DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 41N1
Facility ID: 00176

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E185**

2. STATE VENDOR OR MEDICAID NO. (L2) **977603600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BYWOOD EAST HEALTH CARE**
(L4) **3427 CENTRAL AVENUE NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2006**

6. DATE OF SURVEY **07/14/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **98** (L18)
13.Total Certified Beds **98** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
X 8. Patient Room Size
__ 9. Beds/Room

* Code: **A, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		98		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

CCN-24 E185

Facility's request for continuing waivers involving tag 0458 (Bedrooms measure at least 70 sq ft) has been approved.

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HPR-Dietary Specialist 7/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 7/28/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

Posted 07/07/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24E185

July 28, 2016

Ms. Annette Thorson, Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

Dear Ms. Thorson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 30, 2016 the above facility is certified for:

98 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 98 skilled nursing facility beds.

Your request for waiver of F458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Electronically delivered

July 28, 2016

Ms. Annette Thorson, Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: Project Number SE185025 and Complaint Number HE185039

Dear Ms. Thorson:

On June 8, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 13, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for an extended survey completed on May 19, 2016 that included an investigation of complaint number HE185039. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On July 14, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on May 19, 2016, as of June 30, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 30, 2016.

However, as we notified you in our letter of June 8, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 19, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of May 19, 2016:

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 19, 2016 be rescinded as of June 30, 2016.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Your request for a continuing waiver involving the deficiency cited under F458 at the time of the May 19, 2016 extended survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
24E185 (Y1)	(Y2)	7/14/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 06/30/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 06/30/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 7/28/2016	SIGNATURE OF SURVEYOR 31223	DATE 7/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/19/2016	

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 28, 2016

Ms. Annette Thorson, Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

Re: Reinspection Results - Project Number SE185025 and Complaint Number HE185039

Dear Ms. Thorson:

On July 14, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 19, 2016, that included an investigation of complaint number HE185039. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

An equal opportunity employer.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00176 Y1	A. Building B. Wing Y2	7/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 30601 Reg. # MN St. Statute 144.56 Subp. 2c LSC	Correction Completed 06/30/2016	ID Prefix 30805 Reg. # MN Rule 4655.4400 G LSC	Correction Completed 06/30/2016	ID Prefix 31145 Reg. # MN Rule 4655.7830 Subp. 4 LSC	Correction Completed 06/30/2016
ID Prefix 31980 Reg. # MN Rule 626.557 Subd. 3 LSC	Correction Completed 06/30/2016	ID Prefix 32000 Reg. # MN Rule 626.557 Subd. 14 LSC	Correction Completed 06/30/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 7/28/2016	SIGNATURE OF SURVEYOR 31223	DATE 7/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 41N112

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 41N1
Facility ID: 00176

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E185**

2. STATE VENDOR OR MEDICAID NO. (L2) **977603600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BYWOOD EAST HEALTH CARE**
(L4) **3427 CENTRAL AVENUE NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2006**

6. DATE OF SURVEY **05/19/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **98** (L18)

13.Total Certified Beds **98** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
X 8. Patient Room Size
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* Code: **B, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		98		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

CCN-24 E185

Facility's request for continuing waivers involving tag 0458 (Bedrooms measure at least 70 sq ft) has been recommended to CMS.

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 06/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/01/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **03/01/1975** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
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28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

Posted 07/07/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

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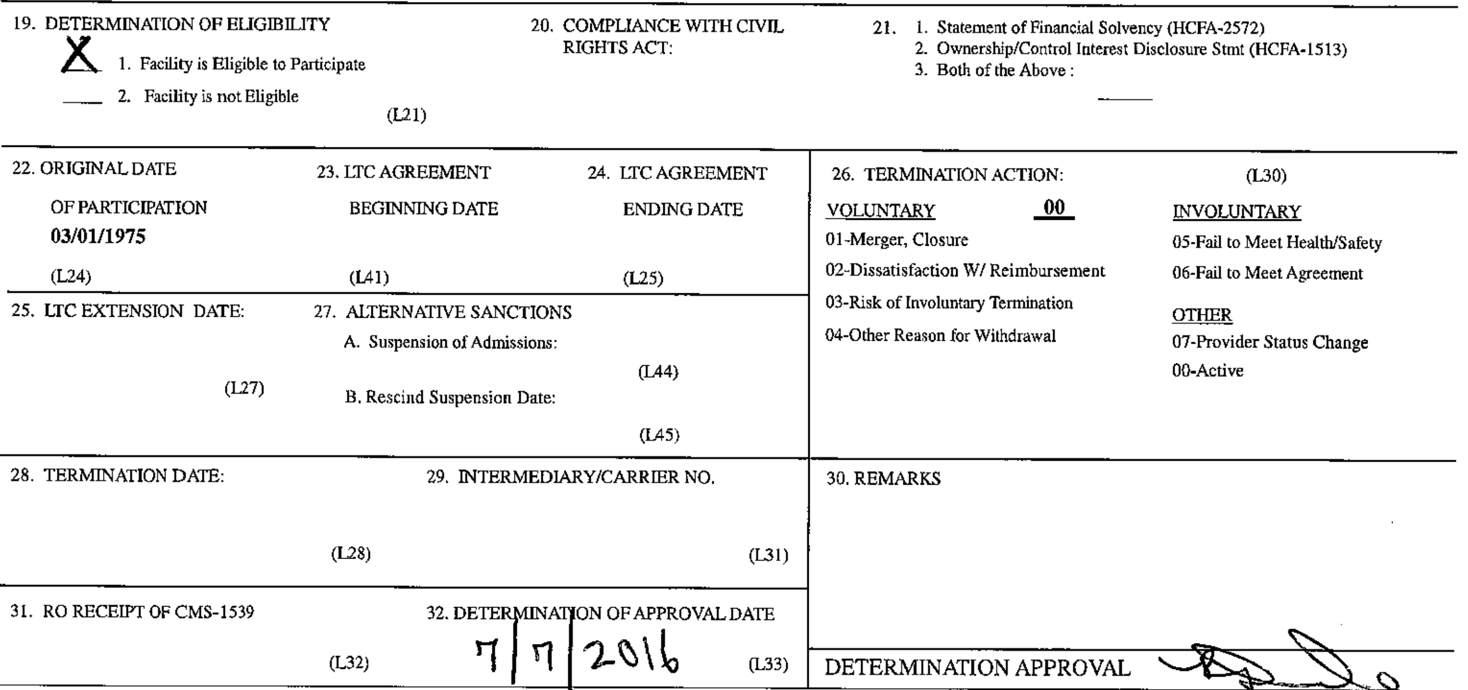

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30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE 7/7/2016 (L33)

DETERMINATION APPROVAL [signature]

Protecting, maintaining and improving the health of all Minnesotans

Electronically Submitted
June 8, 2016

Mr. Randal Hagemeyer, Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

RE: Project Number SE185025 and Complaint Numbers HE185037 and HE185039

Dear Mr. Hagemeyer:

On May 19, 2016, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the May 19, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number HE185037 which was substantiated and HE185039 that was found to be unsubstantiated.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate**

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 18, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility’s Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective June 13, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiencies cited at F226 and F323, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bywood East Health Care is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 19, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing

before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 ______	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	**3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.

Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

"A recertification survey began on May 16, 2016. Conditions in the facility constituted Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to residents health or safety which resulted in an extended survey that was completed on May 19, 2016.

The Immediate Jeopardy (IJ) at F323 related to the facility's failed response to elopements which resulted in the high potential for harm or death. The IJ began on 4/12/16 and the director of nursing (DON) was notified of the immediate jeopardy on 5/17/16 at 5:00 p.m. The IJ was removed on May 18, 2016 at 12:50 p.m.

