at 4:00 p.m. and stated she was unable to confirm the text message occurred between R15 and R16 and did not feel the text message was verbal abuse. The facility Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy effective 11/28/17, indicated abuse included verbal abuse which was defined as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents. Examples of verbal abuse included threats of harm. When an incident or suspected incident of abuse was reported the investigation would include residents' statements, roommate statements, involved staff and witness statements of events, a description of the resident's behavior and environment at the time of the incident, and observation of resident and staff behaviors during the investigations.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to inform and update 1 of 3 residents (R2) of their discharge planning process and status, and failed to follow-up with referral agencies to determine progress of discharge planning into the community. Findings include: R2 was interviewed on 3/11/20, at 11:41 a.m. and stated he had been waiting a long time to relocate to a new facility and the facility was not helping him. R2 stated he only had a worker from the county helping him. R2's quarterly Minimum Data Set ((MDS) dated [DATE], included [DIAGNOSES REDACTED]. The MDS indicated R2 had an active discharge plan, however return to community was left blank. R2's Care Plan dated 9/26/19, identified R2 wished to discharge to a lower level of care when available and appropriate referral for relocation services had been completed and directed staff to evaluate and discuss the prognosis for independent or assisted living, identify, discuss and address limitations, risks, benefits and needs for maximum independence. The care plan indicated R2's primary places lived were

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F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) homelessness. The provider note dated 3/9/20, indicated R2 states CADI waiver (housing waiver) was denied. Plans to f/u (follow-up) with relocation worker. Director of social services (DSS) was interviewed on 3/12/20, at 12:15 p.m. and explained R2 was working with relocation services and looked at a couple of facilities. DSS indicated on 2/6/20, R2 was assessed for a housing waiver and explained usually after that the assessor and relocation worker meets with R2 to discuss relocation and continue to work directly with R2 via cell phone. DSS stated I do step back and let the county take over and relocation worker and indicated once R2 had a discharge location the worker notified DSS two weeks ahead of time and a discharge care conference would be scheduled to address R2's needs. DSS indicated she had not heard from the worker which meant R2 was not ready to discharge. DSS stated if R2 was not getting his discharge needs met he would tell me. DSS indicated she was not aware of any issues R2 was having regarding discharge, however stated she did not know where R2 was at in finding housing. R2 was interviewed on 3/12/20, at 1:46 p.m. and stated he was denied his waiver for housing due to not meeting the criteria. R2 stated he thought it was due to asking the Public Health Nurse/Assessor (PHN) for a bus pass due to lack of money to get to and from his daily [MEDICATION NAME] appointments, however was not sure. R2 stated he had been trying to discharge for well over two months, however now he was not sure what to do without the housing waiver. R2 indicated had no way to pay for housing without this waiver and was previously homeless. R2 stated the facility had not helped and explained he relied on the relocation worker and PHN. R2 stated he needed a doctor appointment due to needing disability social security funding, however the facility did not help him with this and identified his relocation worker had to schedule the appointment. R2 was observed, held a sheet of paper in his hand and said I cannot read this, however R2 stated he saw the word denied but was unable to read the paper due to vision issues. R2 stated he asked the facility staff to help him and indicated no one had come to help. PHN was interviewed via telephone on 3/12/20, at 2:20 p.m. and stated it was her understanding the facility should have been involved with R2's discharge process. PHN stated she had reached out to the DSS on multiple occasions and no follow-up communication regarding requested paperwork needed for R2's discharge was received. PHN explained the paperwork was for disability certification for R2 and indicated the relocation worker had to meet with R2 to assist in obtaining needed paperwork and scheduling an upcoming doctor appointment for social security disability funding after no response from the facility. PHN further indicated a notice had been sent to R2 which indicated he had been granted the housing waiver. PHN explained many residents who do not have assistance reading the paperwork get confused due to a listing of what they are and/or are not eligible for on the same page. The administrator was interviewed on 3/12/20, at 4:07 p.m. and stated it was her expectation for social services to have been in continuous contact with relocation services and assisted R2 with discharge. The facility Discharge Care Plan Guideline effective 11/28/17, indicated it was the guideline of the facility that residents would be evaluated for their discharge goals, preferences and care needs to meet their goals and developed into a comprehensive discharge care plan. The resident would be periodically reassessed to identify changes that require modification of the discharge plans and update the care plan as needed. The facility must develop and implement an effective discharge planning process that focused on the residents discharge goals, preparation of residents and been an active partner for the resident. If the resident indicated an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
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 interview and document review, the facility failed to act upon a resident concern regarding change in condition and failed to follow physician orders [REDACTED]. Findings include: R2 was interviewed on 3/11/20, at 11:41 a.m. and said he felt like he had pneumonia and indicated I can hardly talk I am so sick. R1 stated I feel miserable and indicated he had been waiting for chest x-ray results since yesterday. The nurse practitioner (NP) was interviewed on 3/11/20, at 11:52 a.m. and verified she wrote orders on 3/9/20, for a chest x-ray after R2 told NP he had been feeling badly for a few days. The NP indicated on [DATE], it was her understanding the x-ray company came to the facility while R2 was at his daily [MEDICATION NAME] appointment so the chest x-ray was not completed. The NP stated she would have expected the chest x-ray to be completed on 3/9/20, and if it was not completed she would have expected to have been notified. The NP also stated she would have wanted to be notified if R2's chest x-ray was not completed on [DATE], however verified she was not notified. The NP indicated she also called the facility in the late afternoon on 3/9/20, and gave a nurse a telephone order to monitor R2's vital signs every shift for five days. The NP identified R2's medical record lacked vital sign monitoring per orders and/ or lung assessments. Furthermore, the NP indicated she now ordered R2's chest x-ray for immediately within two to four hours. Licensed practical nurse (LPN)-D was interviewed on 3/11/20, at 12:00 p.m. and stated I think there was a paper there I was supposed to call those in at some point today. LPN-D was observed to go through papers at the nurses desk and turned to the NP and said it came in last night as he handed the NP R2's chest x-ray results. The NP was interviewed on 3/11/20, at 12:05 p.m. and stated R2's chest x-ray indicated early infiltrate and she would have been expected the on-call group would have been called last night. The NP further stated she had been here all morning and nobody notified me today. R2's quarterly Minimum Data Set ((MDS) dated [DATE], included [DIAGNOSES REDACTED]. R2's Care Plan dated 12/26/19, identified R2 had altered respiratory status and difficulty breathing related to [MEDICAL CONDITION] and directed staff to monitor signs and symptoms of potential respiratory infection weekly vital signs and as needed. R2's Care Plan dated 12/26/19, identified R2 required [MED]gen therapy related to [MEDICAL CONDITION] and directed staff to monitor for signs and symptoms of respiratory distress and report respirations, pulse, oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, cough, skin color and accessory muscle usage to the