

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Bywood East Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3427 Central Avenue Northeast Minneapolis, MN 55418	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598</p> <p>Based on interview and document review, the facility failed to provide timely notification to a provider/guardian for a missing resident for 1 of 1 residents (R1), who was sent to appointment without an escort and was missing for seven hours at the hospital until family member (FM)-A found him lost and confused looking for his room.</p> <p>Findings include:</p> <p>R1's Significant Change Minimum Data Set (MDS) dated [DATE], indicated R1 had a non-traumatic brain dysfunction, diabetes, asthma, anxiety, and Schizophrenia. R1's MDS further indicated independent with Activities of Daily Living, ambulate independently, and had acute on-set mental status change with disorganized thinking.</p> <p>R1's Care Plan, dated 9/18/24, indicated R1 had cognitive impairment, was not safe in the community, and could not leave the facility without an escort. R1 was at risk for falls due to impaired cognition, received psychotropic medication, and had a history of substance abuse.</p> <p>R1's progress notes identified on:</p> <p>1) 9/18/24 at 7:30 p.m.: The resident did not return from his appointments. The police, DON, administrator, and social services notified of the missing person. The staff also searched the whole facility inside per policy and did not find the resident. Missing person report was filed.</p> <p>3) 9/18/24 at 9:21 p.m.: Resident left for appointment at 1:15 p.m. and has not returned. Missing person's report filled with police. No case number given.</p> <p>4) 9/18/24 at 10:30 p.m.: The Guardian called writer that the resident was found in downtown Minneapolis and the police were called and said to call them back when he gets to the facility.</p> <p>During an interview on 10/8/24, at 5:55 p.m. family member (FM)-A stated the facility did not call to notify her R1 was missing on 9/18/24 until 9:30 p.m. A family member drove to downtown Minneapolis and found R1 at 10:00 p.m. on Chicago Avenue (A highly trafficked [NAME] area). R1 had been walking around since 3:00 p. m. R1 was confused, saying he was looking for his room and reported R1 was upset and thirsty.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 10/09/24, at 10:02 a.m., with R1's nurse practitioner (NP)-A identified she was aware R1 had a fall with a brain bleed in August 2024, and was not okay with R1 being sent to his appointment without an escort, and felt this was a bad situation for R1. NP-A further stated she just found about the elopment from LPN-B, sometime in the last week two weeks. NP-A felt she should have been notified immediately. In addition the NP-A stated she works with the hospital and would be bringing this up to her department, and also talk with the facility about being notified of events like this.</p> <p>During an interview on 10/9/24, at 11:00 a.m. FM -A stated R1's mental state was like a child and had concern for his history of substance abuse considering the area R1 was lost and that he had possible access to substances.</p> <p>During an interview on 10/09/24 at, 11:30 a.m. the facility social worker (SW) identified she did waited to call FM-A until she knew all of the facts so she did not upset her.</p> <p>During interview on 10/14/24, at 11:42 a.m. licensed practical nurse (LPN)-B stated she is the quality assurance nurse at the facility and although R1 was to receive medications at 5:00 p.m. on 9/18/24, the staff did not realize he was missing until 7:30 p.m. due to knowing he was at an appointment and did not realize his return time. The staff did sign out and provide R1 his medications when he returned around 10:30 p.m. since it was just a vitamin and senna for his bowels. LPN-B further stated she thought R1's physician/NP was notified immediately.</p> <p>The facilities Significant Change Policy revised 1/2024, indicated It is the policy of Bywood East Health Care to notify the physician and if unable to get the MD or designee or if unsatisfied with the response of the MD to notify the Medical Director of any significant change in the condition of the resident. Significant change examples are given in the procedure and should also include all significant changes that the nurse by experience or education identifies as needing to be reported as well. The policy further indicated to notify the resident's designated contact(s) of the change in the resident's condition and the actions we have initiated.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598</p> <p>Based on interview and document review the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft and ensure a lock box was provided for personal property and/or monies for 1 of 1 resident (R1) who had loss of property after removing \$50.00 from his account. R1 had recent traumatic brain injury and no recollection where the money went. The facility also failed to investigate where the missing money went or implement safety measures to protect resident property from potential loss or theft.</p> <p>Findings include:</p> <p>R1's significant change minimum data set (MDS dated [DATE], indicated R1 had a non-traumatic brain dysfunction, diabetes mellitus asthma, anxiety, and Schizophrenia. R1's MDS further indicated independence in activities in daily living ambulates independently, had acute on-set mental status change with disorganized thinking.</p> <p>R1's Care Plan, dated 9/18/24, indicated R1 had cognitive impairment, received psychotropic medication, and had a history of substance abuse.