STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E185	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bywood East Health Care	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure residents were protected from resident-to-resident abuse for 2 of 2 residents (R3 and R4) who were in a verbal and physical altercation which resulted a thoracic (T9) fracture with facial injuries for R4 and a swollen, bruised hand for R3. This resulted in an Immediate Jeopardy (IJ) for both R3 and R4.The IJ began on 8/14/25 at 10:45 p.m., when R3 and R4 had a verbal altercation, were separated by staff with one verbal redirection towards R3, but no other behavioral interventions were implemented despite a significant history of physical altercations for both residents, leading to R3 seeking R4 out again, re-engaging in the verbal altercation before starting a physical altercation which resulted in R4 needing emergency medical treatment for facial lacerations and a T9 fracture. The director of Nursing (DON) and quality assurance nurse (QA) were notified of the IJ at 3:45 p.m. on 8/22/25. The IJ was removed at 4:25 p.m. on 8/26/25, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had bipolar disorder, alcohol dependence, post-traumatic stress disorder (PTSD), was cognitively intact, and had physical and verbal behaviors towards others. The MDS indicated R3 was independent in activities in daily living (ADL)'s. R3's Care Plan (CP) revised 8/20/25, indicated a history of verbal and physical altercations (8 physical and 2 verbal since) since 9/2024 with care planning interventions focusing on staff encouragement and redirection.-9/14/24 verbal altercation with another resident. Encourage to de-escalate. -9/28/24 resident to resident altercation. Encourage R3 to not stand in front of door in lounge and let other residents pass with adequate space.-9/29/24 resident to resident altercation. Encourage R3 to walk away from potential altercations and inform staff member.-9/30/24 resident to resident altercation. Staff to supervise in smoking area and resident lounge daily to reduce the risk of altercations.-10/11/24 verbal altercation, staff directed to remove himself from altercations before they escalate.-12/11/24 resident to resident physical altercation, arguing over a lost item and incident escalated. Staff directed to inform nurse of missing items so situation can be resolved appropriately.-5/1/25 resident to resident physical altercation, R3 wanted to change the TV channel in the resident lounge. Staff to remind R3 the TV is in a shared space for all residents.-5/08/25 resident to resident altercation over TV in lounge. Staff to remind R3 the remote is to be shared with other residents.-5/16/25 resident to resident altercation, R3 approached another resident for payment for a shirt. Staff to encourage R3 to inform facility staff of any missing items and not to approach other residents.-8/14/25 resident to resident altercation, always identify and remain aware of location of resident, keep R3 arm's length away from R4. R4's quarterly MDS dated [DATE], indicated R4 had alcohol dependence and adjustment disorder with depressed mood. The MDS indicated R4 was cognitively intact with disorganized thinking, had no behaviors and was independent with ADLs. R4's CP indicated a history of verbal and physical altercations (4 physical, 2 verbal) since 6/2024 with care plan interventions focusing on staff encouragement and redirection for R4. -6/28/24 resident to resident verbal altercation. Staff directed to encourage R4 to notify staff member when witnessed other residents in an altercation and let staff members intervene with incident. -7/24/24 resident to resident verbal altercation in the dining room, throwing food at another resident. Staff to remind R4 it was not appropriate to throw food or yell at other residents, encourage to remove himself from other altercations. -12/08/24-resident to resident physical altercation. Staff were to encourage resident to report altercations to staff and move away before they escalate.-12/11/24 resident to resident physical altercation, arguing over a lost item. Staff to encourage R4 to inform nurse of missing items so situation can be resolved appropriately.