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	04/17/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure the facility's state survey results were kept in a location that was readily accessible to all residents. This had the potential to affect all 70 residents and/or visitors who could wish to review the information. Findings include: R47's quarterly Minimum Data Set (MDS) dated [DATE], indicated R47 had intact cognition. R48's quarterly MDS dated [DATE], indicated R48 had severely impaired cognition. During an interview on 4/15/25 at 12:12 p.m. with R47 and R48, they confirmed they did not know that state survey results were available to be read and R47 confirmed he would be interested in seeing them. During an observation and interview on 4/15/25 at 1:03 p.m., the administrator stated the survey results were kept in a binder in the locked office of the first-floor nursing station. The administrator was observed to obtain a binder with the state survey results from a shelf in the locked first-floor nursing station office. The administrator stated the binder had been kept in the office since he started at the facility due to concerns of residents taking the binder or ripping pages out. A policy regarding posting survey results was requested and not received.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** 33925 Based on interview and document review, the facility failed to ensure voiced allegations of potential verbal and/or mental abuse were reported to the administrator and State agency (SA) in a timely manner for 3 of 4 residents (R21, R26, R55) reviewed who reported potential allegations of abuse. Findings include: R21 R21's quarterly Minimum Data Set (MDS), dated [DATE], identified R21 had intact cognition but demonstrated delusional thinking during the review period. On 4/14/25 at 12:51 p.m., R21 was interviewed in their shared room with the doorway partially open at her request. R21's roommate was not present, however, a bed and personal belongings were present on their side of the privacy curtain. R21 stated she felt abused by her roommate and expressed the roommate often called her derogatory names and swore at her. R21 added, [Roommate] calls me a slut, and says, F [expletive] you [to me]. R21 named the roommate by name and expressed they had lived together for at least a couple months. R21 stated she wasn't sure when the last time the roommate had called her a derogatory name was, and expressed she had never reported it because by the time she [roommate] falls asleep, I would be sleeping, too. R21 stated she didn't like being called these names or being sworn at adding, It angers me! R21 stated she didn't always feel safe in the room due to this alleged abuse. Immediately following, on 4/14/25 at 1:01 p.m., the allegation of potential verbal and/or mental abuse was reported by the surveyor to the care center administrator and director of nursing (DON). The administrator expressed R21's roommate had not been present in the room for a couple weeks due to hospitalization , however, expressed they would review it. R21's care plan, printed 4/14/25, identified R21's actual and potential problems along with corresponding goals and interventions. This outlined a statement, VULNERABLE ADULT STATUS . Potential for abuse, neglect and/or exploitation ., along with a goal which read, [R21] will not be abused, neglected or exploited, through next review. The plan listed several interventions including educating R21 on which door to use, staff to monitor for reports of neglect or abuse, and implementing the care center vulnerable adult (VA) policy. On 4/15/25 at 9:57 a.m., nursing assistant (NA)-A was interviewed, and verified they had cared for R21 multiple times prior. NA-A explained they had overheard R21 being called names by her roommate including slut and bitch, adding further, [Roommate] comes up with all kinds of stuff [names]. NA-A stated they last heard R21 being called names by the roommate about a month ago when in the main dining room. NA-A stated they didn't report it to anyone, either, as there were nurses present who also witnessed it. NA-A stated nobody from the care center administration had ever visited with them about it before, such as to investigate it, but added R21 did seem bothered by it adding, [R21] said she'd rather have a different roommate. NA-A added, She [R21] gets scared real easily. (continued on next page)

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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	The Centers for Medicare and Medicaid (CMS) ASPEN Complaints/Incidents Tracking System (ACTS) system was reviewed. A Facility Reported Incident (FRI; MN112301), dated 4/15/25, identified the allegation of abuse which had been reported to the administration by the surveyor on 4/14/25, however, lacked evidence the allegation of potential resident-to-resident verbal abuse had been reported to the State agency (SA) prior for R21 despite staff witnessing it approximately a month prior. On 4/15/25 at 10:40 a.m., the administrator and DON were interviewed. DON stated they had filed a VA report with the SA on 4/14/25 after the allegation was presented by the surveyor. The administrator and DON both verified they were unaware of the allegation prior to 4/14/25, and expressed none of the staff had reported it to them so, as a result, it had not been reported to the SA prior to 4/14/25. DON stated staff should immediately report such allegations if seen or heard, so it can be acted upon. R26, R55 Two Common Entry Point (CEP) reports were submitted to the State Agency (SA) on 3/26/25 at 12:05p.m., and 12:10 p.m., respectively, that alleged verbal/mental abuse by staff to R29 and R55. These two reports were submitted by facility physician (MD). R26's annual Minimum Data Set (MDS) dated [DATE], identified R26 with intact cognition, no signs of delirium, and diagnoses of a seizure disorder, anxiety, depression, traumatic brain injury, and schizophrenia. R55's quarterly MDS dated [DATE], identified R55 with intact cognition, no hallucinations, and diagnoses of a bladder dysfunction requiring a catheter and bipolar (mental disorder characterized by periods of depression and abnormally elevated mood). R26 and R55 MD progress notes (PN) dated 3/26/25, identified unknown staff were rude to R26 and called R55 a derogatory name. PN stated R55 was uncomfortable and agitated when asked who the staff member was that allegedly called her a derogatory name. The PN also identified the director of nursing (DON) was informed of allegations. During interview with DON on 4/15/25 at 1:52 p.m., DON verified MD did inform him of R26 and R55 allegations of staff verbal abuse on 3/26/25 and DON stated he did not call or file a complaint with the SA. During interview with administrator on 4/15/25 at 2:21 p.m., the administrator stated he was unaware of the allegations of staff verbal abuse to R26 and R55 until 4/15/25 when the DON informed him. The administrator stated notification to SA regarding abuse allegations should have been done but wasn't. (continued on next page)