An investigation of complaint number HE185037 was completed at the time of the survey and was found substantiated at F280 and F323.

An investigation of complaint HE185039 was also conducted however it was unsubstantiated.

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

Electronically Signed — 06/17/2016

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.

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F 000	Continued From page 1 The facility's request for the health waiver of the following deficiency has been approved: F458 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LAST 80 SQ FT/RESIDENT	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		6/30/16

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F 225	Continued From page 2 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of neglect were thoroughly investigated and reported to the designated State agency (SA) for 1 of 4 residents (R13) reviewed for elopement. In addition the facility failed to ensure background screenings were verified for 8 of 8 employees whose files were reviewed. Findings include: A review of R13's Admission Record Resident Information sheet indicated diagnosis of schizoaffective disorder, impulse disorder and borderline intellectual functioning. R13's admission Minimum Data Set (MDS) dated 3/24/16, indicated he had intact cognition and was independent with all activities of daily living. A Life Skill/Life Safety Pedestrian Safely [sic] evaluation dated 4/12/16, indicated the following: R13 did not understand the importance of signing in/out of the facility and indicated 20 seconds after reminder, he forget what to do. R13 was not able to recite the facility address or phone number and did not have a cell phone, nor did he have a wallet or identification card. This evaluation further indicated R13 did not understand jay walking, did not cross the street	F 225	The facility has not employed any individuals who have been found guilty of abusing neglecting or mistreating residents as outlined in F tag 225. The facility has and continues to take all allegations of abuse, neglect or mistreating of residents very seriously. R13 was reviewed for safety on 5/17/16 at 5:00 pm. He was placed in the semi secure unit with 15 minute visual checks. IDT developed a temporary care plan to increase his one-on-one activities and ensure that he was taken to smoke safely. Through the combined efforts of the IDT and staff, the resident remained free of elopement over the next two days until discharged to a more secure building. The facility IDT reviewed all residents on 5/17/16 with review of their Health Care Center Assessment for Resident s Ability to Leave the Facility Safely (RALFS), current wander guard list, and care plans. The facility developed a wander risk assessment and completed it for the entire building on 5/18/16. The two lists were compared and there was 100% agreement identifying residents at risk. The facility trained staff to use the list to	

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F 225	Continued From page 3 appropriately, and did not demonstrate an ability to look both ways before walking across the street. The notes included, "writer had to hold resident back...very impulsive." Further, the evaluation noted R13 was unable to demonstrate waiting for traffic to clear and had to be held back several times for safety reminders, did not hold his head up when walking, and walked between parked cars. The notes included, "is very impulsive, poor decision making skills. Walks into the street with no regard for safety." R13's care plan dated 3/22/16, identified a potential for abuse to self and/or to/from others related to impulsive behaviors and borderline intellectual functioning. The care plan further identified a history of unsafe behaviors: "such as running out into the street without looking, approaching strangers in the community and going up to strangers' cars in traffic." Care plan interventions included: assess and review quarterly, document and report any incidents, educate staff, monitor and intervene as needed. The care plan further identified use of a Wanderguard (bracelet system that activated selected doors when attempting exit) due to engaging in unsafe behaviors outside of the facility by going up to strangers in their cars on busy streets. The care plan indicated R13 had also displayed these behaviors at the previous facility he'd lived in. A review of Bywood East Health Care Progress Notes dated 3/11/16 through 5/18/16 indicated the following: 1) 3/26/16, At approximately 3:00 a.m., staff noted R13 outside the back door. R13 stated he did know when he went outside but demonstrated	F 225	identify residents that needed escorts, wore wander guards, where an elopement risk, at risk for falls and stair mobility. IDT reviews and updates RALFS quarterly and as needed. The list is reviewed for changes at Falls and Behavior meetings and updates are distributed to all departments. Incident reports have been refined to improve data collection, and staff has been educated to report any wandering or elopement that results in the resident being out of the sight of staff or reaching the public sidewalk or alley. Additionally, the Life Skills / Safety Pedestrian Safety Evaluation will be utilized when concerns are identified. The IDT reviewed all policies involving abuse, neglect and mistreatment. The facility continues to report and investigate all concerns. Education was provided to all staff. All open investigations will be maintained in a log and reviewed at morning stand up meeting. The Administrator, Director of Social Services or designee and Director of Nurses or designee will review the log weekly. Continued compliance will be the responsibility of the Director of Nursing, the Assistant Director of Nursing and the Director of Social Services. The log will be presented to QA quarterly for 6 months then ongoing as needed. Date certain for compliance is 6/30/16.	

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F 225	Continued From page 4	F 225		

how he exited. The noted indicated R13 held his arms and hands at shoulder level and was able to exit through the door without triggering the alarm.

2) 4/2/16, R13 was found knocking on the front door to be let in at 2:15 a.m. and again at 2:30 a.m.

3) 4/3/16, At 5:15 a.m., R13 was observed going out the back door with another resident. When the other resident returned R13 was not with him. Staff went outside to look for R13 but did not find him outside. Staff got into a car to look for R13 and found him walking south from a local pharmacy several blocks away. R13 was noted to cross the street "irregardless of any passing car." The notes further indicate that at 7:00 a.m., another staff was driving south to work and noted R13 to be walking haphazardly south on the sidewalk.

4) 4/5/16, a resident called out loudly that R13 had gone outside via the fire door. The alarm had not sounded so staff thought the resident was mistaken, "somewhat later" R13 appeared at the locked front door knocking to get in.

5) 4/6/16, R13 was heard pounding on the main lobby door at 1:00 a.m. and could not state how long he had been outside.

6) 4/7/16, At 3:00 a.m. R13 was knocking on the glass of the front lobby door to gain access. The progress notes indicated, "Staff on his floor was not aware he had eloped."

7) 4/11/16, A note indicated R13 had a Wanderguard in place but leaves the building "up to 15 times per day."

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F 225	Continued From page 5	F 225		

8) 4/24/16, At 4:00 p.m. R13 was noted to be outside the facility pushing a local pharmacy's shopping cart with a couple of bags containing pop.

9) 4/28/16, At 6:00 p.m. the assistant director of nursing observed R13 at 37th avenue and central avenue (down the street from the facility) as she was driving home.

10) 5/7/16, R13 eloped from the facility at approximately 1:35 a.m. through the south emergency exit and could not be seen in the dark. He did not return for approximately 20 minutes.

11) 5/17/16, on 5/16/16 staff found R13 at 37th avenue and Central Avenue. He appeared to be headed back towards the facility. R13 refused a ride back to the facility.

During an observation on 5/17/16, at 12:34 p.m. R13 was laying in his bed and appeared to be asleep. A Wanderguard bracelet was observed on his right wrist.

During an interview on 5/17/16, at 12:43 p.m. NA-B stated the Wanderguard will activate the elevator and the exit doors of the facility. NA-B also stated she was aware R13 wore a Wanderguard bracelet but stated he has gotten out of the facility any way. NA-B stated the second floor residents with Wanderguard's have 30 minute checks but the third floor residents are not routinely monitored.