-3/16/25 resident to resident altercation, R4 pushed another resident from his chair. Staff to encourage R4 to notify staff member when he witnessed other residents in an altercation and let staff members intervene. -7/08/25 resident to resident altercation, R4 kicked the back of another resident's wheelchair. Staff to encourage R4 to notify staff if another resident was in his wheelchair path so staff can assist the other resident to move out. R4's CP further indicated Associated Clinic of Psychology (ACP) started working with R4 on 2/2024, assisting with insomnia and behavioral elements to his care. CP interventions listed from ACP included, encourage R4 to choose his own battles to avoid altercations, listen to R4's concerns to assist in deescalating, validate his emotions in relationship to challenging peer interactions, encourage R4 to move away and breath, read a book, or talk with others, accept what he cannot control and direct to watch television (TV) A Facility Reported Incident dated 8/14/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to immediately report an allegation of sexual abuse to the state agency (SA) for 1 of 1 resident (R1, R2) when R2 was found engaged in a sexual act with R1 without staff's knowledge of R2's consent. Findings include: R2's admission minimum data set (MDS) dated [DATE], indicated R2 was cognitive impaired. R2's Care Plan dated 8/19/25, indicated R2 had potential for abuse, neglect and/or exploitation related to vulnerable adult status. R1's admission MDS dated [DATE], indicated R1 was cognitively intact. A Facility Reported Incident (FRI) dated 8/14/25 at 1:40 p.m., indicated on 8/13/25 at 7:31 p.m., writer received a call that R2 and R1 were found to be engaging in a sexual act. Writer was told R1 offered R2 a cigarette in exchange for sex. This morning at approximately 11:30 a.m. writer went to go speak with resident (R2) and she stated nothing happed and she was okay and had no memory of the incident, she was her normal routine, had a BIMs of 5 (cognitively impaired), with no complaints of pain noted. During interview on 8/20/25 at 12:03 p.m., director of nursing (DON) stated when she received the call on 8/13/25, there was a mix up and they thought it was a different resident with the same name and the resident they thought was with R1 was alert and orientated and was able to consent. The DON stated when she went to interview the wrong resident at 8:00 a.m. she was sleeping and when she did talk to her at 11:30 a.m. she realized it was the incorrect resident. The DON stated once she realized it was R2 who was cognitively impaired she immediate informed the social worker and the staff. The DON further stated she also called the police and informed R2's case manager and responsible party. The DON stated she was aware the report made to the SA was late and should have been reported sooner. During interview on 8/22/25 at 10:00 a.m., DON stated the incident should have been immediately reported to the SA, and due to the confusion of which resident it was, the report was filed the next day. In addition, the DON stated she had only been at the facility for less than a week and she was just getting to know the residents at the facility. Facilities Vulnerable Adult Abuse Prevention Policy revised 2/22, indicated a mandated reporter who has reason to believe that a vulnerable adult is being or has been mistreated, or how has knowledge that a VA has sustained a physical injury that is not reasonably explained shall immediately report that information internally to the Administrator, Director of Nursing, Director of Social Services or designee immediately.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to thoroughly investigate a resident-to-resident abuse allegation for 2 of 2 residents (R3 and R4) and a resident-to-resident sexual assault allegation for 2 of 2 residents (R1, R2) to determine incident details, interview all parties involved, appropriately assess and identify interventions to reduce likelihood of future abuse. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had bipolar disorder, alcohol dependance, post-traumatic stress disorder (PTSD) and was cognitively intact. R4's quarterly MDS dated [DATE], indicated R4 was cognitively intact with disorganized thinking and had no behaviors. A Facility Reported Incident dated 8/14/25 at 10:45 p.m., indicated R3 and R4 engaged in a verbal altercation on the smoking patio. Staff were able to separate them and R3 went back into the building to his room on the third floor. Several minutes later R3 returned to the smoking patio and R4 was seen on the ground where R3 was hitting him in the face. R4 was sent to the hospital for his injuries and returned the next day. The Investigation Report dated 8/20/25, indicated the Care Plan was updated to include intervention to keep R3 and R4 in eye's view and to intervene if they are within arm's length. R4 was diagnosed with a fracture to his T9, and R3 refused to speak with writer. In addition, the investigation indicated the police were involved and did not take R3, and all staff were educated on what to do if a fight would occur between R3 and R4. In addition, the smoking patio will be locked at 