

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  24E185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/07/2026
NAME OF PROVIDER OR SUPPLIER  Bywood East Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3427 Central Avenue Northeast Minneapolis, MN 55418	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and document review, the facility failed to ensure appropriate infection control while providing laundry services as well as failed to review the facility Infection Prevention Program policy annually. These deficient practices had the ability to affect all residents who resided in the facility. Findings include: Laundry: During a laundry room tour and interview on 5/6/26 at 8:10 a.m., other staff (O)-E stated they put a personal T-shirt on over their clothes when handling dirty laundry and used the same T-shirt when hanging clean laundry. O-E stated they used disposable gowns when handling laundry of a resident with an infection. They stated they had no concerns wearing the same clothing for clean and dirty laundry if the resident did not have an infection. During an interview on 5/7/26 at 12:40 p.m., the director of maintenance (M)-A stated that they work with an external company for on-site laundry and housekeeping services. M-A stated they thought laundry staff wore gloves and a gown when handling dirty laundry, but they were not concerned if no gown was worn if staff's clothing did not touch the dirty clothing. M-A stated they would provide more disposable gowns if needed. Policy Review: Bywood East infection Control and Prevention Program dated 4/26/24, had no indication of an annual review. During an interview on 5/7/26 at 8:09 a.m., the director of nursing (DON) stated they were aware that the infection prevention program policy was overdue for review, and they were working on a process for an annual review of all infection prevention policies.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review the facility failed to have the appropriate funds available for 2 of 3 (R41, R21) Medicare/Medicaid residents who wanted to withdraw funds outside of scheduled withdrawal hours set up by the facility. In addition, insignificant funds were available on the evening shift for any residents. This had the potential to affect all residents who kept funds with the facility. Findings include:R41's comprehensive MDS dated [DATE], identified R41 was cognitively intact.During an interview on 5/4/26 at 1:20 p.m., R41 stated they could get five dollars out on the weekends by going to the nurse's station. R41 stated Monday through Friday they could take their money out from 1:00 p.m. to 2:00 p.m R41 stated if you missed the time the business window was open you could not get your money.R21's comprehensive Minimum Data Set (MDS) dated [DATE], identified R21 was cognitively intact.During an interview on 5/4/26 at 1:25 p.m., R21 stated the facility kept money for him and he could access this money five times per week, Monday through Friday from 8:00 a.m. to 9:00 a.m., and from 1:00 p.m. to 2:00 p.m R21 said he was not able to take money out on weekends.During an interview on 5/6/26 at 11:46 p.m., business office coordinator (BOC)-G stated the business office opened the window Monday through Friday, twice a day from 8:00 a.m. to 9:00 a.m., and then from 1:00 p.m. to 2:00 p.m BOC-G stated if residents wanted their money outside of these hours or for large amounts of money they could make a request. On a weekend the times they could get their money was posted. It was as follows:Business office banking hoursMonday-Friday 8-9am and 1-2pmWeekends and holidays available through the 1st floor nursing station 9-10am and 1-2pmPer request outside posted hoursBOC-G stated residents could come to her window or door anytime and knock. She stated if they knocked on her window at 9:30 a.m., she would re-direct them to the 1:00 p.m. time, unless they were leaving the building and needed the money right away. During an interview on 5/6/26 at 12:04 p.m., trained medication aide (TMA)-A verified he worked weekends. TMA-A stated if a resident asked him about getting money on the weekend he would direct them to the nurse.During an interview on 5/6/26 at 12:06 p.m., registered nurse (RN)-A verified she worked weekends. RN-A stated if residents requested money on the weekends, she would direct them to make the request during the times that were posted. RN-A stated on Friday evening the business office would deliver a box with a code to open it. Inside the box would be a sheet of paper with the resident's name and their balances. RN-A stated all they could give a resident would be five dollars a day. RN-A opened the insulin room, then opened the cart where the cash box would be stored. There was not a box with money in the cart. RN-A