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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	A facility provided Vulnerable Adult Abuse Prevention Policy, dated 6/24, identified several definitions of abuse including, Verbal Abuse [underlined] refers to any oral, written, or gestured language that includes insulting, threatening, disparaging and derogatory terms to the resident, regardless of their ability to comprehend or hear the remark(s). The policy outlined mental abuse was defined as, . either verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. The policy directed that a mandated reporter who had knowledge or belief of someone being abuse should report it immediately to the administrator, DON, or their designee. The policy then outlined, The P&P [policy] will be referenced in order to determine if the incident should be reported to external agencies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure voiced allegations of potential verbal and/or mental abuse were acted upon, investigated, and if needed, adequate protection provided to ensure safety and well-being for 3 of 4 residents (R21, R26, R55) reviewed who reported potential allegations of abuse. Findings include: R21 R21's quarterly Minimum Data Set (MDS), dated [DATE], identified R21 had intact cognition but demonstrated delusional thinking during the review period. On 4/14/25 at 12:51 p.m., R21 was interviewed in their shared room with the doorway partially open at her request. R21's roommate was not present, however, a bed and personal belongings were present on their side of the privacy curtain. R21 stated she felt abused by her roommate and expressed the roommate often called her derogatory names and swears at her. R21 added, [Roommate] calls me a slut, and says, F [expletive] you [to me]. R21 named the roommate by name and expressed they had lived together for at least a couple months. R21 stated she wasn't sure when the last time the roommate had called her a derogatory name and expressed she had never reported it because by the time she [roommate] falls asleep, I would be sleeping, too. R21 stated she didn't like being called these names or being sworn at adding, It angers me! R21 stated she didn't always feel safe in the room due to this alleged abuse. Immediately following, on 4/14/25 at 1:01 p.m., the allegation of potential verbal and/or mental abuse was reported by the surveyor to the care center administrator and director of nursing (DON). The administrator expressed R21's roommate had not been present in the room for a couple weeks due to hospitalization , however, expressed they would review it. R21's care plan, printed 4/14/25, identified R21's actual and potential problems along with corresponding goals and interventions. This outlined a statement, VULNERABLE ADULT STATUS . Potential for abuse, neglect and/or exploitation ., along with a goal which read, [R21] will not be abused, neglected or exploited, through next review. The plan listed several interventions including educating R21 on which door to use, staff to monitor for reports of neglect or abuse, and implementing the care center vulnerable adult (VA) policy. The care plan lacked evidence of any issues or altercations between R21 and her roommate. On 4/15/25 at 9:57 a.m., nursing assistant (NA)-A was interviewed, and verified they had cared for R21 multiple times prior. NA-A explained they had overheard R21 being called names by her roommate including slut and bitch, adding further, [Roommate] comes up with all kinds of stuff [names]. NA-A stated they last heard R21 being called names by the roommate about a month ago when in the main dining room. NA-A stated they didn't report it to anyone, either, as there were nurses present who also witnessed it. NA-A stated nobody from the care center administration had ever visited with them about it before, such as to investigate it, but added R21 did seem bothered by it adding, [R21] said she'd rather have a different roommate. NA-A added, She [R21] gets scared real easily. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Medicare and Medicaid (CMS) ASPEN Complaints/Incidents Tracking System (ACTS) system was reviewed. A Facility Reported Incident (FRI; MN112301), dated 4/15/25, identified the allegation of abuse which had been reported to the administration by the surveyor on 4/14/25, however, lacked evidence the allegation of potential resident-to-resident verbal abuse had been reported to the State agency (SA) prior for R21. R21 and her roommate's medical records were reviewed, and both lacked evidence the allegation of potential verbal and/or mental abuse witnessed in the dining room had been investigated; nor evidence of what, if any, interventions or steps were taken to ensure protection (i.e., safety checks, etc.) of R21 despite this behavior being witnessed by direct care staff. When interviewed on 4/15/25 at 10:19 a.m., licensed practical nurse (LPN)-A stated they had not heard about, either directly or in-directly, R21 being called names by her roommate. LPN-A stated they doubted it ever actually happened adding, She [R5] made it up, adding again, She [R5] makes stories up. LPN-A stated if someone, including R21 or staff members, had reported such to them, the DON would have been notified so they could review it and, if needed, develop interventions for R21 or her roommate. On 4/15/25 at 10:40 a.m., the administrator and DON were interviewed. DON stated they had filed a VA report with the SA on 4/14/25 after the allegation was presented by the surveyor. The administrator and DON both verified they were unaware of the allegation prior to 4/14/25, and expressed none of the staff had reported it to them so, as a result, it had not been investigated. DON stated staff should immediately report such allegations if seen or heard, so it can be acted upon and safety checks, if needed, implemented to keep residents safe. 44656 R26, R55 Two Common Entry Point (CEP) reports were submitted to the State Agency (SA) on 3/26/25 at 12:05p.m., and 12:10 p.m., respectively, that alleged verbal/mental abuse by staff to R29 and R55. These two reports were submitted by facility physician (MD). R26's annual Minimum Data Set (MDS) dated [DATE], identified R26 with intact cognition, no signs of delirium, and diagnoses of a seizure disorder, anxiety, depression, traumatic brain injury, and schizophrenia. R55's quarterly MDS dated [DATE], identified R55 with intact cognition, no hallucinations, and diagnoses of a bladder dysfunction requiring a catheter and bipolar (mental disorder characterized by periods of depression and abnormally elevated mood). R26 and R55 MD progress notes (PN) dated 3/26/25, state both verbalized staff were rude to R26 and called R55 a derogatory name. The PN also identified the director of nursing (DON) was informed of allegations. PN stated R55 was uncomfortable and agitated when asked who the staff member was that allegedly called her a derogatory name. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with R55 on 4/14/25 at 2:21 p.m., R55 stated staff made derogatory statements to her and I don't like it. [It] hurts my feelings. R55 unable to identify the staff member or when the abuse occurred. During interview with trained medication aide (TMA)-A on 4/15/25 at 10:17 a.m., TMA-A stated expectation of staff to notify the nurse manager and DON if there were allegations or witnessing verbal, emotional, or physical abuse to management immediately for investigation. During interview with TMA-B on 4/15/25 at 10:31 a.m., stated expectation of all staff to report allegations or witnessing verbal, emotional, or physical abuse to management immediately for investigation. During interview with licensed practical nurse (LPN)-A on 4/15/25 at 11:02 a.m., LPN-A stated expectation of all staff to report allegations or witnessing verbal, emotional, or physical abuse to management immediately. LPN-A stated expectation of an investigation such as interviewing residents and staff about the allegation and then documenting it in the electronic medical record (EMR). During interview with TMA-C on 4/15/25 at 11:12 a.m., stated expectation of all staff to report allegations or witnessing verbal, emotional, or physical abuse to management immediately for investigation. During interview with R26 on 4/15/25 at 2:18 p.m., R55 stated unknown staff member is very rude and unprofessional. She says things to me that I am not ok with. Makes me mad and frustrated. R55 could not identify staff member or when it occurred. R55 stated facility was aware of concern. During interview with DON on 4/15/25 at 1:52 p.m., DON stated expectation of staff to notify him as soon as possible after staff see, hear, or suspect abuse. DON stated all allegations of abuse should have documentation of an investigation into a PN of the EMR. DON verified MD did inform him of R26 and R55 allegations of staff verbal abuse on 3/26/25. DON stated he failed to initiate and document an investigation involving R29 and R55's allegations of staff abuse. During interview with administrator on 4/15/25 at 2:21 p.m., stated he was unaware of the allegations of staff verbal abuse to R26 and R55 until 4/15/25 when the DON informed him. The administrator stated expectation of staff and DON to interview the resident and staff and any other involved residents should be done right away when we are made aware to try to get a full picture of what happened. The administrator stated it was unfortunate that there was no documentation of the facility investigating these allegations. The administrator stated a thorough investigation should have been done but wasn't. A facility provided Vulnerable Adult Abuse Prevention Policy, dated 6/24, identified several definitions of abuse including, Verbal Abuse [underlined] refers to any oral, written, or gestured language that includes insulting, threatening, disparaging and derogatory terms to the resident, regardless of their ability to comprehend or hear the remark(s). The policy outlined mental abuse was defined as, . either verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. The policy directed that if circumstances warranted, the resident shall be removed from the situation of abuse adding, The resident will be placed in an environment where safety can be provided. The policy then outlined, Upon receiving a report of an incident, the resident will be assessed and an investigation initiated.

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	24E185	A. Building B. Wing	04/17/2025

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure a subset (i.e., discharge) Minimum Data Set (MDS) was completed and transmitted to the Centers for Medicare and Medicaid (CMS) database in a timely manner for 3 of 5 residents (R58, R62, R30) reviewed for MDS accuracy. Findings include: The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified all applicable MDS along with their completion and transmission dates required. This included, Discharge Assessment - return not anticipated, listed with a transmission date of, MDS Completion Date + 14 calendar days. R58 R58's Census List, printed 4/15/25, identified R58's status and location (i.e., room) within the care center for the entire duration of his stay. This identified R58 discharged on [DATE] with text adjacent, STOP BILLING, and, DD-discharge date . R58's corresponding progress note, dated 10/25/24, identified R58 had left the care center against medical advice (AMA) and returned home. However, R58's medical record lacked evidence a discharge MDS had been started, completed or transmitted to CMS despite R58 discharging multiple months prior. R62 R62's Census List, printed 4/15/25, identified R62's status and location within the care center for the entire duration of his stay. This identified R62 discharged on [DATE] with text adjacent, STOP BILLING, and, DD-discharge date . R62's progress note, dated 11/23/24, identified R62 had signed out on leave of absence on 11/22/24 and never returned to the care center. The record lacked evidence R62 ever returned after this date. However, R62's medical record lacked evidence a discharge MDS had been started, completed or transmitted to CMS despite R62 discharging multiple months prior. R30 R30's Census List, printed 4/15/25, identified R30's status and location (i.e., room) within the care center for the entire duration of his stay. This identified R30 discharged on [DATE] with text adjacent, STOP BILLING, and, DD-discharge date . R30's corresponding progress note, dated 12/10/24, identified R30 was discharged to another care center. However, R30's medical record lacked evidence a discharge MDS had been started, completed or transmitted to CMS despite R30 discharging multiple months prior. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	On 4/15/25 at 12:50 p.m., registered nurse (RN)-A was interviewed via telephone, and verified they completed the MDS(s) for the campus. RN-A reviewed R58, R62, and R30's medical records and verified each of them did not have a discharge MDS completed. RN-A stated there had been some issues with the electronic system and RN-A wasn't always seeing residents when they were discharged . RN-A stated the discharge MDS(s) were just missed, however, verified they should be completed adding such was important to help ensure proper payment to the care center but also for continuity of care between visits and other stays (i.e., other care centers). RN-A verified they could still complete and submit the discharge MDS for these residents and would do so. A facility' policy on MDS completion was requested, however, none was received.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with consumed medications to promote continuity of care and ensure accurate care-planning for 2 of 5 residents (R25, R4) reviewed for MDS accuracy. Findings include: The Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified a purpose to offer clear guidance on how to use (i.e., code) the RAI which was divided in multiple sections. The manual outlined, Section N: Medications, which directed an intent to record the number of days during the review period a type of various medications, including hypoglycemic and antipsychotics, were administered to the resident. The manual outlined consumption of these high-risk medications could have potential for side effects which . can adversely affect health, safety, and quality of life. The manual outlined, N0415 B1. Antianxiety: Check if an anxiolytic medication was taken by the resident ay any time during the 7-day look-back period ., and, N0415 J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period. R25 R25's quarterly MDS, dated [DATE], identified the section labeled, Section N - Medications, and recorded R25's consumed medications during the review period with sections to record if the medication was consumed while a resident and if an indication was present. The MDS recorded R25 did not consume any hypoglycemic medications with a response recorded, No. However, R25's Medication Administration Record (MAR), dated 1/2025, identified an order which read, Semaglutide . Inject 0.75 ml subcutaneously one time a day every Thu [Thursday] for DM [diabetes mellitus] ., with a listed start date recorded, 03/16/2023. This recorded the medication as being administered on 1/2/25 (within the assessment reference date; ARD). A National Library of Medicine (NIH) feature, dated 2/2024, identified semaglutide was a glucagon-like peptide-1 receptor agonist approved by the US Food and Drug Administration (FDA) for treatment of type 2 diabetes mellitus. On 4/15/25 at 12:50 p.m., registered nurse (RN)-A was interviewed via telephone, and verified they completed the MDS for the campus. RN-A reviewed R25's medical record and verified the administered dose of semaglutide would be considered a hypoglycemic medication and should have been coded on the MDS. RN-A stated the MDS was coded in error and they would a correction for it. RN-A stated it was important to code the MDS accurately so as to have an accurate plan of care for the resident. R4 (continued on next page)