During an interview with the director of nursing (DON) on 5/17/16 at 1:50 p.m., the DON stated

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F 225	Continued From page 6 R13 was unsafe to be out of the facility unsupervised. She verified R13 wears a Wanderguard but confirmed he was able to get out of the door before the alarm sounded by lifting up his arm with the bracelet. The DON stated there had been times when R13 had been out of the facility and not within sight of staff. The DON stated there had been no formal investigation following R13's elopements from the facility and no reports to the SA. A facility policy titled Bywood East health Care Vulnerable Adult Abuse Prevention Policy, dated 7/15/15 was reviewed. The policy indicated: "Bywood East Health Care adheres to the Vulnerable adult act, the Elder Justice Act, and all state/federal abuse prevention statutes and does not tolerate any forms of abuse including neglect." The policy directed staff to screen upon admission for a known history of potentially dangerous behaviors as well as his/her ability to leave the facility safely. In cases where these concerns are brought forward, the case was carefully considered to ensure placement was appropriate. The policy further directed staff to develop an individual abuse prevention plan to include measures to minimize the risk for the resident. "All incidents shall be immediately reported and the information supplied to the appropriate state agency."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		6/30/16

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F 226	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse reporting policy and procedures for 1 of 4 residents (R13) reviewed for elopement and failed to implement policies for conducting background studies for employees prior to them having any direct patient contact for 6 of 8 employees (E1, E2, E5, E6, E7, E8) whose files were reviewed. Findings include: Reporting A facility policy titled Bywood East health Care Vulnerable Adult Abuse Prevention Policy, dated 7/15/15 was reviewed. The policy indicated: "Bywood East Health Care adheres to the Vulnerable adult act, the Elder Justice Act, and all state/federal abuse prevention statutes and does not tolerate any forms of abuse including neglect." The policy directed staff to screen upon admission for a known history of potentially dangerous behaviors as well as his/her ability to leave the facility safely. In cases where these concerns are brought forward, the case was carefully considered to ensure placement was appropriate. The policy further directed staff to develop an individual abuse prevention plan to include measures to minimize the risk for the resident. "All incidents shall be immediately reported and the information supplied to the appropriate state agency." A review of R13's Admission Record Resident	F 226	The facility has not employed any individuals who have been found guilty of abusing neglecting or mistreating residents as outlined in F tag 225. The facility has and continues to take all allegations of abuse, neglect or mistreating of residents very seriously 100% of all staff have had their files verified for background checks as of 6/17/16. Human Resources (HR) will use a log for tracking the submission and completion of all back ground checks. IDT and HR reviewed the need for background checks to be completed before day one, and no hire will be allowed to work unobserved until the background check is completed. Applications have been updated to include background check submission once hired. The facility will be using NetStudy 3.0 starting 7/1/16 with every new hire. The hiring department head, human resources and the administrator will sign off on log as hires occur. HR will be responsible for ongoing compliance. The log will be reviewed at QA quarterly for 6 months then ongoing as needed. R13 was reviewed for safety on 5/17/16 at 5:00 pm. He was placed in the semi-secure unit with 15 minute	

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BYWOOD EAST HEALTH CARE	**3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8 Information sheet indicated diagnosis of schizoaffective disorder, impulse disorder and borderline intellectual functioning. R13's admission Minimum Data Set (MDS) dated 3/24/16, indicated he had intact cognition and was independent with all activities of daily living. A Life Skill/Life Safety Pedestrian Safely [sic] evaluation dated 4/12/16, indicated the following: R13 did not understand the importance of signing in/out of the facility and indicated 20 seconds after reminder, he forget what to do. R13 was not able to recite the facility address or phone number and did not have a cell phone, nor did he have a wallet or identification card. This evaluation further indicated R13 did not understand jay walking, did not cross the street appropriately, and did not demonstrate an ability to look both ways before walking across the street. The notes included, "writer had to hold resident back...very impulsive." Further, the evaluation noted R13 was unable to demonstrate waiting for traffic to clear and had to be held back several times for safety reminders, did not hold his head up when walking, and walked between parked cars. The notes included, "is very impulsive, poor decision making skills. Walks into the street with no regard for safety." R13's care plan dated 3/22/16, identified a potential for abuse to self and/or to/from others related to impulsive behaviors and borderline intellectual functioning. The care plan further identified a history of unsafe behaviors: "such as running out into the street without looking, approaching strangers in the community and going up to strangers' cars in traffic." Care plan interventions included: assess and review quarterly, document and report any incidents,	F 226	visual checks. IDT developed a temporary care plan to increase his one-on-one activities and ensure that he was taken to smoke safely. Through the combined efforts of the IDT and staff, the resident remained free of elopement over the next two days until discharged a more secure building. The facility IDT reviewed all residents on 5/17/16 with review of their Health Care Center Assessment for Resident s Ability to Leave the Facility Safely (RALFS), current wander guard list, and care plans. The facility developed a wander risk assessment and completed it for the entire building on 5/18/16. The two lists were compared and there was 100% agreement identifying residents at risk. The facility trained staff to use the list to identify residents who needed escorts, wore wander guards, were an elopement risk, and/or at risk for falls and stair mobility. IDT reviews and updates RALFS quarterly and as needed. The list is reviewed for changes at Falls and Behavior meetings and updates are distributed to all departments. Incident reports have been refined to improve data collection, and staff has been educated to report any wandering or elopement that results in the resident being out of the sight of staff or reaching the public sidewalk or alley. Additionally, the Life Skills / Safety Pedestrian Safety Evaluation will be utilized when concerns are identified. The IDT reviewed all policies involving abuse, neglect and mistreatment. The	

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	24E185	A. BUILDING ______ B. WING ______	05/19/2016

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F 226	Continued From page 9 educate staff, monitor and intervene as needed. The care plan further identified use of a Wanderguard (bracelet system that activated selected doors when attempting exit) due to engaging in unsafe behaviors outside of the facility by going up to strangers in their cars on busy streets. The care plan indicated R13 had also displayed these behaviors at the previous facility where he resided. A review of Bywood East Health Care Progress Notes dated 3/11/16 through 5/18/16 indicated the following: 1) 3/26/16, At approximately 3:00 a.m., staff noted R13 outside the back door. R13 stated he did know when he went outside but demonstrated how he exited. The noted indicated R13 held his arms and hands at shoulder level and was able to exit through the door without triggering the alarm. 2) 4/2/16, R13 was found knocking on the front door to be let in at 2:15 a.m. and again at 2:30 a.m. 3) 4/3/16, At 5:15 a.m., R13 was observed going out the back door with another resident. When the other resident returned R13 was not with him. Staff went outside to look for R13 but did not find him outside. Staff got into a car to look for R13 and found him walking south from a local pharmacy several blocks away. R13 was noted to cross the street "irregardless of any passing car." The notes further indicate that at 7:00 a.m., another staff was driving south to work and noted R13 to be walking haphazardly south on the sidewalk. 4) 4/5/16, a resident called out loudly that R13	F 226	facility continues to report and investigate all concerns, education was provided to all staff. All open investigations will be reviewed and morning stand up using a log. The Administrator, Director of Social Services or designee and Director of Nurses or designee will review the log weekly. Continued compliance will be the responsibility of the Director of Nursing, the Assistant Director of Nursing and the Director of Social Services. The log will be presented to QA quarterly for 6 months then ongoing as needed.	

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F 226	Continued From page 10	F 226		

had gone outside via the fire door. The alarm had not sounded so staff thought the resident was mistaken, "somewhat later" R13 appeared at the locked front door knocking to get in.

5) 4/6/16, R13 was heard pounding on the main lobby door at 1:00 a.m. and could not state how long he had been outside.

6) 4/7/16, At 3:00 a.m. R13 was knocking on the glass of the front lobby door to gain access. The progress notes indicated, "Staff on his floor was not aware he had eloped."

7) 4/11/16, A note indicated R13 had a Wanderguard in place but leaves the building "up to 15 times per day."

8) 4/24/16, At 4:00 p.m. R13 was noted to be outside the facility pushing a local pharmacy's shopping cart with a couple of bags containing pop.

9) 4/28/16, At 6:00 p.m. the assistant director of nursing observed R13 at 37th avenue and central avenue (down the street from the facility) as she was driving home.