doctor as needed. R2's Progress Notes (PN) and provider notes were reviewed 3/5/20, through 3/11/20, and revealed the following: -The PN dated 3/5/20, indicated R2 was confused, sleepy, and no alcohol noted on breath. The PN indicated R2 had an unsteady gait and was taken to his room in a wheelchair. A subsequent PN dated 3/5/20, indicated R2 was checked and NP was updated in regards to previous findings; The provider note dated 3/9/20, indicated R2 reported not feeling well chest x-ray ordered today, blood work ordered for tomorrow [DATE], vital signs every shift for five days; -The PN dated [DATE], indicated R2 left for the hospital and would be back around 11:00 a.m. through 12:00 p.m., however when x-ray came for R2's chest x-ray R2 did not show up. A subsequent PN dated [DATE], indicated R2's chest x-ray completed on evening shift, awaiting results, overnight nurse notified; -The provider note dated 3/11/20, indicated R2 reported feeling feverish and chilled, increased cough, shortness of breath, sputum production and decreased appetite. R2 reported he continued to feel like he has pneumonia. The chest x-ray was ordered for 3/9/20, to be performed the same day. It does not appear to have been attempted that day. Assessment and plan chest x-ray concerning for community acquired pneumonia orders for antibiotics in addition to suspected [MEDICAL CONDITION] exacerbation steroids ordered. R2's Physician order [REDACTED]. R2's X-Ray Patient Report dated [DATE], identified chest x-ray was completed impressions bilateral lower lobe [CONDITION]/ early infiltrate (filling of air spaces with fluid). LPN-A was interviewed on 3/12/20, at 11:53 a.m. and explained when a provider wrote an order for [REDACTED]. LPN-A explained if the resident was unable to have the x-ray completed the day ordered the nurse was to call the provider and/ or on-call for further direction. LPN-A stated if the results of the x-ray were normal they were not expected to call them into the provider, however if there were abnormal they were to call the provider and/ or the on-call if it was after hours. LPN-A indicated the last time he saw R2 he had complained about feeling weak at the end of his shift and informed the oncoming overnight nurse to keep eye on him something might be going on. LPN-A verified this was 3/5/20. R2 was interviewed on 3/12/20, at 1:46 p.m. and explained he was in real bad shape until he finally got on antibiotics and steroids on 3/11/20, and stated I been telling them I sick for a while now. R2 indicated he knew when he had pneumonia due to having a long history of the having had pneumonia. R2 stated last Thursday on 3/5/20, I could hardly breathe, I could not eat. R2 stated he waited for the NP to come into the facility after the weekend on 3/9/20, and told her he was sick. R2 further stated the NP ordered a chest x-ray after seeing him, however indicated since the x-ray was not completed on 3/9/29, he asked the nurse to schedule the x-ray after his daily [MEDICATION NAME] appointment that he couldn't miss. The director of nursing (DON) and administrator were interviewed on 3/12/20, at 4:07 p.m. The DON stated it was her expectation for an ordered chest x-ray to have been completed the day ordered and indicated if the x-ray was not able to have been completed as ordered it was her expectation for the nurse to notify the provider for guidance. The DON stated she expected staff to call the provider and/ or on-call after hours with abnormal chest x-ray results. Furthermore, the DON verified she expected staff to complete an assessment including lung sounds and vital signs per provider orders. The facility

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	245203	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Notification of Changes Guideline revised 7/2[DATE]9, indicated the practice of the facility was to ensure changes in resident's condition or treatment were immediately reported to the attending physician or delegate. The policy indicated the nurse would immediately notify the medical provider when a resident experienced deterioration in health status and when the need to alter treatment occurred. The policy further indicated the nurse would document the notification in the medical record including any new orders.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a comprehensive assessment, ongoing monitoring and implement interventions to promote safe smoking practice for 1 of 1 resident (R11) reviewed for smoking hazards. Findings include: R11's Care Plan dated 3/9/18, identified R11 was a safe smoker with smoking apron and directed staff to instruct about risks, instruct about facility policy on smoking locations, times, and safety concerns, notify nurse for violation of facility smoking policy, appropriate footwear when going outside, can smoke unsupervised given six cigarettes per day, smoking apron on when smoking, supplies stored with nurse station. R11's Smoking Risk Evaluation dated 8/21/19, identified R11 as a smoker, who did not smoke in authorized areas, aware of facility safe smoking policy, and wore appropriate footwear/ clothing to go outside to smoke. R11's significant change Minimum Data Set ((MDS) dated [DATE], identified R11 had moderate cognitive impairment and [DIAGNOSES REDACTED]. The MDS identified R11 was a current tobacco user. R11's Bedside Kardex dated 3/12/20, directed staff to ensure R11 wore smoking apron when going outside to smoke. Housekeeping Manager (HM)-A was interviewed on 3/11/20, at 9:23 a.m. and verified the front entrance was littered with cigarette butts and indicated residents were not supposed to smoke there, however did not always follow the rules. HM-A confirmed there was no receptacle for cigarette butts and/ or ashes due to residents not allowed to smoke in the area. Maintenance director was interviewed on 3/11/20, at 9:32 a.m. and verified maintenance was supposed to clean the cigarette butts, however indicated the area was supposed to have been no smoking and stated residents do what they want and smoke anyway. Maintenance director explained there was not flame retardant receptacle as it was a no smoking area and indicated that was why the ground was littered with cigarette butts. R11 was observed on 3/11/20, at 12:32 p.m. outside the front entrance of the facility smoking without smoking apron on. R11 did not have any burn holes in his clothing and/ or wheelchair. When R11 finished smoking he set his lit cigarette butt on the ground. The receptionist was interviewed on 3/12/20, at 8:57 a.m. and explained we try to monitor residents and not allow them to smoke at the front entrance and indicated she had been instructed to tell the residents not to smoke there, however indicated the residents would keep ripping the no smoking sign down. The receptionist indicated sometimes the residents would not listen and she would send an email to the administration and allow them to handle it. The receptionist stated she tried to redirect the residents, however most would smoke there anyway. Nursing Assistant (NA)-B was interviewed on 3/12/20, at 10:02 a.m. and confirmed R11 did smoke, however was not aware he needed to wear a smoking apron. Licensed practical nurse (LPN)-A was interviewed on 3/12/20, at 10:04 a.m. and verified R11 was supposed to wear a smoking apron and staff were supposed to remind him when giving R11 his three cigarettes for the shift. R11 was interviewed on 3/12/20, at 10:05 a.m. and explained he only wore the smoking apron sometimes because he needed help to put it on. R11 raised his arm and indicated he had arthritis and could hardly use his arms to get the apron on independently. R11 stated he smoked outside the front entrance of the facility and was not aware it was a no smoking area. R11 further indicated he would put his cigarettes butts onto the ground due to no available ashtray. The director of nursing (DON) and administrator were interviewed on 3/12/20, at 3:47 p.m. The DON stated it was her expectation for staff to help with placement of smoking aprons. The administrator indicated the front entrance was a no smoking area and staff were to redirect residents to the designated smoking areas. The administrator stated since the area was no smoking there were no available ashtrays in the area. The facility Policy and Procedure for Safe Smoking reviewed 2/18/19, indicated residents could smoking in designated smoking areas which included the smoking patio off of the dining room. The policy included for safe disposal of cigarettes and ashes the facility would provide ashtrays and fireproof metal containers. Residents who ignored the policy would receive consequences which included verbal then written warnings.
