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	02/26/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to protect residents from physical abuse by contracted staff for 1 of 3 residents (R1) reviewed for abuse.Findings include:R1's diagnoses list dated 2/25/26 included disorganized schizophrenia, dementia, history of traumatic brain injury and mild cognitive impairment.R1's annual Minimum Data Set, dated [DATE] indicated R1 was rarely understood and had moderately impaired cognition.R1's care plan dated 1/14/26 included a focus of potential for abuse neglect and/or exploitation related to vulnerable adult status with a goal of [R1] will not be abused. Interventions included but are not limited to staff will follow Vulnerable Adult (VA) policy to keep resident free from exploitation, abuse and/or neglect.R1's general condition note dated 2/11/26 indicated R1 was hit at 2:00 p.m. by an external vendor. R1 had slight redness to his left cheek.During an observation and interview on 2/25/2026 at 1:03 p.m., R1 was observed sitting in a wheelchair in the dining room. R1 declined an interview by shaking head side to side then self-propelled the wheelchair out of the room.On 2/25/2026 at 2:49 p.m. video footage from 2/11/26 at approximately 2:00 p.m. was reviewed in the presence of assistant director of nursing (ADON). The video revealed R1 was sitting in a wheelchair by the elevator doors. Several other residents and staff members were in the area. A tall male (identified by director of nursing (DON) as a contracted laboratory technician (LT-A)) walked up to the elevator and used his hand to motion to R1 to move back away from the closed elevator door. LT-A's mouth was seen moving and his right arm was swinging up and down. LT-A stepped forward and slapped R1's face with his open right hand. R1 lifted his arms as assistant director of nursing (ADON) intervened. At the conclusion of the video ADON stated she intervened immediately and took LT-A to the administrator's office. LT-A told the ADON R1 said something derogatory about LT-A's mother and LT-A would slap anyone who said anything derogatory about his mother. ADON stated if LT-A was willing to slap a resident with so many people around and questioned what would he do in a resident room with a resident who couldn't speak up for themselves?.During an interview on 2/25/2026 at 11:39 a.m., contracted lab supervisor (LS) stated LT-A had been to the facility many times and had been terminated as a result of an internal investigation of the incident at the facility. LS further stated laboratory technicians did not receive VA abuse prevention training and could not recall any training related to not slapping a resident at a facility. During an interview on 2/25/2026 at 2:25 p.m., director of nursing (DON) stated a slap on the face was considered abuse. DON further stated facility staff did not provide supervision of laboratory technicians in the facility. Residents were protected from abuse by contracted staff through VA abuse prevention training. DON stated the facility did not provide VA abuse prevention training for contracted staff from the laboratory.During an interview on 2/26/2026 at 10:35 a.m., the administrator (admin) stated residents were protected from abuse by contracted staff through VA abuse prevention training. Admin also stated the facility did not verify VA abuse prevention training for laboratory (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 - Minimal harm or potential for actual harm Residents Affected - Few	technicians before they were allowed to work with residents. The VA Abuse Prevention policy revised 10/1 instructed the facility does not tolerate any form 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. The policy did not address VA abuse prevention education for contracted staff.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and document review, the facility failed to implement written policies to prohibit and prevent abuse from contracted staff and failed to include protocols for providing abuse prohibition education or verification of abuse education for contracted staff. This had the potential to affect all current and future residents residing in the facility.Findings include:On 2/25/2026 at 2:49 p.m. video footage from 2/11/26 at approximately 2:00 p.m. was reviewed in the presence of assistant director of nursing (ADON). The video revealed R1 was sitting in a wheelchair by the elevator doors. Several other residents and staff members were in the area. A tall male (identified by director of nursing (DON) as a contracted laboratory technician (LT-A)) walked up to the elevator and used his hand to motion to R1 to move back away from the closed elevator door. LT-A's mouth was seen moving and his right arm was swinging up and down. LT-A stepped forward and slapped R1's face with his open right hand. R1 lifted his arms as assistant director of nursing (ADON) intervened. At the conclusion of the video ADON stated she intervened immediately and took LT-A to the administrator's office. LT-A told the ADON R1 said something derogatory about LT-A's mother and LT-A would slap anyone who said anything derogatory about his mother. ADON stated if LT-A was willing to slap a resident with so many people around and questioned what would he do in a resident room with a resident who couldn't speak up for themselves?.During an interview on 2/25/2026 at 11:39 a.m., contracted lab supervisor (LS) stated laboratory technicians did not receive VA abuse prevention training.During an interview on 2/25/2026 at 2:25 p.m., director of nursing (DON) stated residents were protected from abuse by contracted staff through VA abuse prevention training. DON further stated the facility did not provide VA abuse prevention training for contracted staff from the laboratory.During an interview on 2/26/2026 at 10:35 a.m., the administrator (admin) stated residents were protected from abuse by contracted staff through VA abuse prevention training. Admin also stated the facility did not verify VA abuse prevention training for laboratory technicians before they were allowed to work with residents. The VA Abuse Prevention policy revised 10/1 did not address protocols for assuring VA abuse prevention education verification for contracted staff. The policy instructed the facility does not tolerate any form 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.