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 _____	06/10/2020

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a call light was within reach for 2 of 4 residents (R21, R20) reviewed for accidents. Findings include: R21's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R21 was severely cognitively impaired. R21's quarterly MDS dated [DATE], indicated R21, had severely impaired vision, required assistance of one to two staff members for bed mobility, and transfers and had fallen in the previous quarter. R21's medical [DIAGNOSES REDACTED]. R21's care plan printed 6/10/20, indicated R21 was at risk for falls but did not address the use of call light to prevent falls. R21 was observed on 6/9/20, at 10:27 a.m. lying in bed with the head of the bed raised, R21 laid in bed with feet all the way to the footboard of the bed and knees bent up toward the ceiling. The bed was in low position and left side of the bed was up against the wall. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light. NA-G fastened R21's call light to pillow above head. The call light fell part way to the floor, NA-G put the call light in R21's hand and told R21 it was his call light. NA-G explained staff were to put the the call light in R21's hand and tell him where it was because he could not see. NA-G verified R21 was able to use the call light if it was available. R20's admission MDS dated [DATE], indicated R20 was cognitively intact, required assistance of two staff members for bed mobility, and transfers and on staff member to walk in room. R20's MDS also indicated he had not fallen prior to admission but had fallen once since admission with no injury. R20's medical [DIAGNOSES REDACTED]. R20's care plan printed 6/10/20, indicated R20 had a self care deficit and instructed staff to encourage resident to use the call light for assistance. R20 was observed on 6/9/20, at 2:19 p.m. lying in bed with his eyes open. The head of the bed was elevated and R20's call light laid on top of the portable stereo on R20's nightstand. The night stand was against the wall and to the right of the head of the bed. When asked what brought him to the facility R20 stated he fell before and since admission. R20 stated when he put on the call light staff would come at their convenience. R20 stated he had fallen because he could not wait for staff to answer his call light. R20 attempted to reach his call light but was unable. R20 asked for his call light. On 6/9/20, at 2:25 p.m., NA-E entered room and gave R20 his call light and asked if there was anything else she could do for him. NA-E verified call light had been out of R20's reach. NA-E verified R20 was able to use the call light and would use it if he had it. NA-E stated they must have forgotten to give it back to him when they helped him repositioned. NA-E verified there were no signs on the wall to remind R20 to use the call light. NA-E stated sometimes the lights get busy but we answer them as fast as we can. During interview on 6/10/20, on 10:52 a.m. the director of nurses (DON) stated call lights should be in reach for all residents, unless it was specifically care planned that the resident should not have a call light because of safety issues or they were unable to use it. Call light policy was requested but not received.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to timely notify a family member/responsible party of resident to resident sexual abuse for 1 of 3 residents (R2) reviewed for abuse. Findings include: According to Nursing Home Incident Reporting documents, a report was submitted to the state agency (SA) on 5/29/20, which indicated R2 had touched another resident inappropriately while in the elevator. R2 was placed on 1:1. R2's quarterly Minimum Data Set ((MDS) dated [DATE], indicated moderately impaired cognition. R2 had verbal and physical behavioral symptoms directed toward others 1-3 days. R2 had other behavioral symptoms not directed toward others 1-3 days. R2 had not rejected cares. R2 had wandered 1-3 days. R2 required supervision with transfers and was independent with walking in corridor and on and off the unit. R2 used a walker. R2's [DIAGNOSES REDACTED]. R2's care plan dated 11/19/18, identified R2 had a behavior problem related to history of reaching out to others and grabbing at them, inappropriate grabbing and touching toward staff and residents. Screaming and yelling when reeducated. R2's care plan directed staff to psychology consult, explain to R2 this is not acceptable behavior, remove from others if applicable, explain risk vs benefit, animal crackers are at the nursing station used for deescalating. R2's care plan dated 12/3/18, indicated R2 had areas of vulnerability related to behaviors, agitation, communication, dementia, irritating to others. The care plan directed staff to notify administrator, director of nursing (DON) and social worker of an adverse event and to observe and provide a safe environment. The care plan lacked instruction to notify R2's guardian. A review of R2's medical record progress notes indicated the guardian was notified of the incident that was reported to the State Agency on 5/29/20, on 6/5/20, seven days after the incident occurred. During a telephone interview on 6/10/20, at 9:26 a.m. with family member/guardian (FM)-A, FM-A stated the facility called and had stated R2 grabbed another resident (R1). FM-A did not know what date had been notified nor what date the incident occurred. FM-A stated had been notified R2 had done that in the past and that R2 would grab people when they needed something. During interview on 6/10/20, at 10:16 a.m. social services (SS)-B stated had not worked the day the incident occurred. SS-B stated it would be the expectation for the staff working that day to notify family. SS-B stated I spoke to the family as soon as I was notified. SS-B noted in a progress note on 6/5/20 of notification to family, which was six days after the incident occurred. During interview on 6/10/20, at 11:37 a.m. the director of nursing (DON) stated as part of the investigation the family would be updated right away and documentation should be in a progress note or interdisciplinary note in the medical record. During interview on 6/10/20, at 12:00 p.m. the facility administrator stated it would be the expectation to update the family following an incident as soon as possible but within 5 days. The facility policy titled Notification of Changes Guideline, dated 11/28/17, directed staff to notify the resident representative for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. Document the notification in the resident's medical record. The nurse would immediately notify the resident's representative of an accident with injury, significant change, need to alter treatment significantly or decision to transfer or discharge.