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** Based on observation, interview and document review, the facility failed implement non-pharmacological interventions and to comprehensively reassess and evaluate individualized behavior interventions for residents with suspect substance abuse for 2 of 2 resident (R16, R1) reviewed for mood, behaviors and substance use. Findings include: R16's quarterly MDS dated [DATE], identified R16 had intact cognition and [DIAGNOSES REDACTED]. R16's Care Plan dated 12/11/19, identified R16 had dependent behavior related to alcohol, [MEDICATION NAME] (meth), homelessness, anxiety, and prostitution and directed staff to allow to verbalize feelings, perceptions, fears, consult pastoral care, social services, psychology services, Rule 25 and psychology services were offered and accepted Rule 25 scheduled for 11/15/19, history of going through CD treatment nine times, encourage to stay sober, assist in identifying triggers, positive activities of interest, risk vs benefits discussion as needed, set realistic goals, positive working relationship, education regarding safe sex practices, support with identification of potential solutions to problems, assist to identify stressors, calm safe environment, allow to vent/ share feelings and stay with R16 during flashbacks and nightmares. R16's Care Plan initiated 2/9/20, indicated R16 reported a history of panic attacks and [MEDICAL CONDITION] behavior when under the influence of meth and directed staff to evaluate possible sleep pattern changes and intervene as appropriate. R16's Care Plan initiated 2/11/20, indicated R16 had behavior problem hiding syringes related to meth use and bottles of vodka were found in R16's backpack. The care plan directed staff to psychology consult, provide calm and safe environment to allow R16 to express feelings, behavior meth use: fast speech, increased fidgeting, diverted eye contact, verbally aggressive, conduct person and room search upon reasonable suspicion of usage, conversation with R16 regarding use, risk vs. benefits completed, positive interaction, attention, stop and talk to her as passing by, explain R16's behavior reinforce why behavior was unacceptable/ inappropriate, intervene as necessary, divert attention, remove from situation and praise improvement in behavior. R16's Progress Notes (PN) and psychology notes were reviewed 12/2/19, through 3/11/20, and revealed the following: -The psychology note dated 12/2/19, identified R16 had a history of [REDACTED]. History of CD treatment nine times and it was unlikely R16 will maintain sobriety for long and directed staff to develop positive working relationships for resources R16 can turn to during times at risk for using; -The psychology note dated [DATE], indicated R16 continued to use drugs on a regular basis particularly alcohol with some instance of meth use. R16 admitted she drank vodka on a daily basis and had no interest in quitting. R16 indicated she completed a Rule 25 for in case needed to find a place to stay. R16 has a history of prostitution, victim of multiple partner's abuse and homelessness. Treatment plan to add [MEDICATION NAME] (anti-anxiety), follow-up next month, psychotherapy and advised to limit drug intake; -The psychology note dated 1/27/20, indicated R16 was possibly intoxicated on alcohol and/ or meth and identified concerns of continued alcohol and meth use and directed staff to observe and take steps as appropriate for her behavior and immediate health condition, continue to invite and encourage R16 to avoid substance abuse as this would hinder her to get placement and places her health at some immediate risk, Rule 25 completed for housing rather than something R16 was interested in doing, and to follow-up with psychology as scheduled from [DATE], appointment; -The PN dated 2/11/20, indicated a bottle of vodka was found in R16's back pack asked for director of social service (DSS) and therapeutic recreation director (TRD) to assist in room search. A subsequent PN dated 2/11/20, indicated during room search a metal tin was found with two syringes, one bottle of [MEDICATION NAME] (nerve pain medication) and one bottle of [MEDICATION NAME] ([MEDICATION NAME]) in addition to one bottle of vodka full and an empty bottle of vodka. R16 walked in and asked to take the bottles off grounds R16 was instructed to leave the bottles. An additional PN dated 2/11/20, indicated R16 understood the consequences of what happened and feels embarrassed social service to follow-up and update care plan; -The PN dated 3/2/20, indicated DSS met with R16 regarding finding meth on R16. R16 this was not what she was expecting when she came to a nursing home. R16 was reminded the continued drug and alcohol use would be found within her medical record making it difficult to find alternative placement. R16 briefly agreed to outpatient treatment then

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) decided it was not needed as long as she could continue to receive relocation services. R16 indicated no one cares about what happens to me DSS indicated she cared and cared about keeping R16 safe. R16 indicated she had a friend to call and pay $60 for services. Writer stated so is this for sexual favors, resident stated yes. R16 indicted she needed to leave to medicate due to too painful. DSS followed R16 to the front door and out of the front door where R16 engaged in conversation with a peer for the person's phone number whom was offering $60. DSS asked R16 to stay, however R16 continued walking and left the facility. A subsequent PN dated 3/2/20, indicated DSS spoke with peer who indicated the friend was going to pay R16 $60 for heavy lifting and the offer of money had nothing to do with sexual interactions; -The PN dated 3/6/20, indicated two bottles of vodka were found during room search, one empty and one half full. A subsequent PN dated 3/6/20, indicated social services made two attempts to completed behavior contract with R16, R16 currently on a leave of absence social services will re-attempt 3/9/20. R16's Kardex dated 3/12/20, indicated risk benefit completed, however lacked direction to nursing assistants (NA) regarding interventions for R16 during times of anxiety and/ or substance abuse. R16's medical record lacked evidence of comprehensive reassessment of R16's continued substance abuse, monitoring of the effectiveness [MEDICATION NAME], sexual and/ or risky behaviors and effectiveness of current interventions. R16 was interviewed on 3/11/20, at 2:45 p.m. and explained she was ready to discharge due to the facility having been very stressful related to relationships with peers and staff. R16 acknowledged she added to the stress with her daily alcohol and drug use. R16 felt as if the facility was looking for excuses to kick her out. R16 stated staff does not care about me and indicated staff were aware she was getting money to purchase alcohol. R16 admitted to a peer giving her six dollars to buy alcohol for the peer, however did not make the purchase as promised and spent the peer's money. R16 indicated this resulted in the peer threatening to break R16's jaw, however after notification to the staff R16 felt as if nothing had been done. R16 denied selling drugs to peers, however acknowledged she did have meth and needles at times on her person. R16 declined to answer any questions related to $60 for sexual services. NA-D was interviewed on 3/12/20, at 5:22 p.m. and explained when R16 was using drugs and/ or alcohol it would be reported to the nurse so the substance could be removed. Licensed practical nurse (LPN)-D was interviewed on 3/12/20, at 5:24 p.m. and stated when a resident