10) 5/7/16, R13 eloped from the facility at approximately 1:35 a.m. through the south emergency exit and could not be seen in the dark. He did not return for approximately 20 minutes.

11) 5/17/16, on 5/16/16 staff found R13 at 37th avenue and Central Avenue. He appeared to be headed back towards the facility. R13 refused a ride back to the facility.

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During an observation on 5/17/16, at 12:34 p.m. R13 was laying in his bed and appeared to be asleep. A Wanderguard bracelet was observed on his right wrist.

During an interview on 5/17/16, at 12:43 p.m. NA-B stated the Wanderguard will activate the elevator and the exit doors of the facility. NA-B also stated she was aware R13 wore a Wanderguard bracelet but stated he has gotten out of the facility any way. NA-B stated the second floor residents with Wanderguard's have 30 minute checks but the third floor residents are not routinely monitored.

During an interview with the director of nursing (DON) on 5/17/16 at 1:50 p.m., the DON stated R13 was unsafe to be out of the facility unsupervised. She verified R13 wears a Wanderguard but confirmed he was able to get out of the door before the alarm sounded by lifting up his arm with the bracelet. The DON stated there had been times when R13 had been out of the facility and not within sight of staff. The DON stated there had been no formal investigation following R13's elopements from the facility and no reports to the SA.

While R13 had left the facility on multiple occasions and was assessed to be unsafe to leave the facility independently, there was no evidence the facility thoroughly investigated the incidents, nor were the incidents reported to the state agency. Further there was no evidence of an individualized abuse plan as directed in the policy.

BACKGROUND STUDIES

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F 226	Continued From page 12 Employee Files were reviewed. It was determined employee background studies were not submitted and returned prior to employees working with residents. The Vulnerable Adult Abuse Prevention Policy indicated: "All applicants for employment in the facility shall, at the minimum, have the following screening check conducted" 1. Reference checks with the current and/or past employer. 2. Appropriate licensing board or registry check. 3. Criminal background check 4. Employers, volunteers, and interns may begin work pending the outcome of the criminal background check, but must be under continuous, direct supervision they had access to persons receiving services. E1's hire date was 10/12/15, DHS [Department of Human Services] request to screen was dated 10/14/15. The temporary (yellow) copy was returned 10/15/15, the final (blue) copy was dated 12/26/15. E2's hire date was 7/21/15, DHS request to screen was dated 7/22/15, received final 7/23/15. E5's hire date was 11/13/15, DHS request to screen was dated 11/17/16, received final 11/19/15. E6's hire date was 5/10/16, DHS request to screen was dated 5/13/16, the facility could not locate a response as of 5/19/16. E7's hire date 5/10/16, DHS request to screen was dated 5/13/16, the facility could not locate a response as of 5/19/16. E8's hire date was 4/8/16, DHS request to screen was dated 4/12/16, received final on	F 226		

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F 226	Continued From page 13 4/14/16. On 5/19/16, at 2:45 p.m. the ADON verified staff begin orientation Day 1 with the human resources (HR) staff, Day 2 with nursing, and are then scheduled to work with residents. The ADON also confirmed the staff reviewed had worked alone with residents prior to their background checks having been completed. On 5/19/16, at 3:00 p.m. HR-A was interviewed and stated she was unaware background checks needed to be completed prior to employees working with residents.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		6/30/16

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F 279	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to promote continence for 1 of 4 residents (R103) reviewed for urinary incontinence. In addition, the facility failed to develop interventions to provide supervision for 1 of 4 residents (R13) reviewed for unsafe elopement. Findings include: R103's admission minimum data set (MDS) dated 5/11/16 indicated he was severely cognitively impaired, required extensive assist of two staff for toileting, transfers and ambulation. A care area assessment (CAA) dated 5/11/16 indicated R103 was frequently incontinent of bladder due to urinary urgency and need for assistance with toileting. R103's care plan dated 5/13/16, identified the resident had frequent urinary incontinence and indicated staff report he will urinate on the toilet when assisted to the bathroom. The care plan directed staff to provide physical sassiest with toileting, but did not identify any frequency. The care plan further directed staff to use verbal reminders for urine control even though R103 was severely cognitively impaired. A facility document titled 2nd Floor Day Shift Toileting, dated 5/20/16, indicated R103 was to be toileted with assistance of two staff before breakfast and before lunch and included boxes for staff to initial when completed. The document did not identify specific needs for R103.	F 279	The facility continues to develop care plans that include interventions for all residents. R103 was reassessed for toileting. His Care Plan and Group Sheets were updated to reflect changes. Audit of the last 90 days of MDS assessments were reviewed. Care Plans and Group Sheets will be reviewed and updated no later than 6/30/16. The facility will continue to review the toileting needs of all residents quarterly with the MDS schedule and PRN should the need arise. All nursing staff have received education on assessment and interventions for toileting. Additionally, direct care staff have been trained and have reviewed the facility group sheets completed by 6/30/16. The facility reviewed R13 s elopement at the time of survey. R13 was reviewed for safety on 5/17/16 at 5:00 pm. He was placed in the semi-secure unit with 15 minute visual checks. IDT developed a temporary care plan to increase his one-on-one activities and ensure that he was taken to smoke safely. Through the combined efforts of the IDT and staff, the resident remained free of elopement over the next two days until discharged to a more secure building. The facility IDT reviewed all residents on 5/17/16 with review of their Health Care Center Assessment for Resident s Ability to Leave the Facility Safely (RALFS),	

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F 279	Continued From page 15 A review of Bywood East Health Care Progress Notes indicated on 5/2/16 at 12:00 a.m., R103 attempted to stand up by himself, took a couple of steps, and fell backwards on to his buttocks. The note indicated he had been incontinent of urine. During an observation on 5/19/16 at 6:36 a.m., R103 ambulated independently from his room to the hallway and fell onto his buttocks and side. R103's pants were observed to be soaked with urine. During an interview on 5/19/16, at 6:53 a.m. NA-D stated she did not know when R103 was supposed to be toileted. She stated she normally works the p.m. (evening) shift and stated they take him to the bathroom before and after supper. She further stated she did not know where to find the toileting sheet for the day shift. During an interview on 5/19/16 at 11:04 a.m., registered nurse (RN)-C stated no one in the facility is on an individualized toileting plan. She stated if a resident is incontinent, they are toileted after breakfast and after lunch. She stated some residents go before meals. RN-B further stated during the MDS assessment period a Resident Toileting Pattern Worksheet was completed by the nursing assistants. A review of R103's worksheet dated 4/29/16 through 5/2/16, indicated the type of incontinent product worn, how much assistance was required and whether he was wet or dry when toileted however, the worksheet was not completed for 6 of 12 shifts and did not identify specific times he was toileted.	F 279	current wander guard list, and care plans. The facility developed a wander risk assessment and completed it for the entire building on 5/18/16. The two list were compared with 100% agreement in residents at risk. The facility trained staff to use the list to identify residents who needed escorts, wear wander guards, were an elopement risk and stair mobility. IDT reviews and updates RALFS quarterly and as needed. The list is reviewed for changes at Falls and Behavior meetings and updates are distributed to all departments. Care plan changes made during Falls or Behaviors will be communicated to staff using the 24 hour books on each station. All staff have received education on the expectation that they review the 24 hour book when coming on to their shift. Charge nurses and or TMAs will be responsible to ensure that direct care staff comply with care plans. All care plans will be reviewed quarterly and with significant change. Continued compliance will be the responsibility of the Director of Nurses, Assistant Director of Nurses and the MDS nurse. Care plan compliance will be presented to QA quarterly for 6 months then ongoing as needed.	