10:00 p.m. instead of being open 24hours/7days a week. During interview on 8/22/25 at 12:13 p.m., interim director of nursing (DON) stated staff attempted to interview R3 once and he refused and staff should have attempted to interview him again to find out more information for their investigation, R4 was interviewed. The Nursing Home Incident Report dated 8/20/25 lacked evidence the facility interviewed other resident witnesses, staff or the security guard during the investigation process to gain an understanding of what was observed, heard and what action staff took during the incident. R2's admission minimum data set (MDS) dated [DATE], indicated R2 was cognitive impaired. R1's admission MDS dated [DATE], indicated R1 was cognitively intact. A Facility Reported Incident (FRI) dated 8/14/25 at 1:40 p.m., indicated on 8/13/25 at 7:31 p.m., writer received a call that R2 and R1 were found to be engaging in a sexual act. Writer was told R1 offered R2 a cigarette in exchange for sex. This morning at approximately 11:30 a.m. writer went to go speak with resident (R2) and she stated nothing happed and she was okay and had no memory of the incident, she was her normal routine, had a BIMs of 5 (cognitively impaired), with no complaints of pain noted. The facility's investigation lacked evidence of interviews with staff involved in the incident, including details such as R2 smoking an actual cigarette when found and her demeanor. Additionally, the facility failed to interview R2's family to get historical significance to best determine possible consent and to determine appropriate interventions to reduce the likelihood R2 would seek out further trades for cigarettes, such as increasing how many cigarettes she gets or how often. During interview on 8/20/25 at 12:03 p.m., director of nursing (DON) stated when she received the call on 8/13/25, there was a mix up and they thought it was a different resident with the same name and the resident they thought was with R1 was alert and orientated and was able to consent. The DON stated when she went to interview the wrong resident at 8:00 a.m. she was sleeping and when she did talk to her at 11:30 a.m. she realized it was the incorrect resident. The DON stated once she realized it was R2 who was cognitively impaired she immediate informed the social worker and the staff. The DON further stated she also called the police and informed R2's case manager and responsible party. In a follow up interview on 8/20/25 at 12:20 p.m., the DON stated R1 was placed on 15-minute checks on 8/13/25, after the incident and when she found out it was R2, R1 was placed on a 1:1 for the safety of the other residents in the facility. During interview on 8/20/25 at 3:08 p.m. R2 stated she has been here a couple of months and stated she could not stand it here. R2 stated she did not recall having sex with anyone, but did recall be sent to the hospital because the facility though she was raped and does not believe she was raped. During interview on 8/20/25 at 4:19 p.m., R1 stated he was outside on the smoking patio next to R2 when she turned around and said do you want to f**k me. R1 described how R2 continued to persuade him and eventually they went to his room where he performed oral sex on her. R1 stated he felt like he was sexually harassed due to R2 wanting to have sex with him and that he does not see her anymore in the facility but knows she still lives there. He went on to say, now he has staff that sit with him all of the time and it has been pissing him off. During interview on 8/20/25 at 7:45 p.m., licensed practical nurse (LPN)-D stated she went into R1's room to give him his medication when he observed him naked from the waist down and

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document review and interview, the facility failed to comprehensively develop and implement a resident centered care plan for 1 of 1 resident (R2) who was at risk of abuse and interventions were not identified to address the root cause of that risk and decrease the likelihood of abuse re-occurring. Findings include: R2's Care Plan dated 8/19/25, indicated R2 was admitted on [DATE], had Alzheimer's Disease with early onset, nicotine dependance, and verbal behavioral symptoms directed towards others. R2's Progress Notes admission date (7/21/25) to 8/20/25, indicated:-7/22/25, out of bed multiples times asking for cigarettes-7/23/25, she was up and out with her cigarettes-7/24/25, R2 comes to writer to get cigarettes, explanation given that she only receives one once an hour, she often comes early. -7/24/25, R2 asks for cigarettes but gets one each hour.-7/25/25. Resident in and out of room requesting cigarette before one hour completion.