

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 03/31/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338</p> <p>Based on observation, interview, and document review, the facility failed to comprehensively assess and appropriately transfer a resident off the floor after an unwitnessed fall with potential head injury for 1 of 1 resident (R2) reviewed for falls.</p> <p>Findings include:</p> <p>R2's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R2 had diagnoses including a personal history of traumatic brain injury. R2 utilized a manual wheelchair independently and required supervision or touching assistance for transfers.</p> <p>R2's progress note dated 3/16/25, indicated R2 was involved in an altercation with another resident, R1, at 8:08 a.m. R2 was coming out of the elevator, R1 wanted to enter the elevator and started dragging R2's out. R1 grabbed R2's wheelchair which flipped him [R2] backward and R2 fell and hit the back of his head on the floor of the elevator. Progress note identified on assessment, no apparent redness, injury or bump noted at this time, included a set of vital signs, and noted R2 complained of pain and his head being broken.</p> <p>R2's additional progress notes dated 3/16/25, indicated R2 was sent to the hospital for evaluation and treatment after the fall and returned with no injuries noted and no new orders. The director of nursing (DON), family, and on-call provider were notified of the fall and safety checks and neurological assessments were completed. R2 refused a skin assessment.</p> <p>On 3/27/25 at 2:55 p.m., video footage without sound from view labelled 2nd Elevator of the altercation between R1 and R2 was reviewed with the administrator and DON. Video footage dated 3/16/25 at 7:50 a.m. , showed R2 sitting in his wheelchair in the elevator facing the open doors. R1 sat in a wheelchair facing the open doors, self-propelled into the elevator, grabbed R2's wheelchair, and R2's wheelchair tipped backward. R2 fell backward, still seated in the wheelchair, with the back of the wheelchair against the floor of the elevator. Three staff members responded to the incident and arrived at the elevator in quick succession, identified by DON and administrator as trained medication aide (TMA)-A, licensed practical nurse (LPN)-A, and nursing assistant (NA)-A. At timestamp 7:50 a.m., a staff member moved the wheelchair out from underneath R2 who remained on the floor of the elevator and moved R1 further away from the elevator. At timestamp 7:51 a.m., two staff members manually assisted R2 off the ground and into his wheelchair and pushed R2 down the hallway out of frame.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/27/25 at 3:05 p.m., after reviewing the video footage, the DON stated it would be considered an unwitnessed fall for R2. The DON stated, before he [R2] gets off the ground I would expect staff to assess him and do range of motion, assess his head, and get vital signs. The DON stated nursing staff did not assess R2 in accordance with his expectations. The DON identified potential consequences of moving R2 prior to completion of a comprehensive assessment as injury because you don't know what's going on. The DON stated he would expect staff to get him up with a gait belt and confirmed the two staff members who transferred R2 off the ground into his wheelchair did not use a gait belt.</p> <p>During an interview on 3/31/25 at 7:48 a.m., TMA-A stated he had responded to the altercation between R1 and R2 at the elevator. TMA-A noted for an unwitnessed fall with potential head injury he would respond, call for a nurse to assist, stay with the resident and get vital signs, and then the nurse would let him know what to do. TMA-A stated he would get them [the resident] up after everything is done with assessing and indicated the nurse would assess the resident and advise staff if it was okay to transfer them off the floor. TMA-A noted we can't just get them up . we don't know what's going on with the resident's body so we need to be careful. TMA-A noted after R2 fell in his wheelchair the nurse obtained vital signs and then they used a transfer (gait) belt to get R2 up and back into his wheelchair. This was not consistent with the events seen in review of video footage of the incident.</p> <p>During an interview on 3/31/25 at 9:08 a.m., LPN-A stated she remembered the altercation between R1 and R2 and when she arrived, R2 was on the floor in his wheelchair on his back with his legs up. LPN-A stated she did an assessment when she got to the elevator and looked at his head and everything, his hands, his skin and staff then picked R2 up and put him back in his wheelchair. R2 complained that his head was hurting so was sent to the hospital for evaluation. LPN-A noted for an unwitnessed fall, you get someone up after assessment . you have to assess them first. This was not consistent with the events seen in review of the video footage of the incident.</p> <p>During an interview on 3/31/25 at 10:33 a.m., the DON stated after an unwitnessed fall he expected nursing staff to complete a comprehensive assessment including a full body assessment, range of motion, vital signs, pain assessment, neurological checks, and examination of the head. The DON stated, assessment should be completed before they move the resident . they may have an injury you haven't noticed. The DON confirmed he did not see nursing staff complete a comprehensive assessment of R2 after his fall prior to being moved. Further, this was not in line with his expectation or the standard of practice to assess the resident before you move them. The DON confirmed the transfer of R2 from ground to wheelchair was also not in line with his expectations because he was transferred without a gait belt. The DON noted this was pretty obvious in review of the video footage.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a return phone call interview on 3/31/25 at 12:15 PM, nurse practitioner (NP)-A stated she was aware of the recent resident-to-resident altercation involving R2 where he fell . NP-A stated she would expect a comprehensive assessment of a resident after an unwitnessed fall including a body assessment, vital signs, neurological checks, checking the back of the head, and mental status examination and expected this to be done right away while still laying down. NP-A stated, you assess first, sometimes it might not be safe to move the person and noted, you don't know what kind of injuries they have sustained, if they sustained an injury you don't want to cause more damage . so you do your assessment first. NP-A identified the potential outcome of worsened injuries such as bleeding, internal bleeding, clotting issues, or broken bones. NP-A stated she expected a resident to be comprehensively assessed after an unwitnessed fall prior to moving them and identified this as best practice because otherwise you go in blindfolded and could do things that hurt the patient more. That's why we do the assessment, comprehensive with full detail, before you move them.</p> <p>Facility policy titled Policy and Procedure Following Resident Accident/Incident dated 11/24, included Procedure: A staff person shall call a nurse to the scene to determine the seriousness of the accident/incident. Nurse STAT will be paged as necessary. 1.) Give First Aid as appropriate. 2.) Nurse will determine if an EMS call is indicated. 3.) An initial set of vital signs shall be taken, including orthostatic blood pressure as able. 4.) Staff will record the incident and the vital signs in the residents' chart. 5.) Note any supporting information from the incident form that may have contributed and make appropriate interventions. Note immediate interventions and supporting information in the Risk Management tab in Point Click Care . If the accident includes a head injury or is unwitnessed by a licensed nurse: 1.) An initial set of vital signs and a neuro check (i.e.: grasp, movement response and pupil check) shall be taken and then repeated every 15 minutes X4, every 1-hour X4, then every 2 hours X2 and every 4 hours X4. These will be recorded on the Neuro Check Flow sheet. 2.) Record the accident, the initial vital signs and neuro check on the resident incident form and in the resident's chart. 3.) The condition of the resident, the vital signs and the neuro check shall be completed in the resident's chart at least every 4 hours. The policy did not address transferring a resident at the scene of a fall.</p>		