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F 279	Continued From page 16 A review of R13's Admission Record Resident Information sheet indicated diagnosis of schizoaffective disorder, impulse disorder and borderline intellectual functioning. R13's admission Minimum Data Set (MDS) dated 3/24/16, indicated he had intact cognition and was independent with all activities of daily living. A Life Skill/Life Safety Pedestrian Safely [sic] evaluation dated 4/12/16, indicated the following: R13 did not understand the importance of signing in/out of the facility and indicated 20 seconds after reminder, he forget what to do. R13 was not able to recite the facility address or phone number and did not have a cell phone, nor did he have a wallet or identification card. This evaluation further indicated R13 did not understand jay walking, did not cross the street appropriately, and did not demonstrate an ability to look both ways before walking across the street. The notes included, "writer had to hold resident back...very impulsive." Further, the evaluation noted R13 was unable to demonstrate waiting for traffic to clear and had to be held back several times for safety reminders, did not hold his head up when walking, and walked between parked cars. The notes included, "is very impulsive, poor decision making skills. Walks into the street with no regard for safety." R13's care plan dated 3/22/16, identified a potential for abuse to self and/or to/from others related to impulsive behaviors and borderline intellectual functioning. The care plan further identified a history of unsafe behaviors: "such as running out into the street without looking, approaching strangers in the community and going up to strangers' cars in traffic." Care plan interventions included: assess and review	F 279		

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F 279	Continued From page 17 quarterly, document and report any incidents, educate staff, monitor and intervene as needed. However, the care plan did not identify how staff was to intervene nor what to do once R13 had exited the facility. The care plan further identified use of a Wanderguard (bracelet system that activated selected doors when attempting exit) due to engaging in unsafe behaviors outside of the facility by going up to strangers in their cars on busy streets. The care plan indicated R13 had also displayed these behaviors at the previous facility he'd lived in. A review of Health Care Progress Notes dated 3/11/16 through 5/18/16, indicated the resident had at least 11 incidents of elopement. During an interview with the director of nursing (DON) on 5/17/16 at 1:50 p.m., the DON stated R13 was unsafe to be out of the facility unsupervised. The DON stated there had been times when R13 had been out of the facility and not within sight of staff. While R13 had left the facility on multiple occasions and was assessed to be unsafe to leave the facility independently, there was no evidence of care planned interventions to keep him from leaving the facility and wandering through high traffic areas. A care plan policy was requested, but not received.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		6/30/16

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F 280	Continued From page 18 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to promote continence for 1 of 4 residents (R103) reviewed for urinary incontinence. In addition, the facility failed to develop a plan of care with effective interventions to reduce falls for 1 of 4 residents (R96) reviewed for falls. Findings include: R96's annual minimum data set (MDS) dated 4/12/16, indicated she was cognitively intact, required extensive assist of two staff for toileting and transfers. R96 had a history of falls since admission to the facility. Fall Risk Assessment - Admission/Annual dated	F 280	The facility continues to review and develop care plans that include interventions for all residents. The statement of deficiency included R103 but did not list observations or documentation. The statement of deficiency did not include R17 but did include observations and documentation. However, both R103 and R17 were reassessed for toileting. Their Care Plans and Group Sheets updated to reflect changes. Audit of the last 90 days of MDS assessments were reviewed. Care Plans and Group Sheets will be reviewed and updated no later than 6/30/16. The facility will continue to review the toileting needs of all residents quarterly with the MDS	

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F 280	Continued From page 19 1/21/16, indicated R96 had sustained multiple falls in the past six months. The assessment indicated R96 "is refusing to ambulate at this time, not because she is "lazy" but because of the pain in her legs. She is using a wheelchair for primary mode of locomotion. She can propels herself, but moves at a very slow pace and staff assist to bring her to destinations prn[as needed]. She is very unsteady/shaky when she stands, and moves her feet very slowly. Staff provide assistance w[with]/bed mobility(lifting legs into bed prn) and with transfers as she is unsteady and needs staff to assist to steady self. No longer is able to transfer independently. Unknown cause for functional decline. Has been seen int he [sic] hospital and labs/testing were wnl[within normal limits]/negative. Requires up to three staff members depending on how she is feeling at the time. Often shaky and very stiff. Is discouraged form [sic] attempting self transfers due to the high numbers of falls (5 past quarter, one with minor injury). History of falls prior to admission, last noted June 2014." The assessment further indicated R96 had wandering, verbally abusive, physically abusive and socially inappropriate behaviors in the previous seven days. During observation on 5/16/16, at 12:05 p.m. R96 was observed being transferred from wheel chair to bed by one nursing assistant lifting R96 under R96's arms without use of a transfer belt. A review of Bywood East Health Care Resident incident reports and care plans 10/1/15, through 5/18/16, indicated the following: - R96 had a fall next to bed on 10/22/15, at 10:30 pm. Resident had reported falling/rolling out bed, later said she was transferring from w/c and fell to	F 280	schedule and PRN should the need arise. R96 s record and care plan was reassessed for fall risk and Care Plan and Group Sheets updated to reflect changes. The IDT used the resident s individual fall assessment to ensure that each resident had up-to-date Interventions. Nursing staff received training on continence and falls by 6/30/16. New forms were reviewed with additional education on root cause analysis. All care plans will be reviewed quarterly and with significant changes to ensure ongoing compliance. Continued compliance will be the responsibility of the Director of Nurses, Assistant Director of Nurses and the MDS nurse. Care plan compliance will be presented to QA quarterly for 6 months then ongoing as needed.	

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F 280	Continued From page 20 knees. Care plan indicated staff were to encourage R96 to ask for staff assistance as needed. - R96 was going through drawer in closet and wheelchair flipped over on 11/18/15. Care plan indicated staff were to remind R96 to ask for assistance to reach items in closet drawers, encourage to move wheel chair closer to area she is working on and not reach past core balance. -- R96 was found sitting on the bathroom floor on 11/21/15, at 6:10 p.m. Care plan did not indicate new interventions -On 11/21/15, at 9:42 p.m. R96 was found on the bathroom floor crying. R96 told staff she had fallen again while transferring from wheelchair to toilet. Care plan indicated staff were to encourage R96 to follow through with physical therapy and occupational therapy recommendations for strengthening and to use call light to summon staff as needed with toileting. -On 12/18/15, at 6:00 p.m. R96 was found on floor in front of bed. R 96 told staff the she had forgotten to lock her wheel chair brakes. Care plan instructed staff to encourage and remind R96 to lock wheelchair brakes before all transfers. -On 1/10/16, at 1215 a.m. R96 was found on floor in room lying on right side in front of bed. R96 stated that had missed a step while transferring self from bed to wheelchair. Care plan indicated DX of dehydration and low potassium on care plan with statement, "drinks fluids through out the day independently."	F 280		

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- 1/12/16, at 2:40 p.m. R96 was found on floor next to bed. Care plan indicted a appointment was made for neurology.

-3/2/16 at 12:18 a.m. R96 was found on the floor in the bathroom. Care plan instructed staff to encourage resident to use call light and follow up with doctor about neurology scans.

Care plan does not address use of grab bar on bed or toileting schedule to reduce incontinence or falls in the bathroom. Care Plan does not address cause of dehydration or interventions to prevent a reoccurrence. Care plan does not indicate what therapy recommendations R96 is to be encouraged to follow.

Undated Nursing Assistant Sheet instructed staff that R96 required assistance with transfers, uses a wheelchair, requires assistance with toileting, was a smoker and had a colostomy. The nursing assistant assignment sheet did not identify R96 as being at risk for falls, needing reminders to ask for assistance, to lock wheelchair brakes or to encourage R96 to use a call light for staff assistance. There was no indication of R96 having any behaviors with staff or during cares.