</p> <p>During interview on 10/08/24, at 5:55 p.m. family member (FM)-A stated, I don't know why the facility allowed [R1] to take out \$50.00 out of his account the day after he returned from the hospital on 9/10/24, when he just had been diagnosed with memory issues. When FM-A was at the facility R1 stated to them he had no idea where the money was and there was no indication what he spent the money on. FM-A stated the facility had promised R1 a lock box in the past and he never received one. FM-A stated she informed the facility of the missing money and nothing was done about it.</p> <p>Review of R1's Account Information on 10/10/24 at 11:00 a.m. with chief financial officer (CO), who provided account statements which indicated R1 removed \$50.00 on 9/10/24.</p> <p>Interview on 10/09/24, at 2:01 p.m. with former medical records (MR) stated R1 did ask to remove \$50.00 out of his account the day after he got out the hospital. MR stated he wanted to buy cigarettes but was unsure if R1 did.</p> <p>During interview on 10/14/24, at 1:00 p.m. the facility administrator stated they were aware R1's money was unaccounted for but were unable to identify what R1 did with his money. The administrator agreed R1 should have been provided with a lock box to store monies or other important items.</p> <p>There was no policy related to personal property provided by the end of survey.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598</p> <p>Based on interview and document review the facility failed to timely report an allegation of missing resident for 1 of 1 resident (R1) who had a traumatic brain injury was cognitively impaired went missing from the facility and was later found on the local hospital grounds.</p> <p>Findings include:</p> <p>In a Wandering and Elopement Risk Assessment, dated 9/17/24, R1 was identified to be at risk for elopement, resident is not safe in the community and cannot leave the facility without an escort. R1 has a recent diagnosis of traumatic brain injury, diabetes, schizoaffective disorder (serious mental disorder), seizure disorder, psychoactive (illicit drug) substance abuse, and opioid abuse. R1 ambulated independently and scored a 99 on his brief interview for mental status (BIM)s, dated 9/17/24, indicating unable to complete.</p> <p>R1's Significant Change Minimum Data Set (MDS) dated [DATE], indicated R1 had a non-traumatic brain dysfunction, diabetes, asthma, anxiety, and Schizophrenia. R1's MDS further indicated independent with Activities of Daily Living, ambulate independently, and had acute on-set mental status change with disorganized thinking.</p> <p>R1's Care Plan, dated 9/18/24, indicated R1 had cognitive impairment, was not safe in the community, and could not leave the facility without an escort. R1 was at risk for falls due to impaired cognition, received psychotropic medication, and had a history of substance abuse.</p> <p>R1's progress notes identified on:</p> <p>1) 9/18/24 at 7:30 p.m.: The resident did not return from his appointments. The police, DON, administrator, and social services notified of the missing person. The staff also searched the whole facility inside per policy and did not find the resident. Missing person report was filed.</p> <p>3) 9/18/24 at 9:21 p.m.: Resident left for appointment at 1:15 p.m. and has not returned. Missing person's report filled with police. No case number given.</p> <p>4) 9/18/24 at 10:30 p.m.: The Guardian called writer that the resident was found in downtown Minneapolis and the police were called and said to call them back when he gets to the facility.</p> <p>During an interview on 10/8/24, at 5:55 p.m. family member (FM)-A stated the facility did not call to notify her R1 was missing on 9/18/24 until 9:30 p.m A family member drove to downtown Minneapolis and found R1 at 10:00 p.m. on Chicago Avenue (A highly trafficked [NAME] area). R1 had been walking around since 3:00 p. m. R1 was confused, saying he was looking for his room and reported R1 was upset and thirsty.</p> <p>During an interview on 10/9/24, at 11:00 a.m. FM-A stated R1's mental state is like a child FM-A and had concern for his history of substance abuse. FM-A felt considering the area [R1] was lost in, he had possible access to substances [illicit drugs].</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/09/24 at, 11:30 a.m. the facility social worker (SW) stated R1's wandering assessment completed 9/17/24, indicated it was not safe for him to be in the community alone and needed an escort. On 9/18/24, R1 went on an appointment with the transportation company without an escort. SW stated she verbally informed the Medical Records staff (MR) that R1 needed an escort, but indicated she might not have heard? and that MR staff was no longer employed at facility.</p> <p>During an interview with MR on 10/09/24, at 2:01 p.m. stated she asked the SW a week prior to R1's appointment and did not receive a clear answer if R1 needed an escort for his appointment on 9/18/24. MR-A stated she was not made aware R1 required an escort for his appointment and allowed R1 to attend his appointments on 9/18/24 unsupervised. He was to attend a 2:00 p.m. physical therapy and 3:00 p.m. occupational therapy appointment at the hospital.</p> <p>During interview on 10/09/24, at 2:45 p.m. director of nursing (DON) stated he received a call from the facility on 9/18/24 after 8:00 p.m. and was notified that R1 was not at the facility. He instructed staff to search the building for R1 and then to call the police. The DON reported he went to look for R1 at the hospital and was unable to locate him.</p> <p>During interview on 10/09/24, at 3:00 p.m. trained medical assistant (TMA)-B, stated she works at the front desk and on 9/18/24, was also working as a TMA. During her shift at 7:30 p.m., she noticed she had not seen R1, and immediately notified management. The SW notified the police.