had suspected drug or alcohol use they would remove the substance and call the on-call medical provider who would direct the nurse what to do next. LPN-D stated the on-call provider would usually direct the nurse to call 911 or hold their medication and sometimes the nurse would be directed to let the resident sleep to become sober. The administrator and director of nursing (DON) were interviewed on 3/12/20, at 5:28 p.m. The administrator stated it was her expectation when a resident was found to have been under the influence of alcohol and/ or drugs to offer treatment, explain risk and benefits every time. The DON stated she would try to meet with each resident herself as she did not want to put staff in the situation. The DON stated the providers were used to get their input how to monitor the resident when they were suspected to have been using. The DON further stated it was important to make sure the resident understood the risks. DSS was interviewed on 3/12/20, at 6:01 p.m. and stated R16 repeatedly declined Rule 25 and indicated the facility just received an updated list of local alcohol anonymous classes that she would review with R16 this week. DSS indicated R16 admitted she actively drank alcohol and the facility continued to offer Rule 25 and benefits. DSS explained she was not CD trained, however completed course work during her education. R1 was interviewed on 3/11/20, at 1:48 p.m. and explained he had been sprayed by piss and found his shoes cut open due to wires in my stuff. R1 identified three residents whom resided in the facility who were selling [MEDICATION NAME] (meth) and [MEDICATION NAME] to other residents. R1 stated after his pain medications were taken away from him I started doing drugs I was not getting my pain meds (medications). R1 verified he would do [MEDICATION NAME] and [MEDICATION NAME] that he would either buy off of the street or from another resident in the facility. R1 explained last night a resident sold him crumbs of meth. R1 confirmed he did use the meth last night. R1 stated he had told facility staff residents were selling pills, however indicated no further follow-up occurred. R1 further stated the staff put wires in his shoes and had cut them open and were listening to our interview and indicated I am not going crazy I can hear them in my room, they can hear me, I am scared I might hurt one of them. R1 stated he had a scissors because I know for a fact they see us and hear our conversation. R1 was observed at this time seated in his wheelchair fidgeting rubbing his skin with his hands, scissors in his lap then hand, looking around quickly, unable to maintain eye contact. R1's annual Minimum Data Set ((MDS) dated [DATE], identified R1 had intact cognition. R1's quarterly 2/20/20, MDS identified R1 had [DIAGNOSES REDACTED]. The MDS indicated R1 had physical behavior symptoms directed toward others one to three days, verbal behavior symptoms directed toward others daily and other behavioral symptoms not directed toward others daily. R1's Care Plan dated 2/6/20, identified R1 had a behavior problem related to verbal outbursts/ aggression toward others, threatening behaviors, refusals of care, non-compliance, throws belongings in hall and directed staff to psychology consult, evaluate pain, calm and safe environment, allow to express feelings, areas for decreased stimulation, evaluate sleep, one to one staffing related to altercation with another resident moved to 15 minute checks on 12/5/19, staff to be on the lookout for developing conflicts and intervene one them as quickly as possible to prevent physical aggression, motivational interviewing, administer medications as ordered, anticipate needs, assist to develop coping methods, activities of interest, redirect, reassurance and build trusting connection. R1's Care Plan dated 2/14/20, identified R1 self-reported drug usage related to [DIAGNOSES REDACTED]. R1's Care Plan dated 3/5/20, identified R1 had a behavior problem related to cursing at residents and staff, taking staff belongings, throwing things at resident, and putting butter knife behind bathroom door and directed staff to remove butter knife, remind door cannot be blocked, complete a risk vs benefits, psychological consult as needed, ask what was seen and provide details, explain visions were not real, ask if R1 feels safe, increase communication, monitor/ document response to problems, monitor/ document feelings, monitor change in behavior if suspected drug use provide calm environment, evaluate pain, calm and safe environment, allow to express feelings, area for decreased stimulation, refused Rule 25 on [DATE]. R1's Progress Notes (PN), psychology notes and provider notes were reviewed 2/10/20, through 3/12/20, and revealed the following: -The psychology note dated 2/10/20, indicated per staff report R1 was more paranoid and felt people were watching him. R1 had a toxicology screen which was positive for meth. Recommendations include to encourage R1 to have a clean UA, focus on strengths, when irritable consider having a different staff approach and accompany him to a different location; -The PN dated 2/24/20, indicated R1 pushed a TV onto R6 after being accused of taking medication off R6's bedside table resulting in a one to two inch cut to R6's left eyebrow. -The psychology note dated 3/2/20, identified R1 was approached last week at which time was very irritable, yelling. The note indicated R1 was feeling down and bad a peer was caught with significant amount of heroin over the weekend when R1 asked him for some [MEDICATION NAME]. R1 was noted to have been medication seeking and had an altercation with a peer in which he reportedly tipped a TV on top of the peer. R1 noted the incident with the TV was a result of the peer refusing to give R1 his [MEDICATION NAME] (narcotic) which made R1 angry. R1 admitted I'm going to have a dirty UA (urine analysis) due to recent events. Recommendations included staff encouraged to allow R1 space when irritable and work on building rapport when not irritable, talking about interests such as basketball, ensure opioid (narcotic) medications are observed taken, redirect when irritable redirect from peers rooms, offer pain management options when sober, and compliment when R1 has clean UA; -The PN dated 3/5/20, indicated R1 exhibited delusional behavior due to somebody in his bathroom watching him and listening. R1 also made statements some people were outside of his window and in the ceiling It was for this writer to decipher resident is hallucinating as oppose of him wanting attention from staff; -The PN dated 3/6/20, indicated R1 was cursing the nurse this is the normal behavior of this res (resident), cursing the staff member during noc (overnight) shift et going back to management to lied on staff; -The PN dated 3/7/20, indicated R1 called 911 to report the social worker hide a camera in his room to monitor his activity, R1 was very paranoid the police came to the facility to talk to R1, however R1 continued to insist there was a hidden camera. A subsequent PN dated 3/7/20, indicated R1 thought there were speakers in the ceiling that were connected to his room and heard DSS in the bathroom talking about him and were listening from the ceiling; -The PN dated 3/8/20, indicated R1 heard people talking to him through the walls and there was a camera in his room. Another PN dated 3/8/20, indicated R1 was approached for wound care and immediately started cursing at staff with all his street language and pushed the chair towards staff in a threatening way behavior was reported to building charge. A subsequent PN dated 3/8/20, indicated R1 educated and agreed to stop cursing; -The PN dated 3/9/20, indicated R1 exhibited delusional behavior and verbally abusive towards staff. A subsequent PN dated 3/9/20, indicated interdisciplinary team (IDT) met and noted on 2/20/20, R1's assessment ranked as severely depressed, resident offered psychology and participates when approached. Facility has met with providers offered psychology support and offered Rule 25. IDT will continue to work with R1 to gain compliance with substance use abuse treatment. Social services also to approach R1 with behavior contract encouraging participation with psychology for an extended amount of time. An additional PN dated 3/9/20, indicated R1 approached director of social services (DSS) and accused DSS of putting cameras into his