During interview on 5/18/16, at 2:24 p.m. R96 said, "I transferred myself to bed and walked a few steps today. R96 said quite a few times when I use the call light they come right away. I try to remember to use the call light but do not always. I do not know why I fall. The falls started at Anoka Regional Treatment Center."

During interview on 5/18/16, at 3:00 p.m. NA-F said R96 does most of the work, R96 grabs the

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the grab bar. I just stand by.

During interview on 5/19/16, at 1:07 p.m. the director of nursing (DON) verified interventions for falls. DON stated R96 was able to use call light. DON verified that R96 was sent to the Emergency room after the 1/10/16, and that R96's potassium was low and R96 received intravenous fluids to correct dehydration and low potassium. DON verified intervention was to encourage R96 to call for help and did not address interventions for dehydration. The DON said If encourage a resident to use a call light is part of the interventions it is ok, if it is the only intervention it is not ok. When asked how do you communicate new interventions to the nursing assistants the DON said make sure the nurse on the floor knew the interventions so that they could tell the nursing assistants. DON said we use communication page in Point Click Care and all staff could see this. Requested copy of communication regarding R96 falls but it was not provided.

Undated Policy and Procedure for care planning and care conferences instructed staff: "It is the policy of Bywood East Health Care Center that a comprehensive, individualized plan of care be developed for each resident. The care plan will be initiated at the time of admission and will be updated as needed to reflect any changes or additions to the resident's care."

R17 had been admitted to the facility on 4/12/13. At the time of admit, R17 was identified as continent of urine. An annual Minimum Data Set (MDS) dated 4/23/16 indicated R17 was cognitively intact and required extensive assist of

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one staff for toileting and personal hygiene. The 4/23/16 MDS further indicated R17 was frequently incontinent of bladder, occasionally incontinent of bowel, and had not had a trial of a toileting program. A Bladder assessment dated 4/22/16, identified urinary incontinence evidenced by wet clothes or incontinence pad.

R17's care plan dated 5/3/16, indicated R17 had behaviors with toileting, and was previously continent of bowel and bladder. The care plan directed staff to discourage caffeine if possible, offer reminders to use the toilet, and toilet using assistance of one staff. The care plan did not identify an individualized toileting schedule nor did it identify interventions related to R17's behaviors.

A facility document titled 2nd Floor Day Shift Toileting, dated 5/20/16, indicated R17 was to be toileted with assistance of one staff before breakfast and before lunch and included boxes for staff to initial when completed. The document did not identify individualized needs for R17.

During an observation on 5/17/16, at 9:44 a.m., R17 was ambulating in the hallway on the unit. She had two wet spots in her pants visible from the back, between her legs.

During an observation on 5/18/16, at 1:26 p.m. R17 was ambulating independently in the hallway of the unit. She had urine dripping down her legs and onto the floor from her room to the nurses station, approximately 15-20 feet. Staff assisted R17 back to her room to assist her with toileting. R17 did not display any behaviors when approached to use the bathroom.

During an interview on 5/18/16, at 1:32 p.m.

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F 280	Continued From page 24 nursing assistant (NA)-G stated R17 was incontinent. She stated the staff toileted the residents when they got up and after meals. NA-G stated R17 would go to the bathroom if staff offered. During an interview on 5/19/16, at 5:34 a.m., NA-D stated R17 received encouragement to use the bathroom at 12:00 a.m., 2:00 a.m., and 4:00 a.m. NA-D stated she does not display any behaviors and will go if offered. During an interview on 5/19/16, at 11:04 a.m., registered nurse (RN)-C stated no one in the facility is on an individualized toileting plan. She stated if a resident is incontinent they are toileted after breakfast and after lunch.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility facility failed to ensure the plan of care was implemented for 1 of 4 residents (R103) reviewed for falls. Findings include: R103's admission minimum data set (MDS) dated 5/11/16, indicated he was severely cognitively impaired, required extensive assist of two staff for	F 282	The facility continues to review and develop care plans that include interventions for all residents. Facility staff are aware of these interventions and use them to provide care for residents. R103 s falls have been reviewed and he has been reassessed using the fall risk assessment. His Care Plan and Group sheets have been revised to indicate that R103 is at risk for falls.	6/30/16

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F 282	Continued From page 25 toileting, transfers and ambulation and indicated he had a history of falls prior to admission to the facility. R103's care plan dated 5/13/16, identified R103 was a risk for falls and interventions directed staff to transfer R103 using assist of two staff for safety, and to apply an alarm when R103 was in bed or up in a wheel chair. A facility document titled 2nd Floor AM Shift Toileting dated 5/15/16, indicated R103 required assist of two staff for toileting. Standard toileting terms identified on the document indicated "transfer belts are used for two person toileting." A review of Bywood East Health Care Progress Notes indicated on 5/10/16 R103 had been found on the floor in another resident's room at 10:00 p.m. and that his chair alarm had been off. During an observation on 5/19/16 at 6:36 a.m., R103 ambulated independently out of his room and into hallway and fell onto his buttocks and side. R103's pants were soaked with urine. R103's wheel chair was in his room and the alarm was not sounding. During an observation at 7:13 a.m., nursing assistant (NA)-D and NA-E assisted R103 to the bathroom. R103 was wheeled to a grab bar in the bathroom where he stood while NA-D and NA-E pulled down his pants and lowered him to a shower chair. The shower chair was wheeled to the toilet. During the transfer, R103 was not wearing a transfer belt. NA-D changed R103's pants and then wheeled the chair back to the grab bar. R103 was assisted to stand up from the shower chair, his feet were pressed against the wall while holding onto the bar with his body at an	F 282	The IDT used the resident s individual fall assessment to ensure that each resident had up-to-date interventions. Care plan changes made during Falls or Behaviors will be communicated to staff using the 24 hour books on each station. All staff have received education on the expectation that they review the 24-hour book when coming on to their shift. Charge nurses and/or TMAs will be responsible to ensure that direct care staff comply. All care plans will be reviewed quarterly and with significant change. Continued compliance will be the responsibility of the Director of Nurses, Assistant Director of Nurses and the MDS nurse. Care plan compliance will be presented to QA quarterly for 6 months then ongoing as needed.	

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F 282	Continued From page 26 angle. A transfer belt was not applied during this transfer either. While NA-D and NA-E applied a clean incontinent brief for R103, the resident was observed to hold on to the bar and lean against NA-E's left thigh for support. NA-D stated, "We are supposed to use a transfer belt." During an interview on 5/19/16, at 6:37 a.m., trained medication aide (TMA)-B stated R103 was at risk for falls. She stated he is supposed to have an alarm in his wheel chair and in bed. TMA-B looked at the alarm on R103's chair and stated it had not been turned on. During an interview on 5/19/16, at 6:44 a.m., registered nurse-B stated R103 is supposed to have an alarm on because he has had a lot of falls. During an interview on 5/19/16, at 11:03 a.m. licensed practical nurse-A stated a transfer belt should be used for all resident who require assistance with transfers. During an interview on 5/19/16 at 11:03 a.m., the director of nursing stated R103 required a two staff transfer and stated a transfer belt should be used for all residents who require assistance with transfers. A care plan policy was requested, but not received.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		6/30/16