</p> <p>During interview on 10/14/24, at 11:42 a.m. licensed practical nurse (LPN)-B stated she is the quality assurance nurse at the facility. She indicated that although R1 was to receive medications at 5:00 p.m. on 9/18/24, staff did not realize he was missing until 7:30 p.m. LPN-B stated staff thought R1 was still at an appointment and did not realize his return time. The staff did sign out and provide R1 his medications when he returned around 10:30 p.m. since it was just a vitamin and Senna for his bowels.</p> <p>During interview on 10/14/24, at 1:00 p.m. the facility administrator stated the staff should not have allowed R1 to attend his appointment without an escort, and they now have systems in place to prevent this from happening again.</p> <p>During interview on 10/17/24, at 11:30 a.m. the facility medical director stated he was unaware of the incident of R1. The medical director further stated after R1's traumatic brain injury (TBI) from his fall in August of 2024, he should not have been sent to appointments alone.</p> <p>Vulnerable Adult Abuse Prevention Policy revised 6/2024, indicated Bywood East Health Care does not tolerate any forms of physical abuse, verbal abuse, sexual abuse, mental abuse, neglect, corporal punishment, exploitation, involuntary seclusion, or misappropriation of resident property by anyone. The following policy protects residents from facility staff, other residents, consultants, volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals. Bywood East Health Care will meet the notification requirements of the law. Staff will report within 2 hours any unexplained, suspicious injuries, or suspected or known abuse.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598</p> <p>Based on interview and document review, the facility failed to ensure comprehensive assessments were completed and interventions implemented for 1 of 1 residents (R1) who was assessed to be unsafe in the community and at risk of elopement. This failure resulted in an immediate jeopardy (IJ) when on R1 left the facility without supervision for appointments, got lost, and was gone for over 5 hours before staff were aware. R1 was found 7 hours later by family member (FM)-A.</p> <p>The IJ began on 9/18/24, at 1:15 p.m. when R1 was sent to his 2:00 p.m. appointment without an escort and subsequently missed a 3:00 p.m. appointment when he became lost. R1 was later found by his family member (FM)-A outside of a highly trafficked area hospital at 10:00 p.m. director of nursing (DON) and administrator were notified of the IJ on 10/10/24, at 12:52 p.m. The facility had implemented corrective action prior to the start of the survey, therefore the deficiency is being issued at past-non-compliance.</p> <p>Findings include:</p> <p>In a Wandering and Elopement Risk Assessment, dated 9/17/24, R1 was identified to be at risk for elopement, resident is not safe in the community and cannot leave the facility without an escort. R1 has a recent diagnosis of traumatic brain injury, diabetes, schizoaffective disorder (serious mental disorder), seizure disorder, psychoactive (illicit drug) substance abuse, and opioid abuse. R1 ambulated independently and scored a 99 on his brief interview for mental status (BIM)s, dated 9/17/24, indicating unable to complete.</p> <p>R1's Significant Change Minimum Data Set (MDS) dated [DATE], indicated R1 had a non-traumatic brain dysfunction, diabetes, asthma, anxiety, and Schizophrenia. R1's MDS further indicated independent with Activities of Daily Living, ambulate independently, and had acute on-set mental status change with disorganized thinking.</p> <p>R1's Care Plan, dated 9/18/24, indicated R1 had cognitive impairment, was not safe in the community, and could not leave the facility without an escort. R1 was at risk for falls due to impaired cognition, received psychotropic medication, and had a history of substance abuse.</p> <p>R1's progress notes identified on:</p> <p>1) 9/18/24 at 7:30 p.m.: The resident did not return from his appointments. The police, DON, administrator, and social services notified of the missing person. The staff also searched the whole facility inside per policy and did not find the resident. Missing person report was filed.</p> <p>3) 9/18/24 at 9:21 p.m.: Resident left for appointment at 1:15 p.m. and has not returned. Missing person's report filled with police. No case number given.</p> <p>4) 9/18/24 at 10:30 p.m.: The Guardian called writer that the resident was found in downtown Minneapolis and the police were called and said to call them back when he gets to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/8/24, at 5:55 p.m. family member (FM)-A stated the facility did not call to notify her R1 was missing on 9/18/24 until 9:30 p.m. A family member drove to downtown Minneapolis and found R1 at 10:00 p.m. on Chicago Avenue (A highly trafficked [NAME] area). R1 had been walking around since 3:00 p.m. R1 was confused, saying he was looking for his room and reported R1 was upset and thirsty.</p> <p>During an interview on 10/9/24, at 11:00 a.m. FM-A stated R1's mental state is like a child FM-A and had concern for his history of substance abuse. FM-A felt considering the area [R1] was lost in, he had possible access to substances [illicit drugs].</p> <p>During an interview on 10/09/24 at, 11:30 a.m. the facility social worker (SW) stated R1's wandering assessment completed 9/17/24, indicated it was not safe for him to be in the community alone and needed an escort. On 9/18/24, R1 went on an appointment with the transportation company without an escort. SW stated she verbally informed the Medical Records staff (MR) that R1 needed an escort, but indicated she might not have heard? and that MR staff was no longer employed at facility.