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) ceiling. DSS responded to R1 that she does not go into resident's room without resident being present. R1 insisted there were cameras on his ceiling and DSS requested if they could meet tomorrow; -The provider note dated 3/9/20, indicated R1 had a urine toxicology screen positive for [MEDICATION NAME] in 2/2020, R1 does not wish to engage in discussion regarding cessation, [MEDICATION NAME] discontinued due to positive urine toxicology screen; -The PN dated [DATE], indicated R1 knew who put cameras in his room and DSS agreed to enter his room with maintenance to look for cameras; -The PN dated 3/11/20, indicated R1 was noted to be anxious and was holding onto a pair of scissors. The resident then stated I have these scissors to protect myself, when writer inquired who he needed protect from, he stated he was going to charged to social worker, as she is spying on him. The PN indicated R1 stated he was not crazy and staff offered to work together to resolve the concerns. R1 gave the scissors to staff and agreed to take a shower; -The PN dated 3/12/20, indicated R1 stated I'm not high, I'm down. I used last night but that was a long time ago. R1 indicated he got them (drugs) here and I'm not going to snitch. R1 was noted to have a yellow area on his blanket, feces on the floor and all bandages removed from his wounds. R1 indicated I'm not crazy from these drugs. R1 was offered to stop using drugs and indicated he was not sure if he wanted to do that. R1 was noted to wheel back into his room and staff indicated they would approach R1 later. A subsequent PN dated 3/12/20, indicated R1 was in the hallway yelling and screaming about people in his room destroying his items, he also stated he was going to kill himself and others. No one specific mentioned. Police was called. An additional PN dated 3/12/20, indicated police and paramedics arrived, R1 calm and cooperative. If any other incident to recall 911 and sent to ER (emergency room). The nurse practitioner (NP) was interviewed on 3/11/20, at 3:04 p.m. stated R1 had all of his narcotic medications discontinued due to testing positive in his urine for meth. NP indicated she was unaware what the plan is for R1 and his continued drug use. The administrator and director of nursing (DON) were interviewed on 3/12/20, at 4:03 p.m. The DON stated chemical dependency education for the staff was a work in progress and explained the facility psychology services would come in and train on specific mental illnesses, however stated right now they are not mandatory, it's not consistent. The DON stated lack of chemical dependency training was one of the biggest barriers in the building. The administrator stated when staff suspected a resident was using substances they would offer treatment and explain the risk and benefits with each incident. The DON stated she would try to meet with each resident due to not wanting staff to be put in the situation, however indicated it was important the resident understood the risk. The administrator stated social services should have reviewed R1's psychology note dated 3/2/20, and would have expected follow-up which would include trying to find the source of the [MEDICATION NAME] and offer treatment. The DON stated she was not aware of the 3/2/20, psychology note. Both the administrator and DON were unaware of [MEDICATION NAME] being sold amongst residents. Nursing assistant (NA)-D was interviewed on 3/12/20, at 5:22 p.m. and stated when a resident was suspected to use drugs they were directed to remove the substance and notify the nurse. Licensed practical nurse (LPN)-D was interviewed on 3/12/20, at 5:24 p.m. and explained when a resident was using drugs they would call security and update the medical provider. LPN-D stated they would also search them and depending on the situation sometimes they just let them sleep. The director of social services (DSS) was interviewed on 3/12/20, at 6:00 p.m. and stated she was aware R1's ongoing substance use and indicated she attempted to have R1 sign a behavior contract, however R1 refused to sign. The facility Policy and Procedure for Alcohol and Unauthorized Drugs revised 2/19/19, indicated unauthorized drugs or alcohol would compromised care and even lead to serious complications or death. Should you witness the use of unauthorized drugs or alcohol notify facility staff as soon as possible. If a resident was found in the possession, use or distribution of unauthorized drugs or alcohol it would be confiscated by facility staff. The facility staff would conduct an initial room search and continue to do random room searches. Residents who ignore the policy endanger themselves and others may receive the following consequences verbal warning then written contract. Persistent violation would result in finding alternative living arrangements.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure dementia services were provided including implementation of personalized behavioral interventions and failed to reassess the effectiveness of interventions for 1 of 1 resident (R12) reviewed for dementia care. Findings include: R12's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 11/27/18, identified R12 had [DIAGNOSES REDACTED]. R12's Behavioral Symptoms CAA dated 11/27/18, identified R12 had behaviors related to touching staff and residents inappropriately, talking inappropriately, rejecting cares, and wandering, however lacked care rationale for care plan decisions. R12's care plan initiated 11/12/19, identified R12 was an elopement risk/ wanderer related to [MEDICAL CONDITION] and directed staff to provide recreational activities, staff were aware of wander risk, wanderguard on right wrist, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, monitor for fatigue and weight loss, and provide escort to outside appointments. R12's care plan initiated 2/11/20, identified R12 had behavioral problem related to history of reaching out to others and grabbing at them, refuses dressing change, limited communication ability secondary to limited English, communicates with gestures, calls others names at times, inappropriate behavior towards staff, screaming, yelling and hitting objects. The care plan directed staff to psychology consult as indicated, provide calm and safe environment, allow to express feelings, provide area for decreased stimulation for negative behaviors, walker for mobility, positive interaction, attention, stop and talk to R12 when passing by, explain what was not acceptable behavior, remove away from others, complete a risk vs benefits, medication adjustment and medication review by pharmacist, medications per orders, provide activities of interest and accommodate status, redirect behavior and remove from others when becomes intrusive or aggressive, educate and remind not to swear names to others, not allowed to smoke with other residents, and hourly checks. R12's quarterly