stated the box with cash would not be delivered until Friday evening. RN-A verified after the business office closed Monday through Thursday, residents would not be able to access their money.During an interview on 5/7/26 at 12:51 p.m., the director of nursing (DON) verified the funds were available during specific times of the day Monday through Friday and at specific times on the weekend. The DON verified residents should be able to access their money when they wanted it.Resident Trust Fund and Authorization Policy dated 10/6/22, identified the following: Resident banking hours are from 8:00AM to 9:00AM. Resident trust cash is available through the Charge Nurse on weekends and holidays from 9:00AM to 10:00AM and again from 4:00PM to 5:00PM. Resident funds are also available outside of banking hours in case of an emergency 24/7 through the Charge Nurse.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and document review the facility failed to provide a safe, sanitary and comfortable environment for 7 of 7 residents (R24, R33, R62, R9, R56, R12, R20) reviewed for environment. Findings include:R24R24's quarterly Minimum Data Set (MDS) dated [DATE], identified R24 had diagnoses which included schizophrenia and depression. In addition, R24's MDS identified she was moderately cognitively intact.R24's care plan dated 1/12/26, identified R24 had significant mental health issues. Interventions included to encourage her to not have food in her room, staff were to tell her keeping food out of her room would help keep the mice out of the traps as she identified the mice as her friends.During an interview on 5/7/26 at 9:08 a.m., the infection preventionist (IP) stated they were aware that R24 was trying to feed the mice. The IP stated they would try to get her to eat in the day room and on every shift, staff were supposed to look for food in her room. In addition, housekeeping staff were supposed to be cleaning her room twice a day.During an observation on 5/7/26 at 9:14 a.m., the IP went to the room and looked under the bed. Near the head of the bed on the side facing the inside of the room was a large amount of black crumbs, the IP said it looked like chocolate cake. The pile was about four inches by six inches. There were also two patties of what looked like white meat.A review of the menus for the past two weeks identified a turkey swiss grilled sandwich was served on 5/6/26, at the evening meal. Breaded pork chops were served on 4/29/26, at the evening meal, on 4/28/26, a caramel brownie was served at the lunch meal, and on 4/27/26, chocolate mousse cake was served at the evening meal.A review of the [NAME] service summary records dated 11/2025-4/2026, identified the following:R24's room was not checked during the month of 4/2026R24's room was not checked during the month of 3/2026R24's room was checked and serviced in the month of 2/2026, with light activity noted (rodent activity)R24's room was not checked during the month of 1/2026R24's room was not checked during the month of 12/2025R24's room was not checked during the month of 11/2025During an interview on 5/7/26 at 9:43 a.m., the maintenance director (MD) stated there were bait stations in some resident rooms, he stated there was not a master list of which rooms. MD verified during the month of 4/2026, none of the bait stations in any rooms were serviced. In addition, MD stated housekeeping was supposed to clean R24's room after breakfast and lunch.During an interview on 5/7/26 at 12:51 p.m., the director of nursing (DON) stated they were aware that R24 was trying to feed the mice. The DON stated she expected staff to check at least daily under R24's bed for food. The DON stated this would be important as food under beds had the potential to attract mice.R33R33's quarterly Minimum Data Set (MDS) dated [DATE], identified R33 had diagnoses which included delusional disorder. R33's MDS identified she was cognitively intact and had behaviors that included rejection of cares four to six days a week but less than daily.R33's care plan did not address room clutter and/or overcrowded with belongings.During an interview on 5/4/26 at 1:09 p.m., R33 stated she had recently found mouse droppings on her bed, she stated her roommate had garbage in their room and that she hoarded food. R33 stated she had been talking to staff at the facility since she arrived in October of 2025, about this concern. R33 stated she had seen mice in the room, and she was concerned the mice might carry diseases.During an observation/interview on 5/4/26 at 12:40 p.m., next to R33's bed were two plastic bins with covers stacked one on top of the other, two bedside stands, an overbed table with a coffee maker and a fruit tray wrapped in plastic. On the floor there was a shopping type bag filled with personal items. R33 also stated the garbage was not removed daily and stated they did not clean on weekends.During an interview on 5/6/26 at 1:43 p.m., the maintenance director (MD) stated he had seen mouse droppings in R33's room and they had pest control traps in that room.A review of the [NAME] service summary records dated 11/2025-4/2026, identified there were not any rodent bait stations in R33's room.R62R62's quarterly MDS dated [DATE], identified R62 had diagnoses which (continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>included paranoid schizophrenia. In addition, R62's MDS identified she was cognitively intact and had behaviors that included rejection of cares four to six days a week but less than daily.R62's care plan dated 2/3/26, identified rejection of care, the plan did not address a plan for not allowing housekeeping staff to clean her room or hoarding food.During an observation on 5/4/26 at 1:31 p.m., there were several plastic bags on the floor next to the bed and on top of one plastic bag was a piece of pie on a plate uncovered.A review of the [NAME] service summary records dated 11/2025-4/2026, identified the there were not any rodent bait stations in R62's room.During an interview on 5/6/26 at 12:55 p.m., trained medication aide (TMA)-B stated residents could bring food from meals to their rooms. TMA-B stated R62 hoarded food and when she was out of the room staff would go in and try to collect garbage.During an interview on 5/7/26 at 8:52 a.m., the infection preventionist (IP) stated she was not aware of concerns about mice in the building. The IP stated they had started Spring cleaning on 4/27/26, and said storing belongings in garbage bags was not a good way to store items. The IP stated they were trying to get R62 to move her belongings into bins. The IP verified the rooms were crowded.R9R9's comprehensive MDS dated [DATE], identified R9 had diagnoses which included post-traumatic stress disorder (PTSD). In addition, R9's MDS identified she was cognitively intact.R9's care plan dated 1/14/26, did not address room clutter and/or overcrowded with belongings.During an observation on 5/6/26, R9's room had bins on the floor which were overflowing onto the floor.R56R56's quarterly MDS dated [DATE], identified R56 had diagnoses which included paranoid schizophrenia, anxiety, depression, and PTSD. In addition, R56's MDS identified she was cognitively intact.R56's care plan dated 3/2/26, did not address room clutter and/or overcrowded with belongings.During an observation on 5/6/26, R56's room had bins on the floor which were overflowing onto the floor.A review of the [NAME] service summary records dated 11/2025-4/2026, identified the following:R56's room was not checked during the month of 4/2026R56's room was checked during the month of 3/2026, with light activity notedR56's room was checked and serviced during the month of 2/2026, with light activity notedR56's room was not checked during the month of 1/2026R56's room was not checked during the month of 12/2025, with light activity notedR56's room was not checked during the month of 11/2025, with light activity notedR12R12's quarterly MDS dated [DATE], identified R12 had diagnoses which included depression and homelessness. In addition, R12's MDS identified he was cognitively intact.R12's care plan dated 3/2/26, did not address room clutter and/or overcrowded with belongings.During an observation and interview on 5/6/26 at 12:36 p.m., R12 talked about Spring cleaning and said he was trying to organize his belongings and maybe throw some things out. R12 was using all of the available space in the first and second bed areas. R12 was using all of the open closet space and cupboards for his belongings.A review of the [NAME] service summary records dated 11/2025-4/2026, identified the there were not any rodent bait stations in R12's room.R20R20's quarterly MDS dated [DATE], identified R20 had diagnoses which included depression, bipolar depression, and schizophrenia. In addition, R20's MDS identified he was cognitively intact.During an observation on 5/4/26 at 2:11 p.m., it was noted the light over his bed was missing the cover.During an observation and interview on 5/7/26 at 10:05 a.m., R20 stated the light was pretty bright without the cover and suggested they take the cover off the light in the middle bed area because it was empty.During an interview on 5/6/26 at 11:23 a.m., the owner stated it was bad if there was pie sitting uncovered in a resident room. The owner stated it was not okay for residents to bring food/desserts to their rooms, stated there was a concern with pest control.During an interview on 5/6/26 at 12:55 p.m., trained medication aide (TMA)-B stated she had never seen mice or mouse droppings in the resident rooms. TMA-B