</p> <p>During an interview with MR on 10/09/24, at 2:01 p.m. stated she asked the SW a week prior to R1's appointment and did not receive a clear answer if R1 needed an escort for his appointment on 9/18/24. MR-A stated she was not made aware R1 required an escort for his appointment and allowed R1 to attend his appointments on 9/18/24 unsupervised. He was to attend a 2:00 p.m. physical therapy and 3:00 p.m. occupational therapy appointment at the hospital.</p> <p>During interview on 10/09/24, at 2:45 p.m. director of nursing (DON) stated he received a call from the facility on 9/18/24 after 8:00 p.m. and was notified that R1 was not at the facility. He instructed staff to search the building for R1 and then to call the police. The DON reported he went to look for R1 at the hospital and was unable to locate him.</p> <p>During interview on 10/09/24, at 3:00 p.m. trained medical assistant (TMA)-B, stated she works at the front desk and on 9/18/24, was also working as a TMA. During her shift at 7:30 p.m., she noticed she had not seen R1, and immediately notified management. The SW notified the police.</p> <p>During interview on 10/14/24, at 11:42 a.m. licensed practical nurse (LPN)-B stated she is the quality assurance nurse at the facility. She indicated that although R1 was to receive medications at 5:00 p.m. on 9/18/24, staff did not realize he was missing until 7:30 p.m. LPN-B stated staff thought R1 was still at an appointment and did not realize his return time. The staff did sign out and provide R1 his medications when he returned around 10:30 p.m. since it was just a vitamin and Senna for his bowels.</p> <p>During interview on 10/14/24, at 1:00 p.m. the facility administrator stated the staff should not have allowed R1 to attend his appointment without an escort, and they now have systems in place to prevent this from happening again.</p> <p>During interview on 10/17/24, at 11:30 a.m. the facility medical director stated he was unaware of the incident of R1. The medical director further stated after R1's traumatic brain injury (TBI) from his fall in August of 2024, he should not have been sent to appointments alone.</p> <p>The facility Wandering/Elopement Prevention Plan Policy and Procedure Revised 02/2024, indicated It is the policy of the facility to provide a safe environment for all residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Assess the resident's needs prior to and after admission to determine his/her ability to leave the facility safely. A wander assessment will be completed on admission day and quarterly by social services.</p> <p>2. Discuss the facility policies on admission with the resident and/or responsible parties regarding wandering prevention program.</p> <p>3 If assessment indicates wandering risk to be appropriate, update orders, elopement/wandering list (located at front reception desk) and care plan.</p> <p>The past non-compliance immediate jeopardy began on 9/18/24. The immediate jeopardy was removed and the deficient practice corrected by 10/1/24, after the facility implemented a systemic plan that included the following actions by ensuring R1 was care planned to require an escort while in the community. All residents were re-assessed for need for an escort while in the community and care plans were updated accordingly. All nursing staff were educated regarding appointment/escort procedures. All residents with any significant change in condition had elopement risk assessments completed. Any resident deemed for elopement risk had interventions in place and care planned for elopement. A list of residents requiring escorts was newly posted at each nurse's station. The facility social worker was educated to immediately update the list of residents requiring escorts when changes requiring supervision by an escort were required.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598</p> <p>Based on interview and document review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) adequately addressed and monitored a known rodent (mouse) infestation that had the ability to affect all 68 residents residing in the facility.</p> <p>Findings include:</p> <p>During interview on 10/09/24, at 12:00 p.m. R4 stated there is mice on second floor where she lives and she sees them all of the time. You really need to check this out while you are here.</p> <p>During observation and interview on 10/09/24, at 12:08 p.m. trained medical assistant (TMA)-A stated R3 takes her lunch trays to her room and sometimes buys snacks to feed the mice in her room. During observation TMA-A walked to R3's room and opened her door, and a mouse was observed to run behind her night stand against her wall next to R3's bed. TMA-A further stated he thinks the mice sometimes come up on her bed.</p> <p>An observation on 10/9/24, at 11:00 a.m. of R3's room revealed a pile of food on top of a large tortilla shell consisting of chicken, fried potatoes, and other foods under R3's bed. The area under the bed had an excess of mouse feces lining the edges of the wall and radiator area as well as scattered throughout open area.