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 provide a thorough investigation for resident to resident sexual abuse when 1 of 1 residents (R1) was touched inappropriately by another resident (R2). Findings include: R1's investigative file dated 5/29/20, indicated R1 reported R2 touched R1 inappropriately while in the elevator. R1's statement record dated 5/29/20, indicated I was waiting for the elevator to come when I felt someone touch my back. I looked back when (R2) brushed hand down. I got on the elevator and (R2) got on with me. We were the only two on the elevator. (R2) was standing in front of me then reached down and grabbed my crotch. I told (R2) if you ever do that again I will kick you in the balls. I then got off the elevator, so did (R2). I went to have a cigarette then I told staff. I was raped before,

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) years ago and I am not going through that again. The facility investigative file lacked evidence that R2 was interviewed or that staff had been interviewed. R1's quarterly MDS dated [DATE], indicated intact cognition. R1 had no behavioral symptoms. R1 was independent with activities of daily living (ADLs). R1's [DIAGNOSES REDACTED]. R1's undated care plan, indicated R1 was vulnerable related to mental illness. R1's care plan directed staff to notify administrator, DON and social worker of an adverse event and to observe and provide a safe environment. R1's care plan lacked documentation and/or interventions related to the resident to resident sexual abuse on 5/29/20. R1's care plan lacked documentation to keep R2 separate from R1. R2's quarterly Minimum Data Set ((MDS) dated [DATE], indicated moderately impaired cognition. R2 had verbal and physical behavioral symptoms directed toward others 1-3 days. R2 had other behavioral symptoms not directed toward others 1-3 days. R2 had not rejected cares. R2 had wandered 1-3 days. R2 required supervision with transfers and was independent with walking in corridor and on and off the unit. R2 used a walker. R2' [DIAGNOSES REDACTED]. R2's care plan dated 11/19/18, identified R2 had a behavior problem related to history of reaching out to others and grabbing at them, inappropriate grabbing and touching toward staff and residents. Screaming and yelling when reeducated. R2's care plan directed staff to psychology consult, explain to R2 this is not acceptable behavior, remove from others if applicable, explain risk vs benefit, animal crackers are at the nursing station used for deescalating. R2's care plan dated 12/3/18, indicated R2 had areas of vulnerability related to behaviors, agitation, communication, dementia, irritating to others. The care plan directed staff to notify administrator, director of nursing (DON) and social worker of an adverse event and to observe and provide a safe environment. R2's care plan lacked documentation and/or interventions related to the resident to resident sexual abuse on 5/29/20. R2's care plan lacked documentation to keep R2 separate from R1. R1's medical record progress notes (PN) was reviewed on 6/9/20. The PN lacked documentation of the resident to resident sexual abuse from 5/29/20. On 6/10/20, the following late entry note was noted: 5/29/20, at 3:57 p.m. Resident reported R2 touched R1 inappropriately in the elevator. R1 reported incident to social services and nursing home administrator. R2's medical record PN lacked documentation of the resident to resident sexual abuse on 5/29/20. During interview 6/9/20, at 9:44 a.m. R1 sated R2 had swiped my bare skin over my shoulders and back before I got in the elevator. Then (R2) grabbed my crotch when I got in the elevator. R1 then stated to R2 I don't know you, if you f-ing ever touch me again your balls are gone! R1 stated I know (R2) has Alzheimer's but I don't care. Nobody should touch anybody like that period. If (R2) comes near me again, (R2) will get it in the f-ing crotch and I will call the police. There is nothing the facility has or can do to keep me safe. I go out to smoke and that is it. I stay shut in my room with the door closed. They (administration staff) told me (R2) has done that to other people. Well, I don't care. My feelings are if (R2) has done it to other people before then they (administrative staff) need to f-ing do something about it. Interview was attempted with R2 on 6/9/20, at 1:56 p.m. R2 was unable to comment. R2 walked past surveyor out of his room to the nurse station. R2 slammed his hands on the nurse's station desk and asked nursing staff for a cigarette. During interview on 6/9/20, at 2:16 p.m. licensed practical nurse (LPN)-B stated