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	24E185	A. Building B. Wing	04/17/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's quarterly MDS, dated [DATE], identified the section labeled, Section N - Medications, and recorded R4's consumed medications during the review period with sections to record if the medication was consumed while a resident and if an indication was present. The MDS recorded R4 did not consume any antianxiety medications with a response recorded, No. However, R4's Medication Administration Record (MAR), dated 1/2025, identified an order which read, busPIRone HCL . Give 5 mg [milligrams] by mouth two times a day for dx [diagnosis] mood and anxiety, with a listed start date recorded, 05/16/2020. This recorded the medication as being administered twice a day on 1/14/25, 1/15/25. and one time on 1/16/25 (all within the ARD). A NIH feature, dated 1/2023, identified in text, Buspirone is an anxiolytic drug. On 4/16/25 at 11:27 a.m., RN-A was interviewed via telephone and, again, verified they completed the MDS for the campus. RN-A reviewed R4's medical record and verified the recorded buspirone doses within the ARD which were not coded on the MDS. RN-A stated it was coded in error and they would submit a modification. RN-A verified medications should be coded based on their pharmacological classification. A facility' policy on MDS completion and accuracy was requested, however, none was received.

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	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bywood East Health Care	3427 Central Avenue Northeast Minneapolis, MN 55418

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and document review the facility failed to ensure resident care plans were comprehensive and up to date to ensure continuity of care for 3 of 3 residents (R55, R57 and R65) reviewed for comprehensive care plans. Findings include: R55 A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined Enhanced Barrier Protection (EBP) were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R55's quarterly MDS dated [DATE], identified R55 with intact cognition, no hallucinations, and diagnoses of a bladder dysfunction requiring a catheter and bipolar (mental disorder characterized by periods of depression and abnormally elevated mood). R55's care plan (CP) printed 4/14/25 identified R55 with potential/actual alteration in bowel and bladder status r/t incontinence, urinary catheter use with date initiated of 10/17/23. CP intervention stated, Use of indwelling catheter. Catheter was placed 9/30/23. CP lacked indication of EBP. Additionally, electronic medical record (EMR) failed to identify EBP in physician orders and progress notes as well. R55's progress note dated 4/12/25 at 1:34 p.m., state Note Text: FOLEY CATHETER every shift for Foley Catheter Assist with emptying bag PRN. Note character of urine, and irritation and proper drainage. During interview with trained medication aide (TMA)-A on 4/15/25 at 10:17 a.m., TMA-A stated staff were informed of resident needs by looking in the residents' CP. During interview with licensed practical nurse (LPN)-A on 4/15/25 at 11:02 a.m., LPN-A stated expectation of staff to look in each residents CP to tell us resident needs. During interview with TMA-C on 4/15/25 at 11:12 a.m., TMA-C stated CP tell staff what to do [for the resident]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/14/25 at 12:45 p.m., no signage or PPE was seen outside R55's door to hallway or visible from the hallway into her room. During observation and interview with R55 on 4/15/25 at 7:57 a.m., R55 stated she had the foley catheter for a long long time, and facility staff do not wear gown or gloves when they help me. During observation on 4/15/25 at 10:02 a.m., no signage or PPE cart was seen outside R55's door to hallway or visible from the hallway into her room. 47495 R57 R57's annual Minimum Data Set (MDS), dated [DATE], indicated R57 was cognitively intact and independent with ADLs. R57's Diagnoses List, dated 2/15/24, indicated R7 had several medical diagnoses including alcoholic cirrhosis of liver and alcohol dependency. R57's progress notes indicated R57 was drinking in his room at least four times in the past 12 months: - On 4/25/24, it was documented that another resident reported R57 had a bottle of vodka in his room and had offered some to the other resident. Staff confirmed R57 had a bottle of vodka in his room and removed the bottle for direction from the director of nursing (DON). - On 5/6/24, it was documented that another resident reported R57 was smoking and drinking in his room. The Social Services Designee (SSD) explained the risks and consequences to R57. R57 refused to sign the Chemical Use Policy. - On 12/29/24, it was documented nursing staff smelled alcohol in R57's room. On 12/30/25, the SSD explained to R57 the risks of violating the ETOH/Substance Abuse Policy. R57 remained dismissive of discussion and refused to sign the policy. - On 2/9/25, it was documented R57 had a bottle of what appeared to be alcohol in his room when staff entered to check R57's blood glucose levels in the morning. On 2/12/25, the SSD met with R57 to discuss the risks of drinking in the facility. R57 refused to sign the policy. R57's electronic medical record contained one Suspected Substance Abuse Assessment, dated 4/24/24. R57's Physician Progress Note, dated 4/15/25, indicated R57 was on naltrexone (a medication used to treat alcohol disorder which reduces cravings and helps control physiological dependence,) and had occasional cravings, drinking ETOH (alcohol) twice a month because a guys gotta have fun. R57's care plan, printed 4/16/25, lacked any problems or interventions related to R57's diagnoses of alcoholic cirrhosis of the liver and alcohol dependence and continued unsupervised alcohol use in the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/25 at 10:00 a.m., trained medication aide (TMA)-C stated she was aware R57 would drink in the facility, stating staff monitor all residents for substance use and staff just knew who to monitor more closely for substance use. TMA-C stated new staff would use the care plan to know how to care for a resident or who to monitor more closely for substance use, such as R57. During an interview on 4/15/25 at 12:30 p.m., charge nurse and licensed practical nurse (LPN)-B stated staff were aware R57 would drink alcohol in his room, stating staff usually smelled it and while staff tried to explain the risks of drinking at the facility, R57 does what he wants to do. LPN-B stated staff should be completing a Suspected Substance Abuse Assessment with each episode of suspected alcohol use at the facility and notifying the doctor and make note of any medications that should potentially be held. During an interview on 4/15/25 at 2:47 p.m., the SSD stated it would be expected that a resident who had multiple episodes of drinking in the care facility be care planned for appropriate interventions and what to monitor. The SSD confirmed R57 had episodes of drinking at the care facility and should have it care planned, confirming it was not. During an interview on 4/16/25 at 12:00 p.m., the director of nursing (DON) confirmed R57's episodes of drinking in the facility was not care planned and should be, to ensure R57 is properly monitored and assessed for alcohol use in the facility. 49339 R65 R65's quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated R65 had intact cognition, used a walker for mobility device, was independent with activities of daily living (ADLs) and was continent of bowel and bladder. Section K swallowing and nutritional status indicated R65 was on a therapeutic diet. Section N: medication indicated R65 was on an antidepressant medication. Section Q indicated there was an active discharge plan in place for the resident to return to the community indicated by a check mark by yes. R65's Diagnosis Report, printed 4/16/25, included the following relevant diagnoses: type 2 diabetes mellitus with hyperglycemia (condition in which the body has difficulty controlling blood sugar levels), major depression disorder, suicidal ideation, adjustment disorder with depressed mood (mental health condition characterized by negative emotional and behavioral reaction to a stressful life event), polyneuropathy (a nerve disorder that causes multiple nerves throughout the body to malfunction simultaneously causing a numbness, tingling, pain or burning), hypertension (high blood pressure) and anxiety. R65's Order Summary Report, printed 4/16/25, included the following relevant orders: -diet: counted carbohydrate diet started 12/2/24 -Sertraline (antidepressant medication) give 50 milligrams (mg) by mouth one time a day for major depressive disorder started 11/27/24 -trazodone (antidepressant medication) give 50 mg by mouth at bedtime for insomnia started 1/18/25 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-daily blood glucose checks started 3/21/25 -metformin (medication to treat type 2 diabetes) give 250 mg tablet by mouth two times a day for diabetes started 11/27/24 -losartan potassium (medication to treat high blood pressure) given 25 mg by mouth one a time for high blood pressure started 11/28/24 R65's care plan, printed 4/14/25, lacked evidence of R65's abilities regarding ADL's, support needed with appointments, use of walker, discharge plan, medication (ability to self-administer medications or facility to administer medications), vision/hearing/dental needs, how diabetes was being managed, how diagnoses were being managed, and psychotropic medications. During interview on 4/14/25 at 1:33 p.m., R65 was observed sitting on his bed and stated he always walked with a walker. R65 stated he was unsure of what the plan was for him regarding discharge or if he was staying at the facility. R65 stated he was diabetic, was on oral medications and got his blood sugars checked for diabetes management. During an interview on 4/15/25 at 9:59 a.m., licensed practical nurse (LPN)-A stated care plans were used to know what was needed for residents. LPN-A stated she did not update care plans and indicated LPN-C was responsible for this. On 4/16/25 at 12:12 p.m., R65 was observed ambulating to the elevator with his walker in the hallway. On 4/16/25 at 8:36 a.m., LPN-B stated she did not update care plans unless I have too and stated DON was responsible for this. During an interview on 4/16/25 at 11:40 a.m., director of nursing (DON) stated he updated and oversaw the care plans. DON stated the expectation would be that a comprehensive care plan would include information about a resident falls risk, elopement risk, ADLs, vulnerabilities, skins, medications, psychotropic medications, and information staff need to care for resident. DON reviewed R65's care plan and verified the information listed above was not included on R65's care plan and should have been. A facility policy titled Care Planning, dated 5/24, indicated the care plan should contain measurable objective and timetables to meet the resident's medical, nursing and psychosocial needs that have been identified in the comprehensive resident assessment.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote acceptance with bathing and/or personal hygiene cares for 1 of 2 residents (R24) reviewed who appeared disheveled and had a pattern of refusing cares. Findings include: R24's quarterly Minimum Data Set (MDS), dated [DATE], identified R24's long-term and short-term memory was impaired. The MDS outlined R24 had both physical and verbal behaviors recorded, however, had no rejection of care behaviors during the review period. Further, the MDS identified R27 needed substantial assistance with bathing, however, was independent with personal hygiene. On 4/14/25 at 12:33 p.m., R24 was observed seated on his bedside while in his room. R24 was dressed in gray-colored sweatpants along with a thick winter coat, and his hair appeared greasy along with him having a visible brown-colored substance over both his hands. R24 stated, I dunno, when asked about it and expressed he was not sure what he had eaten for lunch that day, either. R24 had long, soiled nails present on both hands with several nails having a nail plate of several millimeters (mm) in length along with a dark-colored substance underneath of the plate. R24 was questioned on getting help to clip and clean his fingernails to which R24 abruptly replied, I do that myself. R24 did not answer any further questions about his nail care or bathing. R24's BYWO - Total Body Skin Assessment(s), dated 3/30/25 to 4/14/25, were located within R24's medical record. These identified: On 3/30/25, R24 refused a shower and skin check. The assessment identified a basin and wipes were offered but also refused. On 4/6/25, R24 refused a shower, however, allowed a skin check to be completed. R24's skin was recorded as intact. On 4/13/25, R24 again refused a shower and skin check. A corresponding progress note, dated 4/13/25, identified R24 refused care from staff. The note added, [R24] . didn't allow to be changed yet his clothes were all soiled, all efforts of reapproaching [sic] failed. R24's POC (Point Of Care) Response History, dated 4/15/25, identified the previous 21-days of data collected for R24's bathing self-performance (i.e., how he bathes, level of assistance). However, there was no data collected with dictation present reading, No Data Found. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 9:57 a.m., nursing assistant (NA)-A was interviewed. NA-A explained they had worked with R24 multiple times and had noticed his fingernails to be long and soiled adding, They're disgusting. NA-A stated one of the issues seemed to be other staff don't always re-approach R24 to do cares adding aloud, People don't reproach him [to do it]. NA-A stated R24 would, at times, allow them to help him with bathing and personal hygiene cares; and expressed there were times when they'd (NA-A) return from a weekend off and find R24 in the same clothes which would be soaked in urine and debris. NA-A stated they had noticed if you have a shower water running and hot, then ask R24 as he leaves the elevator from smoking, he was more accepting of the care and would allow it more often. NA-A stated nobody had ever asked them about how they were able to have more success with R24 until now (surveyor). NA-A reiterated the other staff's lack of re-approach as an issue with R24 and expressed, Nobody goes that extra mile. NA-A stated R24 would also, at times, allow nail care from them but then added aloud, I haven't done it in a long time. NA-A stated they were unsure if nail care was charted or not adding, I don't know if they [nurses] do or not. NA-A stated R24 needed help to do nail care adding, He won't do anything on his own. When interviewed on 4/15/25 at 10:19 a.m., licensed practical nurse (LPN)-A stated they had worked with R24 prior. LPN-A stated nail care should be completed for him but then added, He won't let you. LPN-A stated R24 used to allow NA-A to do his cares more often but that also seemed to be declining in acceptance. LPN-A stated nail care, if offered or refused, should be recorded in the progress notes or by the NA under the POC charting. LPN-A stated they would, at times, call R24's family member (FM) and have them speak to him to better facilitate care, however, this was not always successful. LPN-A stated they also had noticed R24 could sometimes be agreeable to care if presented with an extra cigarette. LPN-A stated those interventions would be assessed by the nurse and added to the care plan via the quality person adding aloud, She's the one that does the care plan and stuff. R24's care plan, printed 4/15/25, identified R24's actual or potential problems and needs along with interventions for them. The care plan identified R24 a potential or actual alteration with activities of daily living (ADLs) due to mental illness and impaired cognition. The plan listed a goal which read, [R24] will be clean and well groomed and appropriately dressed, with a last revised date, 10/09/2024. The care plan outlined R24 was independent with most ADLs but needed assistance with personal hygiene and bathing. R24 was recorded as refusing cares with incontinence and the medical provider had been updated. The care plan continued and recorded, R24 frequently refuses shower and weekly skin check. encourage [sic] him to accept shower and weekly skin check. if he continues to refuse document on weekly total body skin assessment. However, the care plan lacked dictation on how to present the bathing or personal hygiene care to promote acceptance as had been described by NA-A. Further, R24's medical record was reviewed and lacked evidence R24's repeated refusals had been assessed or evaluated to determine, what, if any, other approaches or interventions could better facilitate his acceptance of personal cares such as the approach by NA-A or offering of an extra cigarette as expressed by LPN-A. (continued on next page)