stated residents could bring food from meals to their rooms. TMA-B stated R33's roommate hoarded food and when she was out of the room staff would go in and try to collect garbage. TMA-B stated there was a place for residents to safely store belongings in the building next to their building. TMA-B had noted the light cover was missing over R20's bed, she thought it had been about two months since it had been missing. TMA-B verified they used to let residents go into the third-floor conference room to sit and read and just be in a quiet (continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>space, but now the room was locked. TMA-B verified there was not any area in the building for a space to be alone. During an interview on 5/6/26 at 1:43 p.m., the maintenance director (MD) stated he had seen mouse droppings in R33's room and they had pest control traps in that room. During an interview on 5/6/26 at 2:27 p.m., chief financial officer and human resource director stated they were storing resident belongings in the garage that was on the property. During an interview on 5/6/26 at 11:23 a.m., the owner stated it was bad if there was pie sitting uncovered in a resident room. The owner stated it was not okay for residents to bring food/desserts to their rooms, stated there was a concern with pest control. During an interview on 5/6/26 at 1:43 p.m., MD stated there were residents who would not allow housekeeping staff to come in and clean their room. MD stated he had talked with the owner about this concern. He stated R33, R62, R12, were some of the residents who would not allow cleaning. He stated they remove food from under the R24's bed daily. During an interview on 5/7/26 at 9:26 a.m., a representative from the pest control company stated they came to the facility monthly and would fill the bait stations in resident rooms only when management told them to do this. The representative stated poor sanitation and clutter were things that contributed to pest problems. During an interview on 5/7/26 at 8:52 a.m., the infection preventionist (IP) stated she was not aware of concerns about mice in the building. The IP stated they had started Spring cleaning on 4/27/26, and said storing belongings in garbage bags was not a good way to store items. The IP stated they were trying to get R33's roommate to move her belongings into bins. The IP verified the rooms were crowded and stated residents had a safe place to store items in the garage on the property. The IP stated residents could request the conference room to have a place to read and be alone, she said the charge nurse would have the key to the room. During an interview on 5/7/26 at 9:26 a.m., a representative from the pest control company stated they came to the facility monthly and would fill the bait stations in resident rooms only when management told them to. The representative stated poor sanitation and clutter were things that contributed to pest problems. During an interview on 5/7/26 at 9:58 a.m., the MD stated they did store resident belongings in the garage and verified there was not any pest control in the garage. During an interview and observation on 5/7/26 at 10:09 a.m., the MD opened the garage, all of the floor space was covered with items; a pile of plastic bags about five feet high and 10 feet in diameter, which he said were supposed to go into a dumpster. MD stated the resident had moved out two years ago and didn't want the items anymore. In addition, there were walkers, wheelchairs, a dryer, bins with Christmas decorations, mattresses, mattress springs, coolers, a grill, two racks which would be found in hotel lobbies, a suitcase and two to three bins which were storage for a current resident, among other items. MD verified there would not be any room to store any other residents' personal belongings. During an interview on 5/7/26 at 12:51 p.m., the DON stated the hazard with the rooms being cluttered was that they could attract bugs, lead to pest problems, and were a concern for infection control. A policy on housekeeping was requested but not provided.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review the facility failed to ensure bait stations were monitored and serviced to prevent/reduce pest problems for 6 of 6 residents (R24, R33, R62, R9, R56, R12) reviewed for environment. This had the potential to affect all 64 residents who resided in the facility. Findings include:R24R24's quarterly Minimum Data Set (MDS) dated [DATE], identified R24 had diagnoses which included schizophrenia and depression. In addition, R24's MDS identified she was moderately cognitively intact.During an interview on 5/7/26 at 9:08 a.m., the infection preventionist (IP) stated they were aware that R24 was trying to feed the mice. The IP stated they would try to get her to eat in the day room and on every shift, staff were supposed to look for food in her room. In addition, housekeeping staff were supposed to be cleaning her room twice a day.During an observation on 5/7/26 at 9:14 a.m., the IP went to the room and looked under the bed. Near the head of the bed on the side facing the inside of the room was a large amount of black crumbs, the IP said it looked like chocolate cake. The pile was about four inches by six inches. There were also two patties of what looked like white meat.A review of the menus for the past two weeks identified a turkey swiss grilled sandwich was served on 5/6/26, at the evening meal. Breaded pork chops were served on 4/29/26, at the evening meal, on 4/28/26, a caramel brownie was served at the lunch meal, and on 4/27/26, chocolate mousse cake was served at the evening meal.A review of the [NAME] service summary records dated 11/2025-4/2026, identified the following:R24's room was not checked during the month of 4/2026R24's room was not checked during the month of 3/2026R24's room was checked and serviced in the month of 2/2026, with light activity noted (rodent activity)R24's room was not checked during the month of 1/2026R24's room was not checked during the month of 12/2025R24's room was not checked during the month of 11/2025During an interview on 5/7/26 at 9:43 a.m., the maintenance director (MD) stated there were bait stations in some resident rooms, he stated there was not a master list of which rooms. MD verified during the month of 4/2026, none of the bait stations in any rooms were serviced. In addition, MD stated housekeeping was supposed to clean R24's room after breakfast and lunch.R33R33's quarterly Minimum Data Set (MDS) dated [DATE], identified R33 had diagnoses which included delusional disorder. R33's MDS identified she was cognitively intact and had behaviors that included rejection of cares four to six days a week but less than daily.During an interview on 5/4/26 at 1:09 p.m., R33 stated she had recently found mouse droppings on her bed, she stated her roommate had garbage in their room and that she hoarded food. R33 stated she had been talking to staff at the facility since she arrived in October of 2025, about this concern. R33 stated she had seen mice in the room, and she was concerned the mice might carry diseases.During an observation/interview on 5/4/26 at 12:40 p.m., next to R33's bed were two plastic bins with covers stacked one on top of the other, two bedside stands, an overbed table with a coffee maker and a fruit tray wrapped in plastic. On the floor there was a shopping type bag filled with personal items. R33 also stated the garbage was not removed daily and stated they did not clean on weekends.During an interview on 5/6/26 at 1:43 p.m., the maintenance director (MD) stated he had seen mouse droppings in R33's room and they had pest control traps in that room.A review of the [NAME] service summary records dated 11/2025-4/2026, identified there were not any rodent bait stations in R33's room.R62R62's quarterly MDS dated [DATE], identified R62 had diagnoses which included paranoid schizophrenia. In addition, R62's MDS identified she was cognitively intact and had behaviors that included rejection of cares four to six days a week but less than daily.During an observation on 5/4/26 at 1:31 p.m., there were several plastic bags on the floor next to the bed and on top of one plastic bag was a piece of pie on a plate uncovered.A review of the [NAME] service summary records dated 11/2025-4/2026, identified the there were not any rodent bait stations in R62's room.During an interview on 5/6/26 at 12:55 p.m., trained medication aide (TMA)-B stated residents could bring food from meals to their rooms. TMA-B stated R62 hoarded food and when she (continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>was out of the room staff would go in and try to collect garbage. During an interview on 5/7/26 at 8:52 a.m., the infection preventionist (IP) stated she was not aware of concerns about mice in the building. The IP stated they had started Spring cleaning on 4/27/26, and said storing belongings in garbage bags was not a good way to store items. The IP stated they were trying to get R62 to move her belongings into bins. The IP verified the rooms were crowded. R9R9's comprehensive MDS dated [DATE], identified R9 had diagnoses which included post-traumatic stress disorder (PTSD). In addition, R9's MDS identified she was cognitively intact. During an observation on 5/6/26, R9's room had bins on the floor which were overflowing onto the floor. R56R56's quarterly MDS dated [DATE], identified R56 had diagnoses which included paranoid schizophrenia, anxiety, depression, and PTSD. In addition, R56's MDS identified she was