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F 315	Continued From page 27 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to promote continence for 2 of 4 residents (R17, R103) reviewed for urinary incontinence. Findings include: R17's annual Minimum Data Set (MDS) dated 4/23/16 indicated she was cognitively intact and required extensive assist of one staff for toileting and personal hygiene. The MDS further indicated R17 was frequently incontinent of bladder and occasionally incontinent of bowel and had not had a trial of a toileting program. A Bladder assessment dated 4/22/16 identified urinary incontinence evidenced by wet clothes or incontinence pad. The assessment did not identify type of incontinence but indicated R17 had behaviors with toileting and indicated she was previously independent and continent of both bowel and bladder upon admission. The assessment Staff reminded R17 to toilet periodically through the day and received extensive assist due to need for peri care. R17's care plan dated 5/3/16 indicated she was confused, forgetful, and had little insight into her	F 315	The facility continues to review and develop care plans that include interventions for all residents. Facility staff are aware of these interventions and use them to provide care for residents. R103 and R17 were reassessed for toileting and their Care Plans and Group Sheets updated to reflect changes. The facility developed and implemented a new 3-day bowel and bladder form to identify resident patterns of incontinence, abilities for retraining and individual needs. Nursing staff was educated on bowel and bladder incontinence, the 3-day bowel and bladder form, and how to use the daily worksheet to promote resident continence. The last 90 days of MDS assessments were audited to identify residents who were assessed as incontinent. Ongoing reassessments will occur with the MDS schedule and any significant changes. Continued compliance will be the responsibility of the Director of Nurses, Assistant Director of Nurses and the MDS nurse. Compliance will be presented to QA	

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F 315	Continued From page 28 mental illness. The care plan further indicated she had behaviors with toileting and was previously continent of bowel and bladder. The care plan directed staff to discourage caffeine if possible, offer reminders to use the toilet, and toilet using assistance of one staff. The care plan did not identify an individualized toileting plan. A facility document titled 2nd Floor Day Shift Toileting, dated 5/20/16, indicated R17 was to be toileted with assistance of one staff before breakfast and before lunch and included boxes for staff to initial when completed. The document did not identify specific needs for R17. A Bywood East Health Care Progress Note dated 1/30/16 indicated R17's room had an odor. Staff checked her room and found she had defecated in her trash can. During an observation on 5/16/16, at 1:43 p.m. R17's room had a strong urine odor. Her garbage can contained an incontinent brief soiled with urine. During an observation on 5/17/16, at 9:44 a.m., R17 was ambulating in the hallway on the unit. She had two wet spots in her pants visible from the back, between her legs. During an observation on 5/18/16, at 1:26 p.m. R17 was ambulating independently in the hallway of the unit. She had urine dripping down her legs and onto the floor from her room to the nurses station, approximately 15-20 feet. Staff assisted R17 back to her room to assist her with toileting. During an interview on 5/18/16, at 1:32 p.m. a nursing assistant (NA)-G stated R17 was	F 315	quarterly for 6 months then ongoing as needed.	

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incontinent once in a while. She stated the staff toileted the residents when they got up and after meals. NA-G stated R17 would go to the bathroom if staff offered and stated she had been wetting more heavily recently.

During an interview on 5/19/16, at 5:34 a.m., NA-D stated R17 received encouragement to use the bathroom at 12:00 a.m., 2:00 a.m., and 4:00 a.m. NA-D stated she does not display any behaviors and will go if offered. She stated if staff do not wake her up, R17 will be incontinent.

During an interview on 5/19/16, at 11:04 a.m., registered nurse (RN)-C stated no one in the facility is on an individualized toileting plan. She stated if a resident is incontinent they are toileted after breakfast and after lunch.

R103's admission minimum data set (MDS) dated 5/11/16 indicated he was severely cognitively impaired, required extensive assist of two staff for toileting, transfers and ambulation. A care area assessment (CAA) dated 5/11/16 indicated R103 was frequently incontinent of bladder due to urinary urgency and need for assistance with toileting.

R103's care plan dated 5/13/16, identified the resident had frequent urinary incontinence and indicated staff report he will urinate on the toilet when assisted to the bathroom. The care plan directed staff to provide physical sassiest with toileting, but did not identify any frequency. The care plan further directed staff to use verbal reminders for urine control even though R103 was severely cognitively impaired.

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F 315	Continued From page 30 A facility document titled 2nd Floor Day Shift Toileting, dated 5/20/16, indicated R103 was to be toileted with assistance of two staff before breakfast and before lunch and included boxes for staff to initial when completed. The document did not identify specific needs for R103. A review of Bywood East Health Care Progress Notes indicated on 5/2/16 at 12:00 a.m., R103 attempted to stand up by himself, took a couple of steps, and fell backwards on to his buttocks. The note indicated he had been incontinent of urine. During an observation on 5/19/16 at 6:36 a.m., R103 ambulated independently from his room to the hallway and fell onto his buttocks and side. R103's pants were observed to be soaked with urine. During an interview on 5/19/16, at 6:53 a.m. NA-D stated she did not know when R103 was supposed to be toileted. She stated she normally works the p.m. (evening) shift and stated they take him to the bathroom before and after supper. She further stated she did not know where to find the toileting sheet for the day shift. During an interview on 5/19/16 at 11:04 a.m., registered nurse (RN)-C stated no one in the facility is on an individualized toileting plan. She stated if a resident is incontinent, they are toileted after breakfast and after lunch. She stated some residents go before meals. RN-B further stated during the MDS assessment period a Resident Toileting Pattern Worksheet was completed by the nursing assistants. A review of R103's worksheet dated 4/29/16	F 315		

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F 315	Continued From page 31 through 5/2/16, indicated the type of incontinent product worn, how much assistance was required and whether he was wet or dry when toileted however, the worksheet was not completed for 6 of 12 shifts and did not identify specific times he was toileted. The facility was asked to provide their policy for bowel and bladder assessment but none was received.	F 315		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to thoroughly assess, investigate and implement interventions to minimize the risk of elopement for 1 of 4 residents (R13) reviewed for accidents. The facility's failures resulted in an immediate jeopardy (IJ) with potential for serious harm for R13. In addition, the facility failed to thoroughly investigative causative factors for falls in order to determine appropriate interventions to reduce the risk of falls for 2 of 4 residents (R103, R96) reviewed for falls. The immediate jeopardy began on 4/12/16, when	F 323	F323 The facility continues to ensure that the safety of all residents, R13 was reviewed for safety on 5/17/16 at 5:00 pm. He was placed in the semi-secure unit with 15 minute visual checks. IDT developed a temporary care plan to increase his one-on-one activities and ensure that he was taken to smoke safely. Through the combined efforts of the IDT and staff, the resident remained free of elopement over the next two days until discharged a more secure building.	6/30/16

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R13 was determined to be unsafe to leave the facility unsupervised. The director of nursing (DON) was notified of the immediate jeopardy on 5/17/16, at 5:00 p.m. The IJ was removed on 5/18/16, at 12:50 p.m. however, non-compliance remained at a lower scope and severity of D, indicating an isolated issue with potential for more than minimal harm for R13.

Findings include:

R13's Admission Record Resident Information Sheet indicated he had diagnoses including schizoaffective disorder, impulse disorder and borderline intellectual functioning. An admission Minimum Data Set (MDS) dated 3/24/16, indicated R13 had intact cognition and was independent with all activities of daily living.

Although facility staff were aware R13 had displayed behaviors of elopement at his previous placement prior to the resident's admission, a Health Care Center Assessment For Resident's Ability To Leave Facility Safely dated 3/11/16, indicated R13 could leave the facility unescorted. The rationale for allowing R13 to continue to go into the community independently was documented as, "went out independently at prior facility."