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	24E185	A. Building B. Wing	04/17/2025

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 1:26 p.m., the director of nursing (DON) was interviewed, and verified they had reviewed R24's medical record. DON verified the care plan lacked dictation on that specific individual [NA]-A having more success with bathing and personal hygiene cares. DON explained they typically would evaluate someone with prolonged refusals of care which included, at times, having an outside provider visit with them such as ACP (psychiatry clinic). DON stated they typically had a multi-disciplinary approach in these things but expressed staff also had to be careful with their re-approach of R24 as it could lead to behavior, too. DON acknowledged the apparent lack of assessment in the medical record pertaining to R24's ongoing refusals. DON stated showers and bathing were recorded in the weekly skin check forms (BYWO - Total Body Skin Assessment), however, there was no specific place to record nail care offered or completed. DON stated it was important to ensure nail care was offered and done, if able, to promote good hygiene. A facility' provided Personal Hygiene policy, dated 2/2024, identified the facility would ensure each resident maintained good personal hygiene. The policy outlined assistance to do so would be provided based on the individual resident needs and preferences. However, the policy lacked information on how repeated refusals of such care would be addressed or evaluated.

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	24E185	A. Building B. Wing	04/17/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure repeated complaints of pleuritic and/or gastrointestinal distress (i.e., heartburn) were assessed and acted upon to determine what, if any, proactive interventions were needed to promote comfort and prevent complication for 1 of 1 resident (R5) reviewed who complained of heart pain. Findings include: R5's quarterly Minimum Data Set (MDS), dated [DATE], identified R5 had moderate cognitive impairment and several medical conditions including non-traumatic brain dysfunction, heart failure, and schizophrenia. Further, the MDS outlined consumed multiple medications including an anticoagulant (i.e., blood thinner). On 4/14/25 at 2:32 p.m., R5 was observed seated in a chair on the second floor unit. A medication cup was present on the arm of the chair which was approximately 1/2 full of a white colored liquid. R5 was asked by the surveyor if she had any pain to which R5 just repeatedly kept saying aloud, Just my heart. R5 stated the pain just started that day. At this time, licensed practical nurse (LPN)-B approached R5 and picked up the medication cup with white-colored liquid inside and took it away. R5 again repeated, Just my heart, aloud. Following this, LPN-N stated the white-colored liquid in the cup was Maalox (used to treat heartburn) and stated R5 had voiced the complaints of chest pain before which LPN-B stated was heartburn. Later on 4/14/25 at 6:11 p.m., R5 was observed seated in the main dining room. R5 was asked about her chest-related pains and stated, It's feeling better. R5 stated she was not sure if the physician had ever asked her about it or addressed it. R5 denied ever having pains like such prior, too, when asked adding aloud, Not that I know. R5's care plan, printed 4/14/25, identified all actual or potential issues for R5 along with corresponding goals and interventions. The care plan identified R5 had potential for breathing and cardiac complications due to her atrial fibrillation and heart failure, and directed several interventions including consuming the ordered diet, lab work as needed, medications as ordered, and updating the medical provider as needed. The care plan identified R5 had a medical diagnosis of gastroesophageal reflux disease in a section labeled, Diagnosis, however, it lacked any recorded direction or interventions for this condition. R5's Medication Administration Record (MAR), dated 3/2025, identified R5's consumed medications for the period. This included an order which read, Maalox Max Suspension . 30 ml [milliliters] by mouth every 4 hours as needed for indigestion or heartburn ., and had a listed start date recorded, 07/21/2022. This order showed two recorded doses being given starting on 3/25/25, and another dose recorded on 3/27/25. Both of the recorded doses were listed as, E [effective], and both were provided by a trained medication aide (TMA). R5's corresponding progress note(s), dated 3/25/25 and 3/27/25, respectively, identified the medication was recorded, however, lacked any recorded symptoms or rationale why it had been provided. Further, the notes lacked any evaluation of the symptoms (i.e., vital signs) to determine if it could potentially be cardiac-related (i.e., angina, chest pain). (continued on next page)