-7/26/25, Resident is constantly asking for cigarette before her hourly timing. Needs constant redirection.-7/27/25, R2 was in and out of the facility for her cigarette smoking.-7/28/25, R2 came to writer for cigs at 7:30 a.m. and 8:30 a.m Then at 9 a.m., she came into the 2nd floor nursing office and went to the drawer where the cigarettes were kept. Writer saw her take a cigarette. She returned the cigarette when told to do so. Reminder given that cigarette was given every hour and she was due at 9:30 a.m Cigarettes were then moved into a locked cabinet.-7/31/25, Care Conference Notes indicated Social Services and Nursing met. R2 refused to attend and family did not attend. Under section labeled Smoking/Policy: R2 had been assessed as a safe smoker. Under Nursing: R2 was physically stable and was able to move around the facility with no issues. ACT was a service offered, but Guardian did not present at this meeting. The Care Conference Notes lacked evidence input from any care staff was attempted, progress notes were reviewed to determine potential care planning needs, or that R2 was interviewed prior to the meetings to get input about her care needs. No revisions were made to R2's care plan despite consistent notations from staff related to her patterned insistencies with cigarettes.-8/1/25, R2 came out and asked this writer for a cigarette every few minutes for >20 times this shift and goes to the phone and dials phone number and hangs up right away. Redirection successful, however, she needs constant redirection every minute.-8/4/25, Resident was continuously coming to the first-floor nurse station to ask for cigarettes almost the entire night. Resident isn't oriented to time, and all redirections could not succeed.-8/5 through 8/12/25 no Progress Notes documented.-8/13/25, The resident appears in no apparent distress and reported engaging in consensual sexual activity with another resident. No signs of physical injury were observed. 15 minutes checks initiated. -8/14/25, resident sent to hospital for rape kit test-8/14/25, resident return from hospital with orders, no signs of distress-8/15/25, R2 keeps coming to ask for her hourly cigarettes even before time. She is hard to redirect and orient to time.-8/16/25, R2 is scheduled to receive a cigarette every hour. She does not comprehend the time and when the next cigarette is due. Another notes on 8/16/25, R2 comes often to ask for a cigarette.-8/17/25, always waking up to ask for cigarettes-8/18/25, R2 had just been given a cigarette to go outside, she is forgetful and frequently comes to ask for another before an hour has passed. Another note on 8/18/25, she presents with restlessness, frequently requesting her hourly cigarette before the scheduled time. Redirection and orientation at times are challenging. Resting in bed between smoking times.-8/19/25, she requested for cigarette, she is forgetful and frequently comes to ask for a cigarette before an hour. A Facility Reported Incident (FRI) dated 8/14/25 at 1:40 p.m., indicated on 8/13/25 at 7:31 p.m., writer received a call that R2 and R1 were found to be engaging in a sexual act. Writer was told R1 offered R2 a cigarette in exchange for sex. This morning at approximately 11:30 a.m. writer went to go speak with resident (R2) and she stated nothing happed and she was okay and had no memory of the incident, she was her normal routine, had a BIMs of 5 (cognitively impaired), with no complaints of pain noted. During interview on 8/20/25 at 7:45 p.m., licensed practical nurse (LPN)-D stated she went into R1's room to give him his medication when he observed him naked from the waist down and R2 was completely naked lying in his bed. LPN-D stated R2 was observed to be relaxed and smoking a cigarette while he was sitting in-between her knees. R2 did not appear distress after the incident. Review of R2's Care Plan it lacked evidence to indicate her history related cigarette seeking behavior and vulnerabilities related to her smoking. In addition, the care plan was not updated until 8/19/25, after an incident occurred on 8/13/25, and R2 was deemed an independent smoker and deemed safe to smoke within facility safely, despite being observed smoking in another resident's room on 8/13/25. R2's Care Plan did indicate R2 had potential for abuse, neglect and/or