R2 would hit staff and residents and would touch anyone inappropriately. LPN-B stated this had not happened recently. LPN-B stated there was an issue with a female resident about a week ago. LPN-B stated was not aware if staff were to do anything specific with those residents. LPN-B reviewed the kardex and orders and was unable to find an information related to that event or ongoing monitoring. During interview on 6/10/20 at 8:38 a.m. trained medication aide (TMA)-A stated had worked with R2 in the past and today. TMA-A stated R2 will daily bang on the desk when (R2) wants something (R2) will scream. TMA-A stated was not aware if R2 had issues with other residents or if there were any residents R2 needed to be kept away from. During interview on 6/10/20 at 8:43 a.m. licensed practical nurse (LPN)-C stated had worked with R2 in the past. LPN-C was not aware of any residents R2 would need to be kept away from. LPN-C stated R2 had behavior history of reaching out and grabbing staff and residents. Staff are to intervene by redirecting him, give him space and keep him away from what is annoying him. During interview on 6/10/20, at 8:57 a.m. nursing assistant (NA)-C stated had worked with R2 in the past and today. NA-C stated R2 is not supposed to be around female residents. R2 was not aware of any recent events with female residents. During interview on 6/10/20, at 10:16 a.m. social services director (SS)-C stated R1 had come to SS-C to report the event and SS-C had written R1's statement record. When asked who else had been interviewed, SS-C stated R2 had been interviewed and the interview should be in the investigative report. SS-C reviewed the investigative report and found R2's interview was not included. SS-C stated staff were not interviewed because there were no staff witnesses. SS-C stated other residents were interviewed and their interviews were observed in the investigative file. SS-C stated when SS-C started employment six months ago was advised not to chart incidents or follow up in the medical record. As a result, the medical record lacked information regarding the event with R1 and R2 on 5/29/20. SS-C stated the nurse manager should have updated the care plan. SS-C added was unsure if the nurse manager had been in that role on 5/29/20. SS-C stated the administrator would then be the person to follow up with the residents after an event. SS-C stated R2 was seen by Associated Clinic of Psychology (ACP) on 6/8/20 but could not recall if there were new recommendations. During interview on 6/10/20, at 11:37 a.m. the director of nursing (DON) stated was aware of the incident with R1 and R1 on 5/20/20, but had not been DON at that time. DON stated the expectation would be for increased monitoring, keep R1 and R2 away from each other, provide education and update family and physician. It was the expectation that documentation should be in progress notes or interdisciplinary team (IDT) notes. DON reviewed the medical records and stated there were neither IDT notes, nor orders for increased monitoring nor updates to the care plan for R1 and R2 involving the 5/29/20 incident. During interview on 6/10/20, at 12:00 p.m. the facility administrator stated R2 was on 1:1 and then 15 minute checks after the incident on 5/29/20. Additionally, administrator had updated the nurse working at the time. Administrator stated was not aware if the nurse implemented the ongoing 1:1 or 15 minute checks as there was no documentation. Administrator stated this would be documented on a 15 minute checks sheet. A copy of the 15 minute check sheet was requested and not provided. Further, the administrator stated was unaware if anyone had followed up with R1 between 5/29/20 and 6/3/20 until R1 was seen by ACP on 6/3/20. Administrator stated SS-C had followed up at some point but was unable to locate documentation. The facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 11/28/17, indicated sexual abuse was non-consensual sexual contact of any type with a resident. Additionally, residents will be protected from abuse while they are residing at the facility. Residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties. The facility leadership will assess the needs of the residents to be able to identify concerns in order to prevent potential abuse. The IDT will identify the vulnerabilities and interventions on the resident care plan. The facility policy titled Event Management Process, undated, directed staff to immediately act and document actions taken to eliminate any potential for a continued occurrence. Further, to communicate and amend plans of care and assignment sheets as necessary.