R13's care plan dated 3/22/16, identified a potential for abuse to self and/or to/from others related to impulsive behaviors and borderline intellectual functioning. The care plan identified a history of unsafe behaviors. "such as running out into the street without looking, approaching strangers in the community" and "going up to strangers' cars in traffic." Care planned interventions included: assessing and reviewing

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The facility IDT reviewed all residents on 5/17/16 with review of their Health Care Center Assessment for Resident s Ability to Leave the Facility Safely (RALFS), current wander guard list, and care plans. The facility developed a wander risk assessment and completed it for the entire building on 5/18/16. The two lists were compared with 100% agreement in residents at risk.
Incident reports have been refined to improve data collections and staff has been educated to report any wandering or elopement that results in the resident being out of the sight of staff or reaching the public sidewalk or alley. Additionally, as needed the Life Skills / Safety Pedestrian Safety Evaluation will be utilized when concerns are identified.
IDT reviews and updates RALFS quarterly and as needed, the list is reviewed for changes at Falls and Behavior meetings and updates are distributed to all departments.
The facility trained staff to use the list to identify residents who needed escorts, wore wander guards, where an elopement risk, and stair mobility. Group sheets have been updated to include residents at risk to fall.
The facility continues to report and investigate all concerns. The IDT reviewed all policies involving abuse, neglect and mistreatment. The incident policy was reviewed with all staff.
IDT will review all incidents within 72 hours. All open investigations will be reviewed at morning stand up meeting.
All open investigations will be reviewed

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F 323	Continued From page 33 quarterly, documenting and reporting any incidents, educating staff, monitoring and intervening as needed. The care plan further identified use of a Wanderguard (bracelet system that activated selected doors when attempting exit) due to engaging in unsafe behaviors outside of the facility. The care plan also indicated R13 had displayed these behaviors at his previous facility. The facility's Health Care Progress Notes dated 3/11/16 through 5/18/16, revealed the following: 1) 3/13/16 R13 was described at restless, was wandering about the first floor of the facility and attempted to get out of the front door. 2) 3/14/16 Medical records staff reported as she was parking her car on Central Avenue (a busy metro street), R13 walked across the street and approached her car window. A subsequent note indicated another staff was parking her car and R13 also approached her car on the driver's side with cars coming in the same direction. 3) 3/16/16 Staff pulled up in front of the building and R13 approached the car on the drivers side in the lane of oncoming traffic. A subsequent note indicated R13 attempted to exit the facility seven times within one hour and indicated "he walks up to the traffic light and the alley." Another note on the same day indicated R13 had been running in and out of the facility begging for money from visitors. 4) 3/18/16, Staff was walking by the first floor lobby and heard alarm sounding from the door leading to the outside. Staff turned off the alarm and upon returning outside observed R13 running	F 323	and morning stand up using a log. The Administrator, Director of Social Services or designee and Director of Nurses or designee will review the log weekly. Continued compliance will be the responsibility of the Director of Nursing, the Assistant Director of Nursing and the Director of Social Services. The log will be presented to QA quarterly for 6 months then ongoing as needed.	

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F 323	Continued From page 34 across Central Avenue to the bus stop. 5) 3/26/16, At approximately 3:00 a.m. staff observed R13 outside the back door. R13 stated he did know when he went outside, but demonstrated how he exited. The note indicated R13 held his arms and hands at shoulder level and was able to exit through the door without sounding the alarm. 6) 4/2/16, R13 was knocking on the front door to be let in at 2:15 a.m. and again at 2:30 a.m. At 4:45 a.m. R13 was observed leaving via the south stairwell. 7) 4/3/16 At 5:15 a.m. R13 was observed going out the back door with another resident. When the other resident returned R13 was not with him. Staff went outside to look for R13 but did not find him. Staff got into a car to look for R13 and found him walking south from the local pharmacy several blocks away. R13 was crossing the street "irregardless of any passing car." At 7:00 a.m. another staff was driving south to work and observed R13 to be walking "haphazardly" south on the sidewalk. 8) 4/5/16 Staff responded to the exit door alarming to find R13 crossing the street to the median and then crossing to the other side. A second note indicated later in the day another resident called out loudly reporting R13 had gone outside via the fire door. The alarm did not sound so staff thought the resident was mistaken. "Somewhat later" R13 appeared at the locked front door knocking to get in. 9) 4/6/16 R13 was heard pounding on the main lobby door at 1:00 a.m. and could not state how	F 323		

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long he had been outside.

10) 4/7/16 At 3:00 a.m. R13 was knocking on the glass of the front lobby door to gain access. "Staff on his floor was not aware he had eloped."

11) 4/9/16 R13 was brought back into the facility at least four times since 4:00 a.m. At 10:30 a.m. R13 went out the back patio door and into the alley. Staff could not see him until he reached Central Avenue and already several blocks away. He was escorted back to the facility.

12) 4/11/16 A note indicated despite the use of a Wanderguard, R13 left the building "up to 15 times per day." The note further indicted staff was to complete a community safety awareness test to check for appropriateness of the Wanderguard.

13) 4/12/16 Life Skill/Life Safety evaluation performed. R13 was able to answer most questions without issue but was unable to demonstrate his actual ability to put what he could verbally state into practice.

The Life Skill/Life Safety Pedestrian Safely [sic] evaluation dated 4/12/16, indicated the following: "R13 does not understand the importance of signing in/out of the facility...20 seconds after reminder, he forgot what to do." R13 was not able to recite the facility address and phone number, did not have a cell phone, nor did he have a wallet or identification card. The assessment further identified R13 "did not understand jay walking, did not cross the street appropriately, and did not demonstrate an ability to look both ways before walking across the street...writer had to hold resident back. Very impulsive." R13 was unable to demonstrate a need to wait for traffic to

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clear and had to be held back several times for safety reminders. The assessment indicated R13 did not hold his head up when walking, walked between parked cars, and "is very impulsive, poor decision making skills. Walks into the street with no regard for safety."

After the evaluation had been completed, there was still no indication the facility had implemented intervention to promote safety and reduce the risk of elopement which resulted in the following incidences:

1) 4/19/16, R13 left the building several times, setting off the fire alarm door twice but the sound was not loud enough to be heard from the 1st floor desk. He had gone out the front door and "sometimes his wander guard sets off the alarm and sometimes not...At least once he has taken off down the side walk and when staff requested he return, he refuses."

2) 4/24/16, At 4:00 p.m. R13 was outside the facility pushing a local pharmacy shopping cart with a couple of bags of pop.

3) 4/27/16, Staff member reported that R13 was observed on the south side of Central Avenue at 6:45 a.m. R13 crossed Central Avenue without looking both ways. As he crossed into the northbound lane "a car had to stop quickly to avoid hitting him."

4) 4/28/16, At 6:00 p.m. the assistant director of nursing saw R13 at 37th avenue and Central Avenue, approximately three blocks from the facility.

5) 5/3/16, A late entry note for 5/2/16, indicated

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R13 was observed walking across Central Avenue over the railroad tracks through traffic. He then went to the bank and was asking strangers for money.

6) 5/7/16, R13 eloped from the facility at approximately 1:35 a.m. through the south emergency exit and could not be seen in the dark. He did not return for approximately 20 minutes. At 4:45 a.m. R13 set off both the parking lot door alarm and the emergency exit alarm. R13 appeared to be "panhandling" on Central Avenue and refused to come back into the building.

7) 5/10/16, R13 went out the front door for the sixth time that evening. R13 walked north on Central Avenue, got to a corner and crossed during a red light without looking. "A car narrowly missed him," he continued up the road.

8) 5/17/16, A late entry note for 5/16/16, indicated staff found R13 at 37th Avenue and Central Avenue. He appeared to be headed back toward the facility, and refused a ride offered by staff.

During an observation on 5/17/16, at 12:34 p.m. R13 was lying in his bed and appeared to be asleep. A Wanderguard bracelet was observed on R13's right wrist.

During an interview on 5/17/16, at 12:38 p.m. a nursing assistant (NA)-A stated no one on the third floor was considered an elopement risk at that time. