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	12/15/2025

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (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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F 0805 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 interview and document review the facility failed to provide a resident's prescribed therapeutic diet when on 11/17/25, a registered nurse (RN)-A assisted R3 to purchase a sticky bun from the vending machine at the facility because he was unable to do so himself for 1 of 3 residents (R3) reviewed for food and drink. While eating the sticky bun R3 started to choke and went unresponsive, cardiopulmonary resuscitation (CPR) was started and R3 was transferred to the hospital where he subsequently died on [DATE].The immediate jeopardy began on 11/17/25 when RN-A purchased a non-pureed item out of a vending machine for R3, R3 choked on the item resulting in his death was identified on 11/17/25. The chief financial officer (CFO)-A, a director of nursing (DON) was notified of the immediate jeopardy at 3:19 p.m. on 12/15/25. The immediate jeopardy was removed on 12/4/25, and the deficient practice corrected on 12/4/25, prior to the start of the survey and was therefore Past Noncompliance. Findings include: R3's Minimum Data Set (MDS) dated [DATE], indicated he had mild cognitive impairment and no behaviors or depression during the seven days look back. He needed moderate assistance from staff to eat food during mealtimes. His medical history included Schizophrenia, diabetes, major depression, obsessive-compulsive personality disorder, and lung disease. R3's care plan dated 5/26/20, indicated he could independently move around the building in his wheelchair. In addition, he needed assistance from staff to eat. R3's care plan dated 6/5/25, indicated he required a pureed diet. R3's diet order dated 6/19/25, indicated he required a Level 1 Dysphagia (smooth, pudding like texture, no lumps, chunks to allow minimal chewing) food to prevent choking. R3's nutrition assessment dated [DATE], indicated he received a pureed diet and required help from staff to eat. There were no issues with choking while on the pureed diet. R3's incident report dated 11/17/25 indicated earlier in the day, R3 requested assistance from staff to purchase a sticky bun snack from the vending machine and was assisted to retrieve the snack. R3 was in the dining room having trouble breathing, stopped breathing, and fell from his chair. R3 was observed to have food in his mouth, which was removed. R3 had no pulse, CPR was started, AED was initiated, and EMS arrived taking over CPR. R3's progress note dated 11/17/25 at 3:45 p.m., indicated at 2:45 p.m., the camera showed R3 having trouble breathing. He stopped breathing and fell to the floor. Staff started CPR and placed the AED on the resident. EMS arrived and regained a pulse at 3:13 p.m. R3's hospital discharge note dated 11/23/25, indicated on 11/17/25, R3 experienced a witnessed aspiration event followed by an out-of-hospital cardiac arrest, CPR was started with return of spontaneous circulation. During the event he developed a cervical (neck spine bone) fracture, multiple rib fractures, anoxic brain injury (severe lack of oxygen leading to massive brain damage), and seizure activity. On 11/23/25, he was placed on comfort care and pronounced brain dead. On 12/11/25 at 1:20 p.m., registered nurse (RN)-A stated R3 asked her to purchase a sticky bun from the vending machine for him. She knew he sat at the feeding assistance table in the dining room, but she did not think about his ordered diet when she made the purchase. Once she gave him the item she went back to her office. Five minutes later the DON ran into the office and said they had a medical emergency in the dining room. She found staff providing CPR and was shocked to see it was R3. Once the paramedics arrived on scene, she started to ask what happened. She was told he choked. After R3 left for the hospital, she told the DON she purchased a sticky bun from the vending machine for him. On 12/11/25 at 1:45 p.m., the DON stated she was the first nursing staff to arrive at the scene. R3 was on the ground, and he did not have a pulse, and she started CPR. She looked in his mouth and found food lodged in his throat. She removed what she could see and continued CPR until more staff arrived. On 12/11/25 at 2:20 p.m., administrator stated after the incident the facility vending machines were moved to the third floor in a locked room. Residents are allowed access once staff confirmed their diet. The past noncompliance immediate jeopardy began on 11/17/25 was removed and the deficient practice corrected by 12/4/25 after the facility implemented a systemic plan that included the following actions: -The facility staff announcement memo dated 12/4/25, indicating vending machines were locked on the third-floor in the conference room. Staff expectations included: (1) no staff would assist a resident to get food out of the vending machine, (2) if a resident requested an item against his prescribed diet orders, staff would notify the charge nurse, offer a safe snack, and always verify the diet before offering food or drink, and (3) all snacks for residents must be approved by the dietician and come from dietary services. -The facility memo to residents 12/4/25, indicated the vending machines were relocated to the third-floor conference room. Several residents have special diets, and the move would ensure their safety