</p> <p>During observation and interview on 10/10/24, at 9:50 a.m. with licence practical nurse (LPN)-A, nursing assistant (NA)-A, and NA-B identified the food under R3's the bed is from R3 feeding the mice. Staff try to re-direct her not to put the food under her bed she still feeds them. She has been doing this for a while its been awhile for every shift staff try to clean out her room. LPN-A further stated she had been employed at the facility for year. R3 had been doing this since she had been working at the facility. NA-A then stated sometimes, R3 will eat downstairs and sometimes she will bring her tray in her room. R3 feeds the mice and she had smelt a dead one and had seen lots of dead ones. The facility puts traps. R3 piles up juice and tea all over her room. We try stop, take stuff out of her room but she does not like it. At 10:00 a.m. staff walked down to R3's room stated she had heard mice screaming all day long: Lter in the day staff found dead mice in a glue strip in room [ROOM NUMBER] next to R3's room. NA-B then entered the room and stated she has seen and heard mice in R3's room. NA-A then opened R3's bed side drawers and it was noted to have excess of mouse feces in all of the two bed side drawers and the bedside table. Next to R3's bed was a half eaten Almond [NAME] candy bar. NA-A and NA-B then pulled R3's bed away from the wall and there was excess amounts of mouse feces lining the wall and head of the bed, under the wall heater.</p> <p>During interview on 10/10/24 at 11:15 a.m., while R3 is lying in her bed with several potato chip bags around her and toilet paper rolls, R3 stated she left food there intentionally to feed her friends. R3 stated she has four of them the dad is named squeaky and he is the bigger one and I think he is a rat .and then there is a mom and two babies. R3 stated she puts food under her bed to feed them and she sees Squeaky daily but not all of the others. R3 stated she does not think they come in bed with her.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bywood East Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3427 Central Avenue Northeast Minneapolis, MN 55418	
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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 10/10/24, at 2:54 p.m. housekeeper (HK)-A , stated the last two rooms I cleaned room [ROOM NUMBER] and 208, I saw maybe three or four mice under the beds in the rooms today. HK-A stated he can hear the mice when cleaning those rooms, and does not think the glue traps work and feels the mice are getting too smart to go on them. HK-A stated he had opened R3's door and had seen mice in her bed. They jump off when he enters. HK-A stated he had informed maintenance director (MD) and he told him they would eventually get stuck in the glue trap. HK-A stated he had observed a mouse in R3's bed just last week.</p> <p>An additional observation of R3's room indicated on 10/14/24, at 12:45 p.m. there was multiple iced-t brisk bottles on bathroom sink outside of room with a plate with food crumbs and a fork on it on top of napkin, R3's bedside stand had a blue coffee cup with a tea bag, knife, cookie, toast with jelly on inside the cup. In addition there was a plastic cup with 1/4 of orange juice in it, six bottles of Brisk iced tea all with drinks out of them caps on top, an open can of diet coke, 1/2 plastic glass of milk. On the second night stand next to bed, an Almond [NAME] chocolate bar was observed with two bites out of it (drawer it was in empty that had mouse feces in it on 10/10/14). R3's top of bed had 6 toilet paper rolls all with paper removed from them, some with paper bunched up in rolls on the bed, empty sour cream and onion chip bag, Fridays potato skins & cheddar and bacon 1/2 eaten with bag open, BBQ chips bag open with chips still in and various clothing on bed and papers. Under the bed there was a pile of food that looked like bread and some type of egg substance and a doughnut.</p> <p>During observation and interview on 10/10/24, at 2:12 p.m. on second floor, R4 stated the mice are real bad and they come into her room from down stairs. R4 stated she sees the mice coming out from her baseboard heaters along her walls. R4 stated last week she heard a mouse squeaking under her sink and she put a shoe on it. R4 stated there has been a mouse problem the entire time she had been at the facility. The maintenance director puts sticky traps in her room but they don't seem to work. In observation of her room, there was noted to have several mice feces along her wall next to thier bed, along with under her window and under the base-board heater.</p> <p>Review of facility Grievance Tracking Record for 2024, indicated R6 filed a complaint on 1/12/24, for mice and resolution date was 1/14/24.</p> <p>During interview on 10/14/24, at 1:13 p.m. R6 stated the mice were under control for awhile but they are starting come back now that it is getting cooler out. R6 stated he feels the facility should have a company come out regularly and treat the problem, since the facility is just putting down sticky traps that are not working. R6 stated he seen several small mice walking on his baseboard heater. R6 informed the maintenance director of the mouse problem in his room and he was supposed to put a new sticky trap in his room two weeks ago and nothing had been done. R6 stated he had been a resident at the facility for six years and the mice problems has always been an issue.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 10/14/24, at 3:08 p.m. maintenance director (MD) stated he placed sticky traps in rooms where mice have been located. The (MD) further stated they due have a company that comes out to treat pesticides but was unaware when they come or what they treat, although stated he places sticky traps he purchases, and had put steel wool in holes in the resident rooms, and had sealed doors. The MD stated he does not have a log of which rooms that have the sticky traps or when they are changed out, but has an idea. He thought the traps were changed out about monthly. The MD does a weekly walk-through and documents if he would see any mice or feces from them and from the last two weeks he had not seen any. The MD was aware R3 does put food under the bed to feed the mice and its hard to clean her room since she would get angry at staff if they try to remove the food and does not know what to do with [R3]. The MD had only seen the pesticide company maybe twice since he had started working with the company in February 2024.