cognitively intact. During an observation on 5/6/26, R56's room had bins on the floor which were overflowing onto the floor. A review of the [NAME] service summary records dated 11/2025-4/2026, identified the following: R56's room was not checked during the month of 4/2026. R56's room was checked during the month of 3/2026, with light activity noted. R56's room was checked and serviced during the month of 2/2026, with light activity noted. R56's room was not checked during the month of 1/2026. R56's room was not checked during the month of 12/2025, with light activity noted. R56's room was not checked during the month of 11/2025, with light activity noted. R12R12's quarterly MDS dated [DATE], identified R12 had diagnoses which included depression and homelessness. In addition, R12's MDS identified he was cognitively intact. During an observation and interview on 5/6/26 at 12:36 p.m., R12 talked about Spring cleaning and said he was trying to organize his belongings and maybe throw some things out. R12 was using all of the available space in the first and second bed areas. R12 was using all of the open closet space and cupboards for his belongings. A review of the [NAME] service summary records dated 11/2025-4/2026, identified there were not any rodent bait stations in R12's room. During an observation on 5/5/26 at 5:16 p.m., a resident left the dining room with two of the desserts (uncovered) and stated he was going to have them for breakfast. During an interview on 5/6/26 at 11:23 a.m., the owner stated it was bad if there was pie sitting uncovered in a resident room. The owner stated it was not okay for residents to bring food/desserts to their rooms, stated there was a concern with pest control. During an interview on 5/6/26 at 1:43 p.m., MD stated there were residents who would not allow housekeeping staff to come in and clean their room. MD stated he had talked with the owner about this concern. He stated R33, R62, R12, were some of the residents who would not allow cleaning. He stated they remove food from under the R24's bed daily. During an interview on 5/7/26 at 9:26 a.m., a representative from the pest control company stated they came to the facility monthly and would fill the bait stations in resident rooms only when management told them to do this. The representative stated poor sanitation and clutter were things that contributed to pest problems. During an interview on 5/7/26 at 12:51 p.m., the DON stated the hazard with the rooms being cluttered was that they could attract bugs, lead to pest problems, and were a concern for infection control. A policy on pest control was requested but not provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  24E185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/07/2026
NAME OF PROVIDER OR SUPPLIER  Bywood East Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3427 Central Avenue Northeast Minneapolis, MN 55418	

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and document review, the facility failed to ensure a pre-admission screening and resident review (PASARR) level two screening referral was acted upon for 1 of 1 resident (R2) reviewed for PASARR screening process. Findings include:R2's quarterly minimum data set (MDS) dated [DATE], identified diagnoses of disorganized schizophrenia, dementia with behavioral disturbance, developmental disorder of scholastic skills, and metabolic encephalopathy. R2's care plan dated 4/8/26, didn't identify PASARR level two recommendations.During an interview on 5/7/26 at 2:39 p.m., the director of nursing (DON) confirmed a level two screening was not in R2's electronic medical record. The DON stated it was important so they can identify what services were needed for them. A document, OBRA Level 1 screening dated 4/19/24, identified serious mental illness and referral to level two screening with Hennepin County preadmission screening team (PAS) Team.A policy regarding the PAS process was requested but not received.</p>

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation and interview, the facility failed to ensure survey results were available without an individual needing to ask to see the results. This deficient practice had the potential to impact on any person wishing to see, but not ask for, the survey results. Findings include: On 5/5/26 at 6:04 p.m., the administrator stated the survey book was at the front desk behind the desk in a holder, and there was notification of where it was. The book was not visible when facing the desk, a chest-high partition obstructed the book. A posted sign indicated annual state survey results were located at the front desk reception and were available and readily accessible for residents to view 24 hours daily. During an interview with the resident council on 5/6/26 at 2 p.m., an anonymous resident identified the survey results were there, but they had to ask for them.