Minimum Data Set ((MDS) dated [DATE], identified R12 had severe cognitive impairment and [DIAGNOSES REDACTED]. The MDS further indicated R12 used a daily wander/ elopement alarm. R12's provider note dated 2/3/20, indicated R12 had increased shouting loudly, touching females inappropriately, and grabbed out at others. R12 would benefit from calm environment. R12's Progress Note (PN) were reviewed [DATE], through 3/12/20, and revealed the following: -The PN dated [DATE], indicated R12 was telling in the hallway and kept asking to leave the station; -The PN dated [DATE], indicated the director of social services (DSS) and therapeutic recreation director (TRD) were paged to unit three due to R12 was yelling and banging his hands on the table and was stating he would like to move. A subsequent PN dated [DATE], indicated R12 was very loud and disruptive resistive to cares and redirection, yelling and hitting the medication cart and desk with his hands, threatening to hit staff, R12 sat in front of locked door and prevented others from entering/ exiting. Administration came up to talk to R12, however he continued to yell and hit the table. R12 hit staff on chest with was very disruptive he refused any redirection; -The PN dated 2/28/20, indicated Resident was very inappropriate this evening, held writer by the neck scarf .Resident continue to even grab the NAR (nursing assistant) on duty by her neck, holding tight to her uniform on her right side by shoulder. R12 was very hard to redirect and had poor boundaries with staff and increase physical aggression; -The PN dated 2/29/20, indicated R12 scream does not respond to any redirection. R12's Kardex dated 3/12/20, directed staff to rephrase sentences to ensure R12 understands as he understands some English, cue, reorient and supervise, encourage to state thoughts even if R12 was having difficulty, focus on a word or phrase that makes sense or responds to the feeling R12 tries to express, translation services phone number, provide area for decreased stimulation, redirect behaviors and remove from others when R12 was aggressive. R12's medical record lacked evidence of comprehensive reassessment of R12's behaviors and current effectiveness of current personalized behavioral interventions. Licensed practical nurse (LPN)-B was interviewed on 3/12/20, at 9:15 a.m. and stated R12 would yell, make demands, hit staff and other residents, and pounded on items in the unit. LPN-B explained R12 would jump and start yelling without reason. LPN-B indicated the staff were unable to calm him down and when staff were unable to calm R12 down they would walk away. LPN-B stated R12 understood when spoken to in Somali, and explained when R12 was able to explain what he needed this would sometimes help R12 calm down. LPN-B further explained when R12 was in a mood staff get out of his way or they'll be the next to get hit. Nursing assistant (NA)-A was interviewed on 3/12/20, at 9:33 a.m. and NA-A stated yesterday R12 was assisted to the bathroom and during cares R12 made a fist and attempted to hit NA-A. NA-A stated they left R12 in the bathroom and later R12 said sorry. NA-A explained R12 had been upset since he moved to unit three two to three weeks ago and indicated he would repeat himself wanting to go back to unit two. NA-A indicated R12 would take a chair to sit by the door that lead to unit two and at times would pound on the door with his fits wanting to leave. NA-A further explained

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	245203	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT BRYN MAWR	275 PENN AVENUE NORTH MINNEAPOLIS, MN 55405

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) R12's behaviors had increased since moving to unit three which included pounding on items, hitting out at staff and yelling. NA-A stated R12 enjoyed to walk around on unit two and now was limited to his ability to ambulate around unit three. R12 was interviewed on 3/12/20, at 9:41 a.m. and stated he wanted to move back to unit two. R12 explained he wanted to go for walks and was unable to walk around on his current unit. Licensed Practical Nurse (LPN)-C was interviewed on 3/12/20, at 9:53 a.m. and explained R12 was not fluent in English and would get upset easily when he was unable to communicate with staff. LPN-C stated R12 would calm down easily once someone translated his needs. LPN-C indicated R12 had a picture communication book staff were to use with a picture of an item and the Somali word under each picture. NA-A was interviewed on 3/12/20, at 9:58 a.m. and verified R12 had a picture communication book, however identified staff were not utilizing the book with R12 as it was not helpful. Family member (FM)-A was interviewed via telephone on 3/12/20, at 10:12 a.m. and verified she was R12's guardian and explained R12 had resided on unit two, an unsecured unit, for a long time without any known issues. FM-A stated two weeks ago she received a message which indicated R12 was being moved to unit three, the facility locked unit, without any reason and/ or explanation. FM-A indicated R12 was not happy due to not liking the locked unit and stated R12 told her they locked me down and I cannot walk around. FM-A indicated I know he yells but he needs his freedom he's saying I have no freedom. FM-A explained facility staff had not contacted her regarding R12's personal preferences and/ or to schedule a meeting to discuss R12's behaviors. The Therapeutic Recreation Director (TRD) was interviewed on 3/12/20, at 2:36 p.m. and stated he was aware R12 enjoyed walking around unit two, however due to not having enough staff R12 was only taken for a walk once on 3/2/20, since moving to unit three. The TRD indicated if there were enough recreation staff R12 should have been walked one to two times weekly. The TRD indicated R12's behaviors were able to have been redirected. The administrator was interviewed on 3/12/20, at 3:48 p.m. and stated it was her expectation for staff to contact the telephone interpreter service line for communication with R12. The administrator stated she was unaware R12's behaviors were not redirectable. The administrator indicated she would have to refer to the regulations if reassessment was needed. The facility dementia care policy was requested, but not provided.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide medically related social services to attain or maintain the highest practicable psychosocial well-being to provide and/ or make arrangements with effective assessment, care planning and psychosocial support regarding continued request for mental health appointment due to depression with thoughts of suicide for resident for 1 of 1 residents (R14) reviewed for sexual abuse. Findings include: R14's quarterly Minimum Data Set ((MDS) dated [DATE], identified R14 had moderate cognitive impairment and [DIAGNOSES REDACTED]. R14's Care Plan dated [DATE], identified R14 had ineffective coping skills, mental/ emotional illness and directed staff to assess R14's understanding of the situation, allow time to express self and feelings towards the situation, offer choices regarding care and activities, when agitated guide away from source, engage calmly in conversation, staff to walk away calmly and approach later. R14's Care Plan initiated [DATE], identified R14 was at risk for mood problem related to major [MEDICAL CONDITION] and directed staff to evaluate changes in appetite, provide calm safe environment allow to express feelings, notify medical provider if R14 wishes for death, states thinking of harming self or actually harms self, ensure R14 was safe and unable to harm self, evaluate pain, decreased stimulation as