</p> <p>During interview and document review on 10/15/24, at 8:27 a.m. with the the facility administrator and MD, the MD stated he was not sure if the pesticide company went through some of the residents rooms but was not sure. The administrator stated the pesticide company was supposed to come out monthly but when looking through his reports the company had not come to the facility since 8/15/24, and was not sure why. The administrator stated he was unaware if the pesticide company was treating the mouse infestation in the residents rooms.</p> <p>During interview on 10/15/24, at 10:15 a.m. with supervisor of pest control company identified they provide monthly service of the kitchen and quarterly pesticide/rodent treatment to the common areas in the structure, checking rodent equipment for crawling insects, exterior on the outside of the structures. A few years back, they used to do monthly checks and treatments of the residents rooms but that had stopped the supervisors thought due to budget reasons. The supervisor further stated he does not recommend the sticky/glue traps the facility was using for the mice in the rooms, since the mice might start to resist them and dust collects on them and the real problem would not get resolved and would recommend a service call.</p> <p>During observation and interview on 10/15/24, at 11:22 a.m. service worker for the pesticide company arrived at the facility and entered R3's room and immediately stated he saw a mouse attempted to catch it with a stick trap, said he was unable to. He placed sticky traps and blocked some holes in the room commented on food in the room. In addition the service worker went to room [ROOM NUMBER] next too R3's room commented on seeing mice feces on the floor and placed more traps and also entered R4's room and stated he saw the same in R4's room and treated R4's room with traps. The service worker stated he received no phone calls from the facility regarding mice in the residents rooms and recommends treatments in the rooms where mice have been seen monthly. The service worker stated he would talk to the administrator and maintenance today.</p> <p>During interview on 10/15/24, at 1:29 p.m. the director of nursing (DON) stated he was unaware that R3 had mice in her bed and he should have been informed. The DON stated if he had been informed the room would have been cleaned and R3's skin would have been closely monitored.</p> <p>Review of the facilities 2nd Quarter Quality Assurance and Performance Improvement (QAPI) 2024 indicated the following related to pest control for the months of January, February and March indicated Mice/pest control-audits daily-average-2-3 each week mice found per week. The QAPI minutes did not indicate any plan to reduce/or fix the problem.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facilities 3rd Quarter QAPI for 2024, indicated for the months of April, May and June related to pest control indicated reported by maintenance: Mice/pest control: April, May, and June (average):10-12 per month, Previous quarter (average): 10-12 per month. Again there was no plan listed to reduce or fix the problem in the QAPI minutes.</p> <p>During interview on 10/15/24, at 2:00 p.m. the facility administrator stated the maintenance director is new to the facility and his position and should have put a plan in place to reduce the mice/pest control problem and should have been in contact with the pesticide company on a more frequent basis. The administrator stated they are working on a plan for the maintenance director to have monthly communication with the pesticide company.</p> <p>The facility Quality Assessment and Performance Improvement Policy undated, indicated It is the policy of Bywood East to establish, implement, and maintain an ongoing and comprehensive Quality Assessment and Performance Improvement (QAPI) program. The purpose of this program is to identify issues needing action that affect the quality of care and services provided to the residents of Bywood East. The QAPI program will utilize the best available data and evidence to drive improvements. The QAPI program will consist of the Director of Nursing Services, Medical Director, Pharmacist, and at least three other facility staff members. The QAPI program will review data from all departments of the facility on a quarterly and as needed basis to assure that systems are operating at the highest level of quality for our residents. QAPI actives will aim for the highest levels of safety, excellence in clinical interventions and resident and family satisfaction. All decisions involving residents will be focused on their autonomy and preferences, to minimize unplanned transitions of care. When needs are identified we will implement a Performance Improvement Project (PIP) to improve processes, systems outcomes, and satisfaction.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598</p> <p>Based on observation, interview and document review, the facility failed to implement effective and timely pest control measures to reduce and/or eliminate a mouse infestation in the facility. This had potential to affect all 68 residents whom resided in the facility.</p> <p>Findings include:</p> <p>During interview on 10/09/24, at 12:00 p.m. R4 stated there is mice on second floor where she lives and see's them all of the time and you really need to check this out while you are here.