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review the facility failed to ensure staff posting included the current census and visible hours worked. This had the potential to impact all residents who resided at the facility. Findings include: During observations on 5/4/26, 5/5/26, and 5/6/26, staffing sheets were posted on all three floors of the facility. The name of the facility, staff names and disciplines were visible, but the hours scheduled, and current census were not visible. During an interview on 5/7/26 at 12:04 p.m., the director of nursing (DON) stated the scheduler posted the daily staffing on all three units. The DON confirmed the current census was not being included in the posting. During an interview on 5/5/26 at 6:04 p.m., the administrator stated we post the schedule each day on the unit and showed the location where the schedule was posted on the first floor. The schedule was in an acrylic stand behind a plexiglass window. The front page visible through the plexiglass was dated 5/5/26, and included names of staff, and titles sorted by shift. Hours worked were not visible. The administrator reached under a small opening in the plexiglass and spun the posting around. The total hours per shift were listed on the back of the sheet by shift. The administrator confirmed the data on the backside of the plexiglass holder reflected total hours for 5/4/26, not 5/5/26 because the 5/5/26, posting had been slid into the holder on top of the 5/4/26 posting (each printed posting was double sided, names on one side and hours on the flip side). The administrator stated the census was not printed on the daily staffing sheets, but it could be.</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and document review, the facility failed to ensure shared resident' rooms had adequate floor space (i.e., at least 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 any resident who currently or potentially could occupy these shared room spaces. Findings include: A provided Room Assignment and Census Report (RACR), dated 4/13/26, indicated a facility census of 64 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. These 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 RACR indicated three rooms currently housed three residents. The RACR indicated there were two rooms completely empty, with the ability to take two residents, and there were 5 rooms with only one resident in the room, with the ability to take a second resident. On 5/5/25 at 8:30 a.m., a tour of the care center was completed which verified the listed rooms either had three residents inhabiting the spaces or, if needed, could inhabit the space (i.e., new admission). During an interview on 5/6/26 at 9:12 a.m., the director of nursing (DON) stated there had been no conversations during the weekly bed management meetings to move resident around to be able to meet the at least 80 SF per resident requirement. The DON reviewed the RACR and confirmed there were currently two completely empty rooms and five rooms that only had one resident living in them. During an observation on 5/6/26 at 9:40 a.m., the maintenance supervisor (MS) measured room [ROOM NUMBER] and indicated a room size of 230 SF. This gives each resident 76.67 SF of individualized space. During an interview on 5/6/26 at 9:43 a.m., the MS stated all rooms had the same square footage. During an observation on 5/6/26 at 10:19 a.m., R25 had belongings on the floor from the back wall to the foot board of the bed and from the side of the bed to the curtain, which separated R25 from the roommate in the middle. During an interview on 5/6/26 at 10:21 am. R25 stated he was not sure why the facility had three residents to a room. R25 stated it would be nice to have more space to hold personnel belongings and get around but understood if the room was needed for a third resident. During an interview on 5/6/26 at 11:37 a.m., the administrator stated the facility had bed management meetings on a weekly basis. During the meeting the facility would discuss residents with behaviors, incident reports and the need to move residents due to the incidents, and possible admissions. The facility did not discuss moving residents when able to give each resident at least 80 SF of living space. The administrator stated new admissions were made aware the room size was less than 80 SF but did not tell current residents in three person rooms when a bed opened to allow for at least 80 SF of living space. The only time residents found out about that was if they noticed an open room with and requested a bed change. At that time the request would be evaluated. 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.</p>		