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 follow care planned interventions to reduce the risk for falls for 2 of 4 residents (R21, R20) reviewed for accidents. Findings include: R21's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R21 was severely cognitively impaired. R21's quarterly MDS dated [DATE], indicated R21, had severely impaired vision, required assistance of one to two staff members for bed mobility, and transfers and had fallen in the previous quarter. R21's medical [DIAGNOSES REDACTED]. R21's care plan printed 6/10/20, indicated R21 had an actual fall with no injury. Interventions included Hi-lo bed, concave mattress and mat on the floor. Care plan did not address the use of a call light. R21 was observed on 6/9/20, at 10:27 a.m. in bed with the head of the bed raised, R21 laid with feet all the way to the foot of the bed and touched the footboard and knees bent up toward the ceiling. R21 had an air mattress on his bed. The bed was in low position and left side of the bed was up against the wall. A blue fall mat leaned against the wall in room, there was not a fall mat on the floor beside the bed. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light. NA-G fastened R21's call light to pillow above head. The call light fell part way to the floor, NA-G put the call light in R21's hand and told R21 it was his call light. NA-G explained staff were to put the call light in R21's hand and tell him where it was because he could not see. NA-G verified R21 was able to use the call light if it was available. NA-G verified fall mat should be on the floor by bed, but did not place it there prior to leaving the room. R20's admission MDS dated [DATE], indicated R20 was cognitively intact, required assistance of two staff members for bed mobility, and transfers and on staff member to walk in room. R20's MDS also indicated he had not fallen

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) prior to admission but had fallen once since admission with no injury. R20's medical [DIAGNOSES REDACTED]. R20's care plan printed 6/10/20, indicated R20 had a self care deficit and instructed staff to encourage resident to use the call light for assistance. R20's unlabeled nursing assistant care sheet printed 6/10/20, listed safety interventions that included encourage resident to allow staff to assist with ambulation, encourage resident to use call light for assist with transfers and ambulation, and place fall mat next to bed when in bed. R20's Report of Resident Fall event date 5/21/20, at 3:31 p.m., indicated R20 was found on the floor in the dining room. R20 indicated he lowered himself to the floor. Report indicated R20 ambulated to the dining room at the time of the fall. Preventive measures were: encourage use of call light, keep call light within reach. Causative factor was identified as R20 did not ask for help. Report did not identify why R20 needed to lower himself to the floor. R20's Report of Resident Fall event date 6/8/20, at 1:00 a.m., indicated R20 called for help at 2:00 a.m. Staff arrived and found R20 on the floor. The report indicated R20 had a deep laceration on his right right eyebrow, and that R20 was sent to Hennepin County Medical center for stitches. Report indicated R20 had been dozing while sitting in a chair and had refused three times to go to bed when offered. Preventive measures included call light kept within reach, night light, and bed in low position. Report indicated interventions that were in place at time of the fall were wheelchair. Possible causative factor listed on Report of Resident Fall was refusing to go to bed and sleeping while sitting down in a chair. New intervention listed on fall report was placing a call don't fall sign in resident's room. Staff will Remind resident to use call light for assistance. R20 was observed on 6/9/20, at 2:19 p.m. lying in bed with his eyes open. The head of the bed was elevated and R20's call light was lying on top of the portable stereo on R20's nightstand. The night stand was against the wall and to the right of the head of the bed. The left side of bed up was against the wall with a folded blue mat between the foot of the bed and the wall. When asked what brought him to the facility R20 stated he had fallen and could not get up. He stated he had hurt himself. R20 verified he fell before and since admission. R20 stated his balance was not right and that it worried him that he kept falling. R20 stated he had trouble when he walked and had hurt himself when he fell the other night. R20 stated he was sitting up in his chair because sometimes that was the only way to sleep when it is hard to breath. R20 stated he did not have his call light while he was up in his chair. R20 stated when he put on the call light staff would come at their convenience. R20 stated he had fallen because he could not wait for staff to answer his call light. R20 asked for his call light. Notified staff of R20's request. On 6/9/20, at 2:25 p.m. NA-E entered room and gave R20 his call light and asked if there was anything else she could do for him. NA-E verified call light had been out of R20's reach. NA-E verified R20 was able to use the call light and would use it if he had it. NA-E stated they must have forgotten to give it back to him when they helped him repositioned. NA-E verified fall mat was against the wall,and was to be on the floor when R 20 was in bed, but did not put it on the floor. NA-E verified there were no signs on the wall to remind R20 to use the call light. NA-E stated sometimes the lights get busy but we answer them as fast as we can. On 6/10/20, at 8:12 a.m. R20 was lying in bed awake. His call light was in reach. Oxygen tubing was on his forehead not in his nose. Blue floor mat up against the wall between the bed and the wall. There was no sign on walls of the room to use call light. There was a strong odor of urine in room. Resident lying in bed stated he was okay. On 6/10/20, at 9:16 a.m. licensed Practical nurse (LPN)-G entered R20's. LPN G carried medications and a glass of water. LPN- G asked R20 about his oxygen tubing which was still on his forehead. R20 stated he had removed it about half an hour ago. LPN-G put the oxygen tubing into R20's nose and told him they were waiting on hospice nurse to arrive. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, putting her hands under his shoulders and legs. R20 said I was just sitting up. (R20 was in the same position since 8:12 a.m.). -At 9:23 a.m. LPN-G left R20's room with the head of bed up, bed not in low position, The level was slightly higher than knee height. -At 9:36 a.m. LPN-G returned to the room with two glasses of water and a pill cup. R20's feet hung off edge of bed and his feet did not touch the floor. The bed not in low position. R20's hips were twisted. LPN-G did not reposition R20's legs or lower the bed height. Floor mat was not in place. During interview on 6/10/20 at 10:52 a.m. the DON stated R20's floor mat should have been on the floor, and the bed should have been in low position except when staff worked with him. The DON stated care plans should be followed for all residents. The DON stated fall interventions should be in place and call lights should be in place. The DON stated interventions should be updated to the care plan, but if they are in the chart they should be followed. Facility Fall Evaluation Guidelines dated 11/28/17 indicated the purpose was to consistently identify and evaluate residents at risks for falls and those who have fallen to prevent or reduce injuries for falls.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to provide incontinence cares to a dependent resident for 1 of 3 residents (R20) reviewed for urinary incontinence. Findings include: R20's admission Minimum Data Set ((MDS) dated [DATE], indicated R20 was cognitively intact, required assistance of two staff members for toileting and personal hygiene. R20's MDS indicated he was frequently incontinent of bowel and bladder. R20's medical [DIAGNOSES REDACTED]. R20's care plan printed 6/10/20, indicated R20 had bladder incontinence and instructed staff to clean peri-area with each incontinence episode, but lacked time frame for offering assistance. R20's unlabeled nursing assistant care sheet printed 6/10/20, did not address urinary incontinence or interventions to reduce episodes. Continuous observation on 6/10/20, from 8:12 a.m.-9:45 a.m. -At 8:12 a.m. R20 was lying in bed awake. His call light was in reach. Oxygen tubing was on his forehead not in his nose. Blue floor mat up against the wall between the bed and the wall. There was no sign on walls of the room to use call light. There was a strong odor of urine in room. Resident lying in bed stated he was ok. -At 8:44 a.m. R20's door remained shut. Surveyor knocked and with permission entered room. The oxygen tubing was still on the top of R20's head, mask still under his chin. R20 stated sometimes he liked it like that. -At 9:16 a.m. licensed practical nurse (LPN)-G entered R20's room wore a face mask, face shield and gloves. LPN G carried medications and a glass of water. LPN-G set medication on table and took R20's vital signs blood pressure. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, put her hands under his shoulders and legs. R20 said I was just sitting up. (R20 was in the same position since 8:12 a.m.).There was a strong odor of urine in room. -At 9:23 a.m. LPN-G left R20's room. -At 9:36 a.m. LPN-G returned to the room with two glasses of water and a pill cup. LPN-G gave the medication to R20. -At 9:48 a.m. the director of nurses(DON) entered R20's room. The DON lowered bed as she stated the bed needs to be lower when no one is in the room. The DON attempted to assist R20 to sit up on edge of bed. -At 9:49 a.m. LPN-D entered R20's room to help the DON sit up R20. LPN-D asked R20 if he wanted to sit in his wheel chair. R20 said he did not want to sit up. LPN-D left to get supplies. Floor mat not on the floor, call light in place. Strong odor of urine in room. -At 9:54 a.m. breakfast tray arrived. Scrambled eggs, apple juice toast hot cereal put on over bed table out of reach of resident -At 9:56 a.m. LPN-G entered R20's room. - At 9:57 a.m. LPN-D returned to the room. LPN-D and the DON attempted to transfer R20 with a gait belt. R20 was not able to stand all the way up, so he could move up in bed. The DON said to R20, you need to be changed. I will get someone in to help change you. R20 stated he wanted to eat. LPN-D said trained medication aide (TMA)-A is going to come and get him cleaned up. The DON left the room. LPN-D put jelly on R20's toast. LPN-D left the room. R20 sat on edge of bed ate breakfast and bent forward at waist so head was at height of bedside table. -At 10:02 a.m. NA-H entered the room. -At 10:04 a.m. NA-H was in room R20 was eating breakfast. R20 stated he was done. NA-H helped R20 to lie back in bed. NA-H prepared to give R20 a bed bath. NA-H removed two incontinence pads. R20 refused to allow NA-H to wash peri area, but did allowed legs to be washed. R20 did not want to open legs. R20 refused to roll on side. -At 10:25 a.m. NA-H pushed call light for help to roll