needed, evaluate sleep pattern, assist with positive coping skills and reinforce these, behavioral health consults as needed. R14's Care Plan dated [DATE], identified R14 used medication related to depression and directed staff to administer medication per orders, monitor and document side effects, monitor thoughts of hopelessness, hallucinations/ delusions, social isolation, suicidal thoughts, withdrawal, decline in activities of daily living, continence, interventions included provide one to one support and reassurance, allow time to discuss feelings and encourage to participate in activity. R14's Care Plan dated [DATE], identified R14 had a psychosocial well-being problem related to alcohol dependence and directed staff to allow time to answer questions, verbalize feelings perceptions, fears, consult psychology services, offer Rule 25 and other resources related to sobriety, risk vs. benefits discussion, encourage sobriety, R14 would make passing comments regarding suicide without active, continue psychology services, set realistic goals, referrals as needed, offer calm safe environment, and allow to vent/ share feelings. R14's Progress Notes (PN) and psychology notes were reviewed [DATE], through [DATE], and revealed the following: -The psychology note dated [DATE], indicated [REDACTED]. R14's sister [MEDICAL CONDITION] and died two months later which caused R14 to re-experience grief again for the loss of his parents and sister. This in addition to homelessness was making R14's depression into a complex situation along with his medical issues. R14 identified spirituality as an important source of strength. R14 indicated he was treated for [REDACTED]. Recommended to provide grief information and support to R14 to help aide in his sister's death and grief process; -The psychology note dated [DATE], indicated R14 had been having suicidal thoughts and reported the suicidal thoughts were related to thinking about his sister who passed away. R14 reported to talking with staff and was feeling better. R14 was reminded he had access to staff 24 hours per day and denied any further suicidal thoughts. Recommendations included staff to remain aware and attentive, engage in positive activities, please encourage him to abstain from alcohol, and follow up with psychology as scheduled; -The PN dated [DATE], indicated social services spoke with psychology services about R14's drinking and concerns it was affecting his mental health; -The psychology note dated [DATE], indicated R14 was seen for neuropsychological testing which included R14 disclosing his brother and sister both died last month. R14 was noted to have been in the mild range for cognitive impairment. R14 was noted with mild depression, grieving the death of his sister who died on e month ago and mild anxiety. Recommendations given to the director of social service (DSS) included recommend a power of attorney to assist with healthcare and financial decision, support placing R14 in independent living with a life coach to assist with sobriety, participation in chemical dependency (CD) treatment, notify R14 about grief support groups in the local community, places of worship, and other social settings R14 could attend to relive his symptoms or grieving and loss, exercise to improve mood, family and grandchildren are important to mood, use solution focused validation approach to improve mood; -The PN dated [DATE], indicated DSS received a request on behalf of R14 to receive services at an identified mental health facility where R14 was seen in the past. DSS attempted to meet with R14, however he was gone on leave of absence. DSS called and left a voicemail at the facility social services to follow-up. R14 currently being seen by in house psychology. R14's email communications between Transitions Coordinator (TC), Public Health Nurse/ Assessor (PHN) and facility were reviewed [DATE], through [DATE], and revealed the following: -Email dated [DATE], to the DSS indicated PHN was requesting a referral for a mental health evaluation for R14. A subsequent email dated [DATE], indicated TC had already made contact with in-house psychology services to schedule a mental health evaluation. An additional email dated [DATE], indicated there was confusion about the different between a mental health referral / eval and neuropsyche eval as per many previous communications, this is needed now, the neuropsyche eval could wait if needed. The Regional DSS replied on [DATE], and indicated I was assuming that was the same. I will touch base with our .psychologist for him to be seen on Monday .anything specific you need him to be evaluated for? PHN email dated [DATE], indicated we need a good mental health eval/ assessment any mental health [DIAGNOSES REDACTED].this is essential for SMRT (State Medical Review Team) determination. We are now at risk of SMRT denial because this is taking so long and the SMRT said they needed this in early December; -Email dated [DATE], indicated PHN requested DSS to update regarding the status of R14's mental health appointment with an outside facility per R14's request; -Email dated [DATE], indicated TC asked DSS if R14's referral was made for mental health. A subsequent email dated [DATE], from DSS indicated no it was not which indicated the referral was not made for mental health appointment. An additional email dated [DATE], to the Regional DSS indicated PHN had contacted DSS on [DATE], [DATE], [DATE], [DATE], and [DATE], to request a mental health appointment to have been made at R14's provider of choice without response. DSS replied via email dated [DATE], and indicated attempted to call a view (few) times this morning. I left a message . Ombudsman was interviewed via telephone on [DATE], at 9:29 a.m. and stated she was made aware of R14's issues by PHN and had four to five meetings with facility and corporate staff regarding concerns which included lack of assistance with R14's relocation and mental health services, however indicated things have not changed. TC was interviewed via telephone on [DATE], at 10:40 a.m. and explained since ,[DATE], the facility had failed to meet R14's mental health needs due to R14 requesting to see a therapist at an outside facility he'd used in the past and was comfortable with. TC recalled on [DATE], she met with R14 and asked DSS to make a referral to help R14 get mental health help and mentioned this again on [DATE], [DATE], [DATE], without response. TC stated on [DATE], DSS finally responded then on [DATE], indicating R14 was his

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F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) own person and DSS was unable to schedule the appointment without R14 present. TC indicated R14 had made suicidal statements over the past few months and had suffered from major [MEDICAL CONDITION] which was why the mental health support was invaluable for R14. TC explained the DSS was not communicating with TC regarding depression, suicide, and continued alcohol use. TC further explained a month or two ago there was concern expressed to the Regional DSS regarding lack of communication and follow-up from DSS. R14 was interviewed on [DATE], at 11:46 a.m. and stated TC and PHN really helped him, however indicated the facility did not help him. R14 explained he had missed mental health appointments due to not being told when the appointment was scheduled and indicated he had been waiting to be seen by an outside mental health provider, someone he had seen in 2019, for his major [MEDICAL CONDITION]. R14 stated he wanted to follow-up with his mental health provider rather than the facility psychology services related to depression and prior