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, intervention and document review the facility failed to ensure a safe environment and prevent fire hazards for 2 of 2 residents (R5 and R6) when residents were found to be smoking in resident rooms with staff awareness. This resulted in an immediate jeopardy (IJ) for R5 and R6 and could lead to serious harm for all residents, staff, and visitors at the facility. The IJ began on [DATE] at. 4:54 p.m., when a strong smell of cigarette smoke was noted on the third floor near the elevator and trained medication aide (TMA)-A and TMA-B stated the odor was coming from room [ROOM NUMBER] (R6's room). R5 was observed in room [ROOM NUMBER] and was asked to leave by staff. During interview, R5 stated he was in the room and had just been smoking. The nightstand next to bed two was observed to be covered in cigarette ashes and there were multiple cigarettes burns on the floor. The window was also wide open in the room. TMA-A indicated staff often smelled smoke when R5 was in the room. Interview with R6 also revealed he smoked in his room, kept an ashtray in his nightstand and flushed the cigarette butts down the toilet when the ashtray got full. The director of Nursing (DON) and quality assurance nurse (QA) were notified of the IJ at 3:45 p.m. on [DATE]. The IJ was removed at 4:25 p.m. on [DATE], but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: The National Fire Protection Association (NFPA) regulations regarding smoking inside healthcare facilities are designed to ensure the safety of both patients and staff. Here are the key points:Smoking Regulations - the BasicsAt a minimum, smoking regulations need to address the following points:1. Smoking must be prohibited in any location where oxygen, flammable or combustible liquids or gases, or combustible materials are stored or used. Please note that the Authority Having Jurisdiction (AHJ) may designate other hazardous locations where smoking must be prohibited.-No one using oxygen should be allowed to smoke. NFPA 99(12), Sec. 11.5.1.1.1 requires that smoking materials (e. g. matches, cigarettes, lighters, lighter fluid, tobacco in any form) be removed from patients receiving respiratory therapy.-Smokers must remain at least 5 feet away from oxygen in use [see also: NFPA 99(12), Sec. 11.5.2.3.1].-NFPA 99(12), Sec. 11.5.1.1.2 prohibits all sources of open flame in the area of administration. Area of administration is defined in NFPA 99(12), Sec. 3.3.13 as follows: Any point within a room within 15 ft of oxygen equipment or an enclosure containing or intended to contain an oxygen-enriched atmosphere.2. Smoking by residents/patients deemed unsafe to smoke independently must be prohibited, unless thosepersons are under direct supervision (a number of Minnesota nursing home residents have died or been very seriously injured over the years as a result of fires related to misuse of smoking materials). -Your policy should require an assessment of persons allowed to smoke to include the person's ability to light a cigarette, smoke it safely, handle the ashes and put the cigarette out safely. It is also important that the policy include provisions for proper and safe storage of smoking materials for those persons deemed unsafe to smoke independently without staff supervision.-Where nursing home residents are allowed to smoke, your policy should include procedures for extinguishing clothing fires. You will want to make sure that, whatever procedure is chosen for your facility - e.g. Stop, Drop & Roll; fire blanket; or pressurized water or water mist type portable fire extinguishers(dry powder type extinguishers are not recommended as the powder can be easily inhaled and potentially cause immediate breathing and/or long term lung problems), the proper equipment, if any, is immediately available in smoking area(s) and staff are properly trained on an on-going basis on how to extinguish clothing fires.3. A suitable number of noncombustible ashtrays must be provided in areas where smoking is allowed. Note: These ashtrays must be of a safe design, which has been interpreted to mean ashtrays designed so that cigarettes cannot be placed on the outer edge of the ashtray (as it burns down, a cigarette placed on the outer edge of an ashtray can fall out of the ashtray, potentially falling on something combustible and resulting in a fire).4. Smoking areas must be provided with metal containers equipped with self-closing covers for the disposal of cigarette butts and ashes. These containers should not have combustible (e.g. plastic or paper) liners in them. R5's annual Minimum Data Set (MDS) dated [DATE], indicated R5 had non-traumatic brain dysfunction, and was alert and oriented. R5's Care Plan (CP) dated [DATE], indicated R5 had been assessed as a safe smoker in designated areas, was to smoke only in designated areas and had a history of smoking in unauthorized areas of the facility. Staff were instructed to direct R5 to his own floor/room when he was found in a room that was not his and educate R5 on smoking policies and expectations. R5 had history of smoking in other resident rooms and refused to