resident. NA-H stated R20 wore two incontinence briefs, one over the other. NA-H stated both pads were very wet. NA-H stated the bed was soaking wet. -At 10:27 a.m. LPN-D entered R20's room and left to get gloves. LPN-D returned put on gloves on and put anti slip socks on R20's feet. LPN-D assisted R20 to turn toward the wall. Transfer sheet was yellow with urine mid way up R20's back. R20's bottom was pink and intact. -At 10:29 NA-B brought a new transfer sheet to NA-H. NA-B cleaned up clutter in R20's room and put soiled linens in a plastic bag. NA-B stated the sheets were yellow and very wet. NA-B stated two incontinence products were not to be placed on a resident (one on top of the other. NA-H stated R20 was to be checked and changed every two hours at least. NA-H verified resident was to have a floor mat on the floor and they were always have two aides for cares. NA-H put the floor mat down on the floor and verified there was not a sign regarding call lights on the walls of the room. -At 10:50 a.m. NA-D stated R20 was changed at about 6:30 a.m. NA-D denied offering incontinence cares to R20 since. NA-D stated staff check R20 every 10 to 15 minutes and he is to be changed at least every two hours. The DON was present for interview. During interview on 6/10/20, at 10:52 a.m. the DON verified

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	245203	A. BUILDING _____ B. WING _____	06/10/2020

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) there was a strong urine odor in R20's room and the sheets had been saturated with urine. The DON verified resident was not checked and changed for greater than two hours. The DON stated it was her expectation that residents would be toileted or checked and changed every two hours unless their care plan indicated they had a different toileting plan or were independent. The DON stated care plan should be followed for all residents. The DON stated residents should not wear two incontinence pads at the same time.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure the smoking patio was appropriately monitored and smoking schedule enforced for 2 COVID negative residents (R10, R12) observed smoking. The facility further failed to sanitize surfaces between residents for 1 resident (R22) observed touching the handicap button after a COVID positive resident. These practices had the potential to affect 38 COVID negative residents identified as smokers. In addition the facility failed to follow isolation precautions for new admissions (R19) and use personal protective equipment (PPE) appropriately when working with residents (R16, R21, R2 and R20). R7's quarterly MDS dated , 5/15/20, identified R7 with severely impaired cognition and independent with ADLs. R7's [DIAGNOSES REDACTED]. R7's smoking assessment dated , 4/4/20, identified R7 was an unsafe smoker. R12's quarterly MDS dated , 4/13/20, identified R12 was cognitively intact and required one to two person assist with most ADLs. R12's [DIAGNOSES REDACTED]. R12's smoking assessment dated , 4/4/20, identified R12 was a potentially unsafe smoker. R10's admission MDS dated , 5/26/20, identified R10 was cognitively intact and independent with ADLs. R10's [DIAGNOSES REDACTED]. R10's smoking assessment dated , 5/20/20, identified R10 was a potentially unsafe smoker. R11's quarterly MDS dated , 5/12/20, identified R11 with moderately impaired cognition and independent with ADLs. R11's [DIAGNOSES REDACTED]. R11's smoking assessment dated , 4/4/20, identified R11 was an unsafe smoker. R1's quarterly MDS dated , 5/4/20, identified R1 was cognitively intact and independent with ADLs. R1's [DIAGNOSES REDACTED]. R8's admission MDS dated , 2/28/20, identified R8 with moderately impaired cognition and required minimal assistance with ADLs. R8's [DIAGNOSES REDACTED]. R7's smoking assessment dated , 4/4/20, identified R7 was a safe smoker. R13's admission MDS dated , 2/4/20, identified R13 was cognitively intact and required one person assist with most ADLs. R13's [DIAGNOSES REDACTED]. R13's smoking assessment dated , 4/4/20, identified R13 was a potentially unsafe smoker. Smoking monitor During observation on 6/9/20, at 1:56 p.m. R10 wheeled self to smoking patio door. R10 asked, What time are they done? Is that the COVIDs out there? Universal team member (UTM)-A stated, No, it is not. R10 then stated there were positive COVID residents out on the patio. R7 and R11 were on the smoking patio. When interviewed on 6/9/20, at 1:59 p.m. R10 stated there was supposed to be a schedule so that the residents that were COVID positive would not be on the patio at the same time as the COVID negative residents. But they only really do that when you (the state) are here. When interviewed on 6/9/20, at 2:02 p.m. UTM-A stated she was the smoking monitor and the facility gave her pictures of all positive COVID residents so that she could identify who was positive. I tell them all the time they can't share materials and (R11) does it all the time. During observation on 6/9/20, at 2:18 p.m. R1, R7, R8, R11, R12, UTM-A and two other unidentified residents were all under the canopy on the smoking patio. R11 and R1 were sitting within three feet of each other. The administrator walked to the smoking patio door and reminded the residents to stay 6 feet apart even though it was raining. Four of the residents left the patio. R8 returned to the COVID unit. R12 and the two unidentified residents headed toward the non-COVID unit. When interviewed on 6/9/20, at 2:22 p.m. the administrator stated the smoking monitor's job was to watch for and stop residents