thoughts of suicide. R14 identified his sister passed away a while ago and when he was down and depressed this caused him to drink alcohol. R14 acknowledged his drinking would hinder him finding his own place so he wanted all of the help he could get. R14 indicated DSS was supposed to have help him schedule this appointment a long time ago. Director of social services (DSS) was interviewed on [DATE], at 12:10 p.m. and verified PHN had been requesting a mental health appointment for R14 for about a month. DSS indicated the problem was scheduling something for a resident when they were out of the facility and was his own person. DSS confirmed she left a voicemail on [DATE], for an appointment, however had not followed-up since and was waiting for a return call. DSS stated it was not R14 who wanted to be seen it was the PHN and TC who wanted R14 seen. DSS further stated she was aware R14 was depressed since his sister's death and had drank alcohol, however was not made aware of any thoughts of suicide during the past three months. DSS stated if a resident expressed suicide she would follow-up once a day until the person's mood was ok. Furthermore DSS was unaware of offering R14 grief support groups per psychology recommendations. PHN was interviewed via telephone on [DATE], at 2:30 p.m. and explained R14 suffered from major [MEDICAL CONDITION] with occasional thoughts of suicide and would self-medicate with alcohol which lead to further health problems and safety risks. PHN stated R14 never felt a connection with the facility in-house psychology services, part of which was caused by the inability to preset appointments and indicated R14 expressed desire to follow-up with his prior mental health services from 2019. PHN reported R14 had been waiting and waiting after multiple requests and many communications with DSS to get this mental health appointment scheduled. PHN stated DSS would say R14 was his own person, despite numerous requests to assist R14 in scheduling the appointment. The director of nursing (DON) and administrator were interviewed on [DATE], at 4:13 p.m. The DON stated it was allowed for residents to see providers of their choice whether in-house or in the community. The administrator stated it was her expectation to reach out as soon as able and schedule any requested appointments. The administrator stated she had followed-up with DSS regarding R14's appointment on [DATE], and indicated multiple calls had been made in attempt to schedule the appointment. The administrator further stated it was her expectation for social services to follow-up on psychology recommendations. The facility appointment scheduling, social service, and suicide policies were requested, however not provided.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**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 document review, the facility failed to provide a safe, sanitary and comfortable environment for residents related to un-repaired damage to interior and excessive waste and trash on property grounds and outdoor courtyard patio. This had the potential to affect all 103 residents. Findings include: On 3/11/20, at 8:05 a.m. garbage was visible at the entrance of the building. The entrance area was littered with trash that included cups, bottles, and cigarette butts. At 9:18 a.m., the smoking patio was observed to have a strong smell of urine, cigarette butts and food debris that included a large bun and grapes were on the ground. Cups, litter, newspaper, and catheter leg strap were also observed on the ground. There was also a trash can overflowing with trash. At 9:19 a.m., Resident (R)-3 was interviewed and stated he didn't like the trash, and it all needs to be burned. At 9:20 a.m., R10 was interviewed and stated he could smell the urine and residents urinated on the patio so they just had to get used to the smell. At 9:23 a.m., the Housekeeping Manager (HM)-A, was interviewed and toured the grounds. HM-A verified the front entrance was littered with cigarette butts, cups and trash. HM-A stated residents were not supposed smoke in front of the building, so no smoking disposal was provided. HM-A further stated maintenance was responsible to pick up the trash on the grounds. HM-A verified the courtyard smelled of urine, and stated she believed residents urinated there. HM-A further verified the presence of urine and spit on the walls of the patio, food, bottles, cups and cigarette butts on the ground and did not know when the courtyard patio had last been cleaned, but agreed residents did not use ashtrays. During an environmental tour of the building on 3/11/20, HM-A verified there was urine on the walls and toilet in resident room [ROOM NUMBER], and stated the bathroom was shared by 5 residents and the housekeeper cleaned the bathroom daily unless they were short-staffed, then the nursing assistant would clean. At 9:30 a.m., a resident of room [ROOM NUMBER], was interviewed and stated the bathroom had not been cleaned for 2 or 3 days and he won't use the bathroom because the dirty condition bothered him. At 9:32 a.m., the Maintenance Director was interviewed and stated residents urinate and vomit on the courtyard patio. The Maintenance Director further stated the garbage was worse since the snow melted and the patio was scheduled to be cleaned weekly, but he was by himself in the building so hadn't been able to clean the courtyard patio or the front of the building yet. At 9:45 a.m., resident room [ROOM NUMBER] was observed to have a urine odor, a golf ball sized hole in the bathroom door, excrement visible on the toilet and seat, the wall visibly dirty with brown streaks and scuffed that resulted in exposed drywall. Additionally, a hole near the baseboard was observed in the hall across from the door of room [ROOM NUMBER] along with a broken outlet cover, that exposed the wiring. At 9:51 a.m., nursing assistant (NA)-A was interviewed in regards to room [ROOM NUMBER], verified excrement on toilet and stated the toilet area would normally be cleaned by housekeeping if they had enough staff. At 9:57 a.m., Housekeeper-C was interviewed and confirmed room [ROOM NUMBER] had a urine odor and stated residents sometimes urinated on the floor. Housekeeper-C further confirmed excrement was visibly present on the toilet, and stated 4 residents shared the toilet and it was the job of housekeeper or nursing staff to clean. Housekeeping-C verified a hole in the bathroom door, hole in wall in hallway and broken electrical outlet cover in hallway that should all be reported to maintenance. At 10:26 a.m., the Maintenance Director was interviewed and verbalized exposed drywall in room [ROOM NUMBER] needed to be painted, 2x2 inch hole in bathroom door would need to be patched, and verbalized the hallway outlet cover was broken and would be replaced. The maintenance director further verbalized the presence of a 3.5 inch long opening present at mop board that would be patched. At 10:52 a.m., the facility Administrator was interviewed and verbalized the presence of garbage on patio of back courtyard and stated there was much more debris present now due to the melting snow. The administrator further stated maintenance did daily outside rounds, and verbalized a plan to pressure wash the patio. At 10:55 a.m., the Director of Nursing (DON) verbalized the courtyard smells of urine due to resident behavior, and positive reinforcement was used to try to curb the behavior. The DON further acknowledged residents smoked in the front of the building even though no smoking signs were posted and there were no ashtrays there. A facility policy regarding Environmental Maintenance was requested and not provided.