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	24E185	A. Building B. Wing	04/17/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's MAR, dated 4/2025, identified R5's consumed medications for the period. This, again, including an order which read, Maalox . 30 ml by mouth every 4 hours as needed ., and listed the same start date of, 07/21/2022. This order showed three recorded doses being given on 4/2/25, 4/3/25, and 4/14/25; and all of these doses were recorded as, E. R5's corresponding progress note(s), dated 4/2/25, 4/3/25 and 4/14/25, respectively, identified the medication was recorded, however, the notes lacked any recorded symptoms or rationale why the medication was provided. However, a separate progress note, dated 4/14/25 (date when observed by the surveyor), identified, Resident reported to writer that 'my heart hurts' 135/87, 85, 97.5[F], 96% RA, Maalox 30 ml given, MD notified. The note on 4/14/25 was the first time any recorded symptoms or nursing work-up of them had been recorded. When interviewed on 4/15/25 at 8:04 a.m., TMA-A stated they had heard R5 complain about her pleuritic pain prior and would say things like my heart hurts and my stomach hurts. TMA-A stated this had been happening for a long period of time and staff would typically just provide her with Maalox to help it. TMA-A stated they believed the physician was aware of it since there was a as-needed order for it in the MAR. TMA-A stated they would, at times, do vital signs when R5 complained about the pain but then added not every time. When interviewed on 4/15/25 at 8:28 a.m., licensed practical nurse (LPN)-A stated they had worked with R5 prior and were unaware of her voicing chest-related pains like such adding aloud, You're [surveyor] just telling me now. LPN-A stated if someone complained about chest pain, then the nurse should assess with vital signs and it's characteristics to determine if Nitro or other intervention was needed. LPN-A stated this information and evaluation should be recorded in the progress notes. Further, LPN-A stated they were unsure if R5's medical provider was aware of it or not. R5's medical record was reviewed and lacked evidence R5's symptoms had been evaluated, either in real-time or in hindsight, to determine if the reported symptoms of heart pain were potentially cardiac-related or gastrointestinal-related despite R5 having a history of heart failure; nor did the record have evidence it had been reported to the physician or medical team for what, if any, proactive intervention may be beneficial (i.e., scheduled medication) despite R5 consuming the as-needed medication multiple times and the symptoms persisting. On 4/15/25 at 1:26 p.m., the director of nursing (DON) was interviewed, and verified they had reviewed R5's medical record. DON stated if a resident had complaints of potential chest pain, then it should be assessed for it's characteristics to help determine it's cause. DON stated they expected vital signs to always be obtained with such complaints. DON stated if a as-needed medication was given, it also should be re-assessed to ensure effectiveness. DON stated if a resident was routinely using an as-needed medication, then they would like the physician to be updated about it. DON acknowledged the medical record lacked evidence of this process and expressed the floor nurses should be catching those things and making sure management is aware so it could be addressed. This was important to do so the resident can reach their optimal level of functioning and care. A facility' policy on change of condition was requested, however, none was received.

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	24E185	A. Building B. Wing	04/17/2025

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Bywood East Health Care	3427 Central Avenue Northeast Minneapolis, MN 55418