from sharing cigarettes and items. The monitor should also enforce the six foot rule. This is the first time it was raining when (UTM-A) was out there so I think it was hard for her. When interviewed on 6/10/20, at 8:21 a.m. UTM-A stated this was first job in a health care setting and her 5th day on the job. UTM-A stated she was supposed to keep the residents from sharing items and to keep six feet apart. UTM-A stated she was supposed to stop the COVID positive smokers when it was not their turn according to the schedule. A new sign was posted on the smoking patio door which indicted the COVID positive resident smoking times. During observation on 6/10/20, at 8:29 a.m. R13 went out to smoke. R12 approached the door and stated to UTM-A, He is COVID positive and should not be out there. UTM-A went out and spoke with R13. UTM-A stated, So I told him it wasn't his time to be out here and he gave me a smart remark. So I will just sanitize when he leaves. When interviewed on 6/10/20, at 8:30 a.m. R12 stated, I have seen this smoking schedule before but it was not really enforced. When interviewed on 6/10/20, at 8:47 a.m. R13 stated seeing the smoking schedule posted. When I want a cigarette I don't want anyone telling me I can't. Sanitizing During observation on 6/10/20, at 8:42 a.m. R7 sat in a chair in the dining area. R7 went to the patio door and asked to go outside. No one sanitized the chair R7 sat in in the dining area. R7 sat in a chair on the patio. At 8:47 a.m. R7 returned to the dining area to the same chair. No one sanitized the R7's chair on the patio. At 8:50 a.m. R7 left the dining area and no one sanitized R7's chair. During observation on 6/10/20, at 8:52 a.m. R11 approached the smoking patio door. UTM-A told R11 that she had eight minutes before she could go out to smoke. R11 pushed the button to open the door to the patio and went out. The button was not sanitized. At 8:54 a.m. UTM-A pushed button to open door to go out. When interviewed on 6/10/20, at 10:21 a.m. UTM-A stated she would wipe the table when a COVID positive resident gets up. UTM-A confirmed there was no hand sanitizer outside and the closest dispenser was at the station one nurse's desk. When interviewed on 6/10/20, at 10:24 a.m. administrator stated the smoking monitor should wipe the handicap button after any COVID positive resident touched it. When interviewed on 6/10/20, at 10:32 a.m. UTM-A stated, I will wipe the buttons like two times and hour. I will also do it if I see that someone positive touches it too. During observation on 6/10/20, at 2:21 p.m. R7 pushed handicap button to go outside. R22 pushed the button immediately after R7. UTM-A confirmed R22 was not on the COVID positive photo list. When asked if the button was sanitized in between R7 and R22, UTM-A stated, I don't know anything about that. When interviewed on 6/10/20, at 3:45 p.m. administrator stated they have an in person smoking monitor whenever they have the staff for it. Otherwise the patio was under video surveillance at all times. One monitor was located in the administrator's office and the other one at the station ones nurse's desk. Administrator further stated that if anyone noticed COVID positive residents on the smoking patio, the staff should sanitize the table and chairs when they leave. When interviewed on 6/10/2020, 3:55 p.m. LPN-F stated the smoking patio could be observed via the monitor on the desk. The monitor was black. LPN-F pushed the button and stated, But it is not working right now. When interviewed on 6/10/20, at 3:56 p.m. LPN-E stated the monitor at station ones nurse's desk had not been working for a few days. LPN-E stated facility security normally locked the door from 9:00 p.m. until 5:30 a.m. and staff would physically escort residents out to smoke during those hours. LPN-E stated they watch the monitor during other times to make sure residents did not share cigarettes, wore masks and stayed six feet apart. LPN-E also stated that maintenance was responsible for cleaning the patio. The facility provided COVID+ Resident Smoking Times indicated residents who were COVID positive were designated to smoke during the following times: 6:00-7:00 a.m., 9:00-10:00 a.m., 12:00-1:00 p.m., 4:00-5:00 p.m., 7:00-8:00 p.m., 11:00 p.m. - 12:00 a.m., and 2:00 a.m.-3 a.m. The facility Policy and Procedure for Safe Smoking Villa Healthcare dated, 4/1/20, indicated all residents were informed of the Resident Safe Smoking Policy and assessed for safe smoking upon admission. Residents were subject to verbal warning and then written contract if they ignored the Safe Smoking Policy. New admissions R19's Admission Record printed 6/10/20, indicated R19 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. R19's unlabeled nursing assistant care sheet printed 6/10/20, did not indicated R19 was on droplet Precautions, was to be encouraged to stay in her room or to be reminded wear a face mask when out of her room. On 6/9/20, at 9:42 a.m. trained medication administration aide (TMA)-C took morning medications to R19's room. There was no resident name on the door. TMA-C stated R19 was a new resident admitted three days ago. There was no sign on the door indicating any precautions and no isolation cart in the hallway. R19 sat on the bed without a face mask on. TMA-C entered R19's room with medications. TMA-C wore a gown, and face mask but no gloves or eye protection. TMA-C stood within three feet of R19. TMA-C stated on 6/9/20 at 9:46 a.m. she had forgotten her shield. TMA-C stated she was unaware of any precautions R19 should be on. TMA-C stated she followed