</p> <p>During observation and interview on 10/09/24, at 12:08 p.m. to follow up on R4's comment, on second floor trained medical assistant (TMA)-A stated R3 takes her lunch trays to her room and sometimes buys snacks to feed the mice in her room. During observation TMA-A walked to R3's room and opened her door, and a mouse was observed to run behind her night stand against her wall next to R3's bed. TMA-A further stated he thinks the mice sometimes come up on her bed.</p> <p>An observation on 10/9/24, at 11:00 a.m. of R3's room revealed a pile of food on top of a large tortilla shell consisting of chicken, fried potatoes, and other foods under R3's bed. The area under the bed had an excess of mouse feces lining the edges of the wall and radiator area as well as scattered throughout open area.</p> <p>During observation and interview on 10/10/24, at 9:50 a.m. on second floor interview with licence practical nurse (LPN)-A stated the food under R3's the bed is from R3' feeding the mice we try to re-direct her not to put the food under her bed she still feeds. She has been doing this for a while its been awhile for every shift we try to clean out her room. LPN-A further stated she had been her for year she had been doing this since she had been working at the facility. NA-A then stated sometimes, she will eat downstairs and sometimes she will bring her tray in her room, and had went to her room and she feeds the mice and had smelt a dead one and had seen lots of dead ones. The facility puts traps, she piles up juice and tea all over her room. We try stop, take stuff out of her room but she does not like it. At 10:00 a.m. nursing assistant (NA)-A walked down to R3's room stated she had heard mice screaming all day long next to R3's room and later in the day they were found dead in a glue strip in room [ROOM NUMBER] next to R3's room. NA-B then entered the room and stated she also sometimes see's and hears mice in R3's room. NA-A then started opening R3's bed side drawers and it was noted to have excess of mouse feces lining in all of the two bed side drawers and the bedside table next to R3's bed was a half eaten almond joy candy bar. NA-A and NA-B then pulled R3's bed away from the wall and there more excess amounts of mouse feces lining the wall and head of the bed under the wall heater.</p> <p>During interview on 10/10/24 at 11:15 a.m., while R3 is lying in her bed with several potato chip bags around her and toilet paper rolls, R3 stated that the food was left there intentionally to feed her friends. R3 stated she has four of them the dad is named squeaky and he is the bigger one and I think he is a rat, and then there is a mom and two babies. R3 stated she puts food under her bed to feed them and she see's the squeaky daily but not all of the others. R3 stated she does not think they come in bed with her.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 10/10/24, at 2:54 p.m. housekeeper (HK)-A , stated the last two rooms I cleaned room [ROOM NUMBER] and 208, I saw maybe three or four mice under the beds in the rooms today. HK-A stated he can hear the mice when cleaning those rooms, and does not think the glue traps work and feels the mice are getting too smart to go on them. In addition HK-A stated he had opened R3's door and when entering he had seen mice in her bed, and they jump off when he enters. HK-A stated he had informed maintenance director (MD) and he told him eventually they will get stuck in the glue trap. HK-A stated he had observed a mouse in R3's bed just last week.</p> <p>An additional observation of R3's room indicated on 10/14/24, at 12:45 p.m. there was multiple iced-t brisk bottles on bathroom sink outside of room with a plate with food crumbs and a fork on it on top of napkin, R3's bedside stand had a blue coffee cup with a tea bag, knife, cookie, toast with jelly on inside the cup. In addition there was a plastic cup with 1/4 of orange juice in it, six bottles of Brisk iced tea all with drinks out of them caps on top, an open can of diet coke, 1/2 plastic glass of milk, on the second night stand next to bed, an Almond chocolate bar with two bites out of it (drawer it was in empty that had mouse feces in it on 10/10/14). R3's top of bed had 6 toilet paper rolls all with paper removed from them, some with paper bunched up in rolls on the bed, empty sour cream and onion chip bag, Fridays potato skins & cheddar and bacon 1/2 eaten with bag open , BBQ chips bag open with chips still in and various clothing on bed and papers. Under the bed had a pile of food that looked like bread and some type of egg substance and doughnut.</p> <p>R4's quarterly MDS dated [DATE], indicated R4 had moderate cognitive impairment, chronic pulmonary disease and shortness of breath. R4's Care Plan dated 8/08/2024, indicated R4 was at risk for alteration in skin due to diabetes mellitus, independent in activities of daily living and mobility.</p> <p>During observation and interview on 10/10/24, at 2:12 p.m. on second floor, R4 stated the mice are real bad and they come into her room from down stairs. R4 stated she see's the mice coming out from her baseboard heaters along her walls. In addition R4 stated last week she heard a mouse squeaking under her sink and she put a shoe on it. In addition R4 stated she had been at the facility and there has been a mouse problem the entire time she had been at the facility. R4 stated the maintenance director puts sticky traps in her room but they don't seem to work. In observation of her room, there was noted to have several mice feces along her wall next to R4's bed, along with under her window under the baseboard heater.</p> <p>R6 quarterly MDS dated [DATE], indicated mild cognitive impairment, diagnosis of chronic obstructive pulmonary disease. R6's Care Plan dated 6/09/24, indicated R6 was independent with mobility, and has deficit in memory judgement and thought process related to medication use, mental illness and traumatic brain injury. R6's Care Plan further indicated he had mild cognitive impairment, with lower respiratory issues.