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure voiced complaints of difficulty hearing were acted upon, assessed, and if needed, treatment started or referred to audiology to promote quality of life for 1 of 1 resident (R24) reviewed who was hard of hearing (HOH). Findings include: R24's quarterly Minimum Data Set (MDS), dated [DATE], identified R24's long-term and short-term memory was impaired. Further, the MDS outlined R24's hearing was recorded as, 0. Adequate [no difficulty in normal conversation, social interaction, listening to TV], and R24 did not use hearing aids. R24's care plan, printed 4/15/25, identified R24's actual or potential problems and care needs along with corresponding goals and interventions. The care plan outlined, [R24] has potential/actual alteration in communication related to being hard of hearing and needing hearing aids, with a last revised date recorded, 07/11/2022. The care plan directed to minimize background noise, speak with increased volume as needed, observe for communication changes and update the medical provider as needed and, Staff to f/u [follow-up] with [R24] to see if he would like to see in-house audiology. If so, let scheduler know to set up appt [appointment]. On 4/14/25 at 12:33 p.m., R24 was observed seated on his bedside while in his room. R24 was dressed in sweatpants and a winter coat, had no visible hearing aids in, and his television was turned on and had a loud speaker. R24 was interviewed and multiple times would turn his head to one side and say, Huh? R24 acknowledged he was HOH but when asked if he wanted hearing aids abruptly replied, I don't want them. Following, on 4/14/25 at 3:32 p.m., a telephone call was placed to R24's family member (FM). However, they were unable to be reached. When interviewed on 4/15/25 at 9:57 a.m., nursing assistant (NA)-A stated they had worked with R24 prior and noticed he was hard-of-hearing. NA-A stated R24's hearing seemed about the same over the past few months and staff seemed to have to wait a little longer for him to hear and understand things with conversation. R24's progress note, dated 10/16/24, identified a meeting was held with R24's FM, the social worker, administrator and director of nursing (DON). The meeting reviewed any concerns the FM had which included, . would like her father to be scheduled for an appointment related to his hearing. She feels as though resident is having hearing issues and would like for him to be seen . facility will schedule an appointment and notify her of the date and time of the appointment. A subsequent note, dated 10/17/24, identified an audiology appointment was scheduled in November 2024 and R24's FM was notified of such. However, R27's progress notes lacked any evidence if this appointment was completed, refused and, if so, re-scheduled. Further, R24's medical record was reviewed and lacked evidence R24's hearing had been comprehensively assessed to determine what, if any, options had been considered or attempted to potentially improve R24's hearing (i.e., Debrox drops/flush) despite family and direct care staff noticing R24 to be HOH. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/15/25 at 10:19 a.m., licensed practical nurse (LPN)-A stated they had not noticed R24 to be HOH before, however, if someone had reported that then they would have inspected his ears (i.e., check for wax build-up, obstruction) and notified the medical provider. LPN-A stated this would be the floor nurses' responsibility to do, however, was only done if someone complained and not on a routine basis (i.e., quarterly). LPN-A stated if wax build-up was seen, then an order for Debrox drops and flush could be obtained, however, LPN-A stated they were unsure where, if anywhere, an otoscope (medical instrument used to examine the ear canal and eardrum) was kept within the facility. On 4/15/25 at 1:26 p.m., the DON was interviewed, and verified they had reviewed R24's medical record. DON expressed they were unable to locate any documentation to support an audiology appointment had ever happened for R24. DON stated the facility had on-site consultation services, such as audiology, available, however then expressed the process was a little bit different for R24 as his FM often liked to schedule appointments themselves. DON stated they believed an audiology appointment had been scheduled for R24, however, did not believe R24 made it to it, then added, I would have to reach out to ask her [FM]. DON stated there was no routine hearing examinations completed for residents but expressed if someone noticed some type of change then an assessment should be done. This was important to do so residents could reach their optimal level of functioning. A facility' policy on hearing appointments or evaluation was requested, however, none was received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to ensure a resident who had multiple incidents of smoking indoors was reassessed for safe smoking for 1 of 2 residents (R32) reviewed for smoking. Findings include: R32's annual Minimum Data Set (MDS) dated [DATE], indicated R32 was cognitively intact and independent with activities of daily living. R32's most recent smoking assessment, dated 2/27/25, indicated R23 smokes only in designated areas and was deemed a safe smoker. R32's progress notes indicated R32 had at least three incidents of smoking indoors in the past 6-7 months: - On 9/30/24 it was documented R32 violated the facility's smoking policy by smoking in her room. R32 stated she would not smoke in the facility and signed the Smoking Policy. - On 4/9/25 it was documented R32 was caught smoking in her room. R32 was again educated on the risks and consequences of smoking in her room with oxygen being used in the room next to her. - On 4/14/25 it was documented staff informed the social services designee (SSD) that R32 was smoking in her room that morning. The risks of smoking inside were discussed and R32 was documented as expressing her understanding and signed the Smoking Policy. R32's Care plan, revised 1/7/25, indicated R32 had been assesses and deemed a safe smoker. During observation on 4/14/25 at 2:31 p.m., R32 had a bedside table with approximately 15 cigarettes on top along with a lighter. During an interview on 4/15/25 at 10:00 a.m., trained medication aide (TMA)-C confirmed R32 did smoke cigarettes and was assessed as safe to keep her own smoking materials. TMA-C stated she had not witnessed R32 smoke in her room but had seen a cigarette butt in her room. During an interview on 4/15/25 at 12:30 p.m., the charge nurse and licensed practical nurse (LPN)-B stated the SSD was responsible for assessing a resident for safe smoking. LPN-B stated when a resident smoked indoors, staff usually smelled it and would hold onto the residents' smoking materials and educate them on the risks of smoking indoors. During an interview on 4/15/25 at 2:47 p.m., the SSD stated it should be care planned when a resident was found to smoke outside of designated smoking areas. The SSD confirmed R32 had not been reassessed for safe smoking and staff could ask for her cigarettes but if she refused staff could not take them. The SSD stated R32 was also capable of obtaining her own cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 at 12:00 p.m., the director of nursing (DON) stated if a resident was smoking indoors, staff would be expected to hold the residents' cigarettes, stating residents were often able to get their own cigarettes. The DON stated had he been made aware R32 was smoking indoors he would have reassessed her for safe smoking. A facility policy titled Smoking Policy and Contract, updated 3/17/25, indicated, any time a staff member observes and/or has reason to believe that a resident is/was smoking anywhere inside the facility, smoking materials will be extinguished immediately. The incident will also be reported to Social Services, Charge Nurse/Nurse Supervisor, and/or Administrator.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure a physician visit was completed in a timely manner (i.e., every 60 to 70 days) to promote continuity of care and reduce the risk of disease complication for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS), dated [DATE], identified R5 had moderate cognitive impairment and several medical conditions including non-traumatic brain dysfunction, heart failure, and schizophrenia. Further, the MDS outlined consumed multiple medications including antipsychotic and anticoagulant (i.e., blood thinner) medications. On 4/14/25 at 2:32 p.m., R5 was observed seated in a chair on the second floor unit. A medication cup was present on the arm of the chair which was approximately 1/2 full of a white colored liquid. R5 was asked by the surveyor if she had any pain to which R5 just repeatedly kept saying aloud, Just my heart. R5 stated the pain just started that day. At this time, licensed practical nurse (LPN)-B approached R5 and picked up the medication cup with white-colored liquid inside and took it away. R5 again repeated, Just my heart, aloud. Following this, LPN-N stated the white-colored liquid in the cup was Maalox (used to treat heartburn) and stated R5 had voiced the complaints of chest pain before which LPN-B stated was heartburn. R5's Medication Administration Record (MAR), dated 4/2025, identified all of her consumed medications and recorded treatments for the period. The orders included citalopram (antidepressant medication) daily, digoxin (heart failure medication) daily, and risperdal (antipsychotic medication). R5's most recent Psychiatric Progress Note, dated 1/17/25, identified R5 was seen in-person by a medical doctor (i.e., psychiatrist) with recorded diagnoses including schizophrenia and major depressive disorder. The note outlined R5 had improved in behaviors with feeding mice and added, She does continue to refuse medications from time to time. A review was listed of R5's psychiatric medications only and directed, I will see her again in three months' time or sooner if indicated. However, R5's entire medical record was reviewed and lacked evidence R5 had been seen by a physician in-person since 1/17/25 (well over 70 days prior). On 4/16/25 at 8:28 a.m., the director of nursing (DON) was interviewed, and verified they had reviewed R5's medical record. DON stated R5 used a physician from the VA (i.e., community) and, upon calling them, realized it had been about eight months since R5 was last seen by her medical provider from the VA. DON verified the psychiatrist note in January 2025 was the last time they could locate evidence R5 had been seen in-person by a physician so, as a result, they made an appointment for R5 to be seen in May 2025. DON stated they thought the VA would typically schedule the next appointment at each one, however, added aloud, Somewhere along the line, I guess they didn't. DON verified the onsite medical providers were not rounding on R5 and expressed residents should be seen every 60 days to help them meet their optimal level of functioning. DON added, I'm surprised she [R5] fell through the cracks to be honest. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/16/25 at 10:06 a.m. the consulting pharmacist (CP) stated R5 used a provider from the VA for her medical care. However, CP stated when they do a monthly review of the medication regimen(s), they are not looking for compliance with physician visit requirements rather more reviewing the psychiatry notes and medication use. CP stated the facility was responsible to monitor and ensure 60-day physician visits were completed timely adding, I don't keep track of whether they've been seen every 60 days. A facility' provided Physician Visits/Delegation Policy Statement, dated 10/2024, identified the attending physician would visit residents in a timely fashion, consistent with applicable state and Federal requirements. The policy outlined a visit would be completed, . at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure staff implemented appropriate and manufacturer-directed steps to prevent post-administration complication (i.e., thrush) of a steroid-infused inhaler for 1 of 1 residents (R4) observed to receive inhaled medication during the recertification survey. Findings include: R4's quarterly Minimum Data Set (MDS), dated [DATE], identified R4 had moderate cognitive impairment; along with multiple medical conditions including (history of) pneumonia and asthma. On 4/16/25 at 7:20 a.m., medication set-up and administration was observed with trained medication aide (TMA)-A who removed R4's medications from a mobile cart stationed in the hallway. R4 was seated next to the cart and TMA-A removed two inhalers from the cart to provide to R4. These were handed to the surveyor for review and included a metered-dose inhaler labeled mometasone furoate (Asmanex) HFA 200 mcg/act (micrograms/actuation) with an attached pharmacy label which directed to provide two puffs orally twice-a-day. The label had yellow spacing which included various instructions including, Rinse mouth thoroughly after each use. TMA-A administered the other inhaler first, then after a few seconds, picked up the mometasone HFA inhaler and attached a spacer to it. TMA-A then administered the inhaler to R4 as ordered and placed it back on the cart. TMA-A then cleaned the mouth parts of the inhalers before saying aloud, Back to the pills now. TMA-A then set-up the oral medications into a medication cup and then picked up an unopened can of Ensure (liquid nutritional drink) stating aloud, He [R5] likes to take [pills] with this. TMA-A then turned to provide the cup of oral medications to R4 and was stopped by the surveyor and asked about rinsing the mouth prior. TMA-A verified they didn't offer or help R4 with rinsing the mouth before they were about to provide oral medications and swallowed water and expressed aloud, Maybe I forgot. TMA-A stated a rinse should be done after using an inhaler as the medication was like a powder and needed to be removed from the mouth. TMA-A then proceeded to offer and help R4 with an oral rinse before giving him the remaining oral medications. An ASMANEX Patient Information feature, dated 2021, identified the medication was an inhaled corticosteroid used to treat asthma. The feature included a section labeled, How should I use ASMANEX HFA?[,] which included text, Rinse your mouth with water after each dose (2 puffs) of ASMANEX HFA. Spit out the water. Do not swallow it. This will help to lessen then change of getting a yeast infection (thrush) in your mouth and throat. When interviewed on 4/16/25 at 8:37 a.m., the director of nursing (DON) stated a rinse-and-spit should be completed after an inhaled steroid medication. DON stated the Medication Administration Record (MAR) should include directions for such so staff see it, too. This was important to do so the resident operates at their optimal level of functioning. DON stated they had not completed any recent education with the floor staff on this, however, would do so soon. Further, DON stated they were unaware of any audits being completed with floor staff on inhaled medications adding, To my knowledge, no [none]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 10:18 a.m., the consulting pharmacist (CP) was interviewed. CP verified mometasone was steroid-based and a mouth rinse should be completed after use. CP stated to follow the manufacturer' instructions for it as the medication could leave a residual deposit in the mouth and cause oral thrush. CP added rinsing after use would be the standard of what we would recommend. Further, CP stated they would review all the inhalers during their next visit to ensure the rinse directions were added to the orders and MAR, too. A facility' policy on metered-dose inhaler or steroid-infused inhaler use was requested, however, none was received.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations for standard-of-care laboratory monitoring with a consumed cardiac glycoside medication were acted upon and addressed in a timely manner for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS), dated [DATE], identified R5 had moderate cognitive impairment and several medical conditions including non-traumatic brain dysfunction, heart failure, and schizophrenia. Further, the MDS outlined consumed multiple medications including antipsychotic and anticoagulant (i.e., blood thinner) medications. R5's Medication Administration Record (MAR), dated 4/2025, identified all of her consumed medications and recorded treatments for the period. The orders included, Digox[in] . 125 MCG [micrograms] . one time a day related to CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE, with a listed start date recorded, 03/03/2025. The medication was recorded as being given each day of the month along with a pulse check which ranged 70-97 BPM (beat/minute). R5's care plan, printed 4/14/25, identified R5's identified actual or potential problem statements along with goals and interventions. The care plan outlined R5 had potential alteration for breathing and possible cardiac complications due to atrial fibrillation and heart failure. The listed goal read, [R5] will have no complications related to diagnosis through review date, and multiple interventions including to discontinued her oxygen use, elevate the head-of-bed if having breathing troubles, providing medication as ordered, and obtaining lab work as ordered. This section of the care plan was last revised 5/2023, however, it lacked any specific direction or guidance on how often, if at all, R5's digoxin level would be checked or monitored. R5's Omnicare Consultation Report, dated 1/20/25, identified R5's medication regimen was reviewed by the consulting pharmacist (CP). CP identified two separate issues to be reviewed including, 2) Resident receives Digoxin 125 mcg [micrograms] daily. No digoxin level located in facility medical record, with an added recommendation, 2) If not done at clinic, consider ordering a digoxin level and BMP [basic metabolic panel]. The form outlined a section labeled, Physician's Response, which placed a checkmark next to the option reading, I accept the recommendation(s) above, please implement as written. The spacing had corresponding handwriting which read, D/C [discontinue] Sucralfate, however, no additional text was present regarding the digoxin level request/recommendation. R5's subsequent CP medication regimen reviews (MRR), dated 2/2025 and 3/2025, identified no irregularities were found with R5's medication regimen. However, R5's medical record was reviewed and lacked evidence a digoxin level had been obtained, or rationale for why it had not been, despite the recommendation from 1/2025 and R5 consuming the medication on an ongoing basis. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 8:28 a.m., the director of nursing (DON) was interviewed, and verified they had reviewed R5's medical record. DON stated R5 used an offsite medical provider through the VA (Veteran Affairs), however, they were unable to locate a digoxin level in the medical record and, as a result, just had obtained an order to draw one. DON added, Hopefully she [R5] allows them to do it. DON the CP reports and recommendations were typically received and then passed to the floor nurses to get labs and such if ordered. DON acknowledged the second recommendation from the CP report in January 2025 hadn't been addressed, and expressed the CP would normally send something again if a recommendation wasn't acted upon. DON stated it was important to ensure recommendations were acted upon and laboratory monitoring was completed to help ensure R5 was able to reach their highest level of functioning. When interviewed on 4/16/25 at 10:06 a.m., the consulting pharmacist (CP) stated they had requested a digoxin level be checked multiple times over the past several months, however, never was able to locate any results for it. CP stated it could, at times, be difficult to get labs from outside medical clinics such as the VA, too. CP stated they felt the physician who signed the January 2025 report had reviewed it and expressed, My thought would be I've [CP] done my request for it and we're just not getting it from the doctor. CP stated they didn't continue to recommend the level check on subsequent visits as they had already repeatedly asked for it dating back to the previous year. CP reiterated, We just have not gotten a response [from clinic]. CP stated the care center staff were able to follow-up with the provider if a lack of response was a concern. CP explained there was record of R5 using digoxin for several years upon their review, however, was unsure if it was continuous or not adding if someone was stable then digoxin levels were typically checked every six to 12 months to ensure the medication is therapeutic and not putting the patient at risk of digoxin toxicity. A facility' policy on consulting pharmacist recommendations was requested, however, none was received.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure consumed cardiac glycoside medication was appropriately monitored in accordance with the standard-of-care laboratory testing to help reduce the risk of medication toxicity for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: A Cleveland Clinic feature titled, Digoxin, dated 4/2023, identified the medication was used to help with certain heart issues. The feature outlined, Various factors affect how much of the drug your body absorbs and excretes. Digoxin levels that are too high can be life-threatening. The feature outlined the medical provider will check a patient's digoxin level adding, You'll need to have a provider check your digoxin level regularly. They'll tell you how often you need to do this. The medication side effects listed included upset stomach, dizziness, and heart block. Further, the article identified a normal digoxin level range of, 0.5 to 2 ng/ml [nanograms/milliliter], and outlined if levels were too high, then it could lead to an abnormal heart rhythm adding, About 4% to 5% of people taking digoxin have toxicity. Toxicity is fatal for 9% of people who have it. R5's quarterly Minimum Data Set (MDS), dated [DATE], identified R5 had moderate cognitive impairment and several medical conditions including non-traumatic brain dysfunction, heart failure, and schizophrenia. Further, the MDS outlined consumed multiple medications including antipsychotic and anticoagulant (i.e., blood thinner) medications. On 4/14/25 at 2:32 p.m., R5 was observed seated in a chair on the second floor unit. A medication cup was present on the arm of the chair which was approximately 1/2 full of a white-colored liquid. R5 was asked by the surveyor if she had any pain to which R5 just repeatedly kept saying aloud, Just my heart. R5 stated the pain just started that day. At this time, licensed practical nurse (LPN)-B approached R5 and picked up the medication cup with white-colored liquid inside and took it away. R5 again repeated, Just my heart, aloud. Following this, LPN-N stated the white-colored liquid in the cup was Maalox (used to treat heartburn) and stated R5 had voiced the complaints of chest pain before which LPN-B stated was heartburn. R5's Medication Administration Record (MAR), dated 4/2025, identified all of her consumed medications and recorded treatments for the period. The orders included, Digox[in] . 125 MCG [micrograms] . one time a day related to CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE, with a listed start date recorded, 03/03/2025. The medication was recorded as being given each day of the month along with a pulse check which ranged 70-97 BPM (beat/minute). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's care plan, printed 4/14/25, identified R5's identified actual or potential problem statements along with goals and interventions. The care plan outlined R5 had potential alteration for breathing and possible cardiac complications due to atrial fibrillation and heart failure. The listed goal read, [R5] will have no complications related to diagnosis through review date, and multiple interventions including to discontinued her oxygen use, elevate the head-of-bed if having breathing troubles, providing medication as ordered, and obtaining lab work as ordered. This section of the care plan was last revised 5/2023, however, it lacked any specific direction or guidance on how often, if at all, R5's digoxin level would be checked or monitored. Further, R5's entire medical record was reviewed and lacked evidence a digoxin level had been checked or obtained within the last 12 months despite ongoing use of the medication. On 4/16/25 at 8:28 a.m., the director of nursing (DON) was interviewed, and verified they had reviewed R5's medical record. DON stated R5 used an offsite medical provider through the VA (Veteran Affairs), however, they were unable to locate a digoxin level in the medical record and, as a result, just had obtained an order to draw one. DON added, Hopefully she [R5] allows them to do it. DON stated the digoxin level laboratory monitoring should be completed to help ensure the resident operated at their highest level of functioning. When interviewed on 4/16/25 at 10:06 a.m., the consulting pharmacist (CP) stated they had requested a digoxin level be checked multiple times over the past several months, however, never was able to locate any results for it. CP stated it could, at times, be difficult to get labs from outside medical clinics such as the VA, too. CP stated there was record of R5 using digoxin for several years upon their review, however, was unsure if it was continuous or not. CP stated if someone was stable, then digoxin levels were typically checked every six to 12 months to ensure the medication is therapeutic adding digoxin toxicity was a risk to the patient. A facility' policy on medication management and monitoring was requested, however, none was received.

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	24E185	A. Building B. Wing	04/17/2025

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Bywood East Health Care	3427 Central Avenue Northeast Minneapolis, MN 55418

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49034 Based on observation, interview, and document review, the facility failed to ensure food was reheated to an appropriate temperature to reduce the risk of foodborne illness for 12 residents who ingested the food item. Findings include: Captain Ken's Bag Heating Protocol, indicated the chicken pot pie filling was to reach a temperature of 165 degrees Fahrenheit (F). The Facility's temperature log dated 4/14/25 through 4/20/25, indicated the temperature of the chicken and dumplings was 170 F on 4/16/25 for the lunch service. During an observation on 4/16/25 at 10:43 a.m., cook (C)-A took out multiple bags of chicken pot pie filling (confirmed in a later interview) from the steam cooker, cut the tops off the bags, and mixed the item into a large metal container. C-A was not observed to take the temperature of the item. During an observation and interview on 4/16/25 at 10:45 a.m., as C-A was observed to continue prepping food for the lunch meal service, temperature logs were found and indicated the chicken and dumplings temperature was taken at 170 degrees. C-A was observed to take the (per C-A) chicken and dumplings (or chicken pot pie filling) to the steam table and use a thermometer to measure the temperature at 90 F. The director of nutritional services (DNS) stated the chicken and dumplings would need to be reheated. At 11:11 a.m., the DNS stated she had reheated the chicken and dumplings in the oven, and they had reached 145.3 degrees and placed the chicken and dumplings back on the steam table. C-A then began serving the chicken and dumplings to residents. During an interview on 4/16/25 at 11:35 a.m., C-A indicated she had taken the temperature of the chicken and dumplings around 10:45 a.m. to 11 a.m., and the temperature had been 170 degrees. The DNS confirmed it was unusual for the chicken and dumplings to drop 80 degrees in a matter of minutes and stated, That doesn't make sense. At 12:11 p.m., the DNS stated she was assuming the temperature of the chicken and dumplings had not been taken before the surveyor observation and felt the 170 F reading noted on the temperature log was false. The DNS stated the highest temperature she thought the chicken and dumplings ever reached was 145.3 F, but as the chicken and dumplings were purchased pre-made and pre-cooked in a sealed bag, she was not concerned about possible food-borne illness. At 12:21 p.m., on request, the DNS found Captain Ken's cooking instructions and acknowledged that she had not seen these instructions saying the food was to be cooked to 165 F until now and was not sure if this was being followed. The DNS confirmed she would expect the cook to follow these but was unsure if they were. When C-A was asked about when the chicken and dumplings were measured at 170 F she was unable to provide what step in her process of preparing the food she had taken this measurement. C-A then stated she was never sure the chicken and dumplings were 170 F but had just thought it was 170 (F). C-A acknowledged she was never sure the chicken and dumplings had reached 165 degrees, as instructed by the manufacturer. A policy regarding reheating food was requested and not received.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to ensure laundry was handled and transported in a way to prevent the spread of infection to the extent possible. This had the possible to affect all 70 residents residing in the facility. Findings include: During interview and observation on 4/15/25 at 8:06 a.m., the head of maintenance (HOM) stated an outside company laundered the facility's linens and the facility washed the resident personal laundry. The laundry room did not have gowns hanging for use and the HOM confirmed staff did not wear gowns, only gloves and a mask, when handling resident dirty laundry. The facility's linens were brought up to the floors for resident use in large, uncovered bins. Personal laundry was brought up to the floors in uncovered, metal hanging carts. The HOM confirmed clean laundry was not covered when brought up to the floors. On 4/14/25 at 1:24 p.m., the second floor unit was toured and room [ROOM NUMBER] (unoccupied) was found with an open door to the hallway. Inside, a series of blue or red-colored mobile, hard-plastic containers with an open top were present and each had visible white linens (i.e., sheets, towels) inside. The linens were stacked up, but various pilings of them had toppled over and were scattered in the bin. Very few of the linens were covered with another clean sheet or plastic wrapping. In addition, the remainder of the room was visible which had a wall-mounted armoire and, on top, more white linens stacked up along with various medical equipment adjacent such as a stripped hospital-style bed, multiple wheelchairs, a commode, and equipment poles (i.e., IV, tube feeding). The doorway was left open to the hallway which had other resident rooms present. On 4/15/25 at 7:49 a.m., licensed practical nurse (LPN)-A was observed walking down the hallway from the shower room on the second floor unit towards room [ROOM NUMBER]. LPN-A met nursing assistant (NA)-A who was in the hallway and stated aloud to NA-A, We don't have wipes! NA-A motioned her arms and replied aloud, No wipes [affirmed]. NA-A and LPN-A then both entered into Rm. 207 to obtain linens (i.e., towels). When interviewed on 4/15/25 at 9:57 a.m., nursing assistant (NA)-A stated multiple residents on the unit had both bowel and bladder incontinence, and the second floor unit often had issues with supplies being short and staff having to run to other floors to obtain them. NA-A stated there was nobody assigned to re-stock clean linens in the linen closet at the end of the hallway so, as a result, staff often had to dig in those bins (located in Rm. 207) to find clean supplies while doing cares adding, We don't have time for that. NA-A stated the room was cluttered with soiled items and clean items, and had everything [supplies, medical equipment] just shoved in that room. During an interview on 4/15/25 at 12:30 p.m., the charge nurse and licensed practical nurse (LPN)-B stated room [ROOM NUMBER] was intended to be used for clean linens only, stating the laundry aides would put the laundry into a closet at the end of the hallway with multiple shelves for linen storage, and staff should not be digging through the clean linen bins looking for items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During on 4/15/25 at 12:59 p.m., room [ROOM NUMBER] was observed with the door open and the multiple linen bins without covers. During an interview on 4/16/25 at 11:30 a.m., the infection preventionist (IP) stated it was the expectation that all clean linen stay covered for infection control purposes, confirming she had provided education to the aides and laundry aides on the topic. The IP further stated it was the expectation that night shift would put clean linen from room [ROOM NUMBER] into the linen closet at the end of the hallway and staff were to not be rummaging through the bins in 207 for linens, stating the door to room [ROOM NUMBER] should be closed for infection control and to keep the linens clean. The IP confirmed some reeducation would be necessary. A facility policy titled Bywood East Infection Control and Prevention Program , dated 4/26/24, indicated the purpose of the facility's Infection Prevention and Control Program was to provide a framework for the active and ongoing facility-wide efforts to control, prevent, identify and report communicable diseases. 33925

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on interview and document review, the facility failed to implement the current standards of vaccinations regarding pneumonia for 1 of 5 residents (R22) over [AGE] years old whose vaccinations histories were reviewed. Findings include: The Center for Disease Control and Prevention (CDC) identified on the PneumoRecs VaxAdvisor Application, revised 12/11/24 to reflect a change in age guidance, advised for patients over [AGE] years of age, Give at least one does of the PCV15, PCV20, or PCV21 at least one year after the last does of PPSV23. R22's face sheet, printed 4/16/25, indicated R22 was [AGE] years old at the time of survey, was cognitively intact and was initially admitted to the care center on 9/15/23. R22's Immunizations listed in her electronic medical record (EMR) indicated R22 received the PPSV23 (Pneumovax 23) on 6/30/11. No other pneumococcal vaccines were listed in R22's EMR. According to the CDC, R22 should receive at least one does of the PCV15, PCV20, or PCV21 at least one year after the last does of PPSV23. R22's Vaccine Consent or Declination form, dated 10/7/24, did not indicate if R22 consent to or refused the pneumococcal vaccine. During an interview on 4/16/25 at 11:30 a.m., the infection preventionist (IP) stated all residents should be offered the influenza, pneumococcal and COVID vaccines upon admission, however the facility only provided the influenza vaccine and sent residents out for the other two. The IP confirmed R22 consented to the pneumococcal vaccine, and had a second consent, referenced during the interview, that indicated R22 did consent. The IP confirmed that R22 was due for a pneumococcal vaccine and was not yet on the list to receive one. A facility policy titled Bywood East Health Care Immunization Policy, revised 8/2024, The [facility] immunization schedule will follow the recommendations of the Center for Disease Control and Prevention (CDC) and the Minnesota Department of Health. It is recognized that viruses such as COVID-19, influenza and pneumococcal pneumonia are a serious risk for residents in nursing homes and the staff who serve them; therefore, residents will be encouraged to receive all three vaccines.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 47495 Based on observation, interview, and document review, the facility failed to ensure shared resident' rooms had adequate floor space (i.e., 80 square feet [SF] per resident) for 23 of 23 rooms (101, 102, 107, 108, 109, 208, 212, 213, 214, 215, 216, 217, 301, 302, 307, 308, 309, 312, 313, 314, 315, 316, 317). This had potential to affect 69 of 69 residents who currently or potentially could occupy these shared room spaces. Findings include: A provided Room Assignment and Census Report, dated 4/14/25, indicated a facility census of 70 and identified current residents and their corresponding rooms at the care center and also identified rooms with open beds that would be occupied by three residents when full. This identified rooms 101, 102, 107, 108, 109, 208, 212, 213, 214, 215, 216, 217, 301, 302, 307, 308, 309, 312, 313, 314, 315, 316, 317 each either already had three residents present or accommodation to accept three residents within the same room. The Aspen Central Office (ACO) database, which is used by the Centers for Medicare and Medicaid (CMS) to track past survey results and, if applicable, any granted waivers of Federal health requirements identified the care center have several shared room(s) which had less than 80 square feet per resident (via total room square footage divided by number of residents in the space). All rooms at the facility listed above had 232.72 SF total or 77.57 SF per resident. On 4/16/25 at 8:30 a.m., a tour of the care center was completed which verified the listed rooms either currently had three residents inhabiting the spaces or, if needed, could inhabit the space (i.e., new admission). During an in interview on 4/14/25 at 1:32 p.m., R26 stated he did not understand why the care facility put three residents in a room, stating he felt the rooms were big enough for one person, not three. During observation and interview on 4/14/25 at 2:48 p.m., R22 was observed laying in bed, with privacy curtains on each side and two other beds in the room. R22 stated she felt like she had enough space where her bed was, but wished she had more closet and storage space. The closet space, which had 3 separate cubby areas, was observed to be overflowing with clothes and personal items in all 3 cubbies. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 4/15/25 at 9:21 a.m., the administrator stated they had not done any construction to the facility or changes to room size since their previous recertification survey. The administrator stated, to the best of his knowledge, all rooms were the same size and if three beds were in the room, or three spaces were listed on the Room Assignment Report, the facility would potentially admit three residents to the room. The administrator stated they had received no complaints from residents who currently reside in a room with three residents, so they had not discussed spreading out residents into open rooms. The administrator stated he would request a federal waiver based on the rooms that could potentially admit three residents, acknowledging that there were more rooms than requested on last year's waiver. A facility policy titled Policy and Procedure Regarding Waivered Room Sizes, dated 5/2024, indicated potential residents who seek admission to the facility and/or current residents who request a room transfer will be informed of the rooms that do not meet the 80 square foot minimum requirement and facility staff will discuss room organization and assist residents to accommodate their needs and individual preferences as appropriate.