the signs posted on the doors for precautions. On 6/9/20, at 12:30 p.m. R19's name was on the door but no transmissions precaution signage was on the door. There was no isolation bin. On 6/9/20, at 1:57 p.m., the director of nurses (DON) stated R19 had been admitted [DATE]. The registered nurse corporate nurse consultant (RNCC) stated new admissions were placed on droplet precautions for fourteen days from admission. The RNCC stated facility would prefer all residents stay in their rooms, but if they came out, they were encouraged to wear a mask. The RNCC stated she was notified of the admission earlier in day. The DON verified an isolation bin and precaution sign were now in place. On 6/10/20, at 8:29 a.m. nursing assistant (NA)-B looked at droplet precautions sign and isolation cart outside R19's room. NA-B stated she had worked last week and R19 was not on precautions. NA-B stated she need to ask why R19 was on

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) precautions. Eye protection and glove usage R16's quarterly minimum data set ((MDS) dated [DATE], indicated R16 was severely cognitively impaired. R16's medical [DIAGNOSES REDACTED]. On 6/9/20, at 10:16 a.m. NA-G was observed to help R16 adjust her clothing and pull her pants up. NA-B was wore a gown, face mask and gloves. NA- B did not wear eye protection or a face shield. NA-B removed her gloves and put new gloves on and did not use hand sanitizer or wash her hands. R21's quarterly MDS dated [DATE], indicated R21 was severely cognitively impaired. R21's medical [DIAGNOSES REDACTED]. R21 was observed on 6/9/20, at 10:27 a.m. in bed. Nursing assistant (NA)-G verified R21's call light was draped over the light on wall above the bed. NA-G verified R21 was unable to reach the call light in that position. NA-G stated R21 should have a call light and verified R21 was able to use the call light if it was available. NA- B did not wear eye protection or a face shield. NA-B removed her gloves and put new gloves on and did not use hand sanitizer or wash her hands. R2's quarterly MDS dated [DATE], indicated moderately impaired cognition. R2's [DIAGNOSES REDACTED]. R2 resided on a COVID 19 isolation wing. R2's roommate was on droplet precautions for COVID 19. On 6/9/20, at 10:29 a.m. NA-G entered R2's room and picked up R2's breakfast tray and removed tray from room. NA-G removed gloves and put new gloves on and did not use hand sanitizer or wash her hands. NA- B did not wear eye protection or a face shield. On 6/9/20, at 1:57 p.m. the RNNC stated staff should wear goggles or face shield as part of universal care at this time and a face mask. The DON stated staff should use hand sanitizer between glove changes for COVID 19 positive residents. The RNCC stated if one roommate has COVID 19 both roommates were treated with droplet precautions. R20's admission MDS dated [DATE], indicated R20 was cognitively intact, required assistance of two staff members for bed mobility. R20's medical [DIAGNOSES REDACTED]. On 6/10/20, at 9:16 a.m. licensed practical nurse (LPN)-G entered R20's room and wore a face mask, face shield and gloves. LPN G carried medications and a glass of water. LPN-G set medication on table and took R20's vital signs. LPN-G attempted to assisted R20 to sit on edge of bed to take his medication, and put her hands under his shoulders and legs. LPN-G removed gloves, did not wash her hands and used the crank at the foot of the bed to put the head of the bed up. LPN-G put new gloves,did not use hand sanitizer or wash her hands and gave R20 an inhaler and pills. -At 9:36 a.m. LPN-G reentered R20's room with two glasses of water and a pill cup. LPN-G assisted R20 to take his medication and swallow the water. LPN-G's face shield was set mid head and did not come down over nose or wrap around eyes. LPN-G washed hands and looked at face shield in mirror and said, I do not know how it is supposed to be worn. LPN-G adjusted face shield so the bottom edge of the shield came down over nose, but not covering facemask. There was still a gap on both sides of LPN-G's face shield did not cover her eyes. -At 9:45 a.m. LPN-C, the infection control nurse, looked at how LPN -G who wore the face shield and said, I do not know how the face shield should be worn. I will get back to you. On 6/10/20, at 8:34 a.m. NA-G stood at the nurses station wore a face mask but no eye protection NA-G stated she was sure she had her face shield on yesterday. She stated she wore her face shield every time, all the time. NA-B stated she had hand sanitizer and usually used it between glove changes. Minnesota Department of Health Contingency Standards of Care for COVID-19 Personal Protective Equipment for Long Term Care/Assisted Living/ Other Non-Acute Care facility form dated 5/29/20, indicated healthcare providers with face to face contact with COVID-19 negative residents were to wear surgical mask, eye protection and perform hand hygiene plus standard precautions and any other posted Transmission-based Precautions. The form also indicated healthcare providers with face to face contact with COVID-19 positive residents were to wear surgical mask, eye protection, gowns, gloves and perform hand hygiene plus standard precautions and any other posted Transmission-based Precautions. Facility provided copy of undated COVID -19 Personal Protective Equipment (PPE) for Healthcare Personnel poster put out by the CDC(Centers for Disease Control) as guidance for how to wear a face shield. the poster showed face shield covering face from forehead to bottom of chin and out to the front of the ears.