</p> <p>Review of facility Grievance Tracking Record for 2024, indicated R6 filed a complaint on 1/12/24, for mice and resolution date was 1/14/24. Although the following interview indicated:</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 10/14/24, at 1:13 p.m. on first floor R6 stated the mice were under control for awhile but they are starting come back now that it is getting cooler out. R6 stated he feels the facility should have a company come out regularly and treat the problem, since the facility is just putting down sticky traps that are not working and see's the mice just look at them and run away. In addition R6 stated he seen several small mice walking on his baseboard heater. R6 stated he informed the maintenance director of the mouse problem in his room and he was supposed to put a new sticky trap in his room two weeks ago and nothing had been done. R6 stated he had been a resident at the facility for six years and the mice problems has always been an issue.</p> <p>During interview on 10/14/24, at 3:08 p.m. maintenance director (MD) stated he placed sticky traps in rooms were mice have been located. The (MD) further stated they due have a company that comes out to treat pesticides but was unaware when they come or what they treat, although stated he places sticky traps he purchases, and had put steel wool in holes in the resident rooms, and had sealed doors. The MD stated he does not have a log of which rooms that have the sticky traps or when they are changed out, but has an idea and stated they are changed out about monthly. The MD did state he does a weekly walk through and documents if he would see any mice or feces from them and from the last two weeks he had not seen any. The MD did state he was aware R3 does put food under the bed to feed the mice and its hard to clean her room since she would get so angry at us if we try to remove the food and really does not know what to do with R3. The MD stated he had only seen the pesticide company maybe twice since he had started working with the company in February 2024.</p> <p>During interview on 10/15/24, at 8:27 a.m. with the the facility administrator and MD, the MD stated he was not sure if the pesticide company went through some of the residents rooms but was not sure. The administrator stated the pesticide company was supposed to come out monthly but when looking through there reports they have not come to the facility since 8/15/24, and was not sure why. In addition the administrator stated he was unaware if the pesticide company was treating mice in the residents rooms.</p> <p>During interview on 10/15/24, at 10:15 a.m. with supervisor of pesticide company stated they provide monthly service of the kitchen and quarterly pesticide/rodent treatment to the common areas in the structure checking rodent equipment for crawling insects, exterior on the outside of the structures, a few years back they used to do monthly checks and treatments of the residents rooms but that had stopped the supervisors thought due to budget reasons. The supervisor further stated he does not recommend the sticky/glue traps the facility was using for the mice in the rooms, since the mice might start to resist them and dust collects on them and the real problem would not get resolved and would recommend a service call.</p> <p>During observation and interview on 10/15/24, at 11:22 a.m. service worker for the pesticide company arrived at the facility and entered R3's room and immediately stated he saw a mouse attempted to catch it with a stick trap, said he was unable to. He placed sticky traps and blocked some holes in the room commented on food in the room. In addition the service worker went to room [ROOM NUMBER] next too R3's room commented on seeing mice feces on the floor and placed more traps and also entered R4's room and stated he saw the same in R4's room and treated R4's room with traps. The service worker stated he received no phone calls from the facility regarding mice in the residents rooms and recommends treatments in the rooms where mice have been seen monthly. The service worker stated he would talk to the administrator and maintenance today.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 10/15/24, at 1:29 p.m. the director of nursing (DON) stated he was unaware that R3 had mice in her bed and he should have been informed. The DON stated if he had been informed the room would have been cleaned and R3's skin would have been closely monitored.</p> <p>The Facility Pest Management Policy revise 7/24, indicated Pests can pose significant problems to people, property, and the environment. Pesticides pose similar risks. Residents spend the majority of their time at our facility and face greater potential for health effects resulting from pest and pesticide exposure. It is therefore the policy of this facility to incorporate procedures for controlling pests. Maintenance Director (MD)</p> <p>The facility Administrator will appoint a facility MD responsible for overseeing implementation of the Policy and site plans. The MD Coordinator's responsibilities will include:</p> <ol style="list-style-type: none"> 1) Weekly recording pest sightings by facility staff. 2) Coordinating management activities with pest control contractors monthly. 3) Approving appropriate pesticide applications-methods, materials, timing, and location. 4) Assuring that all of the pest control contractor's recommendations on maintenance and sanitation are carried out where feasible. 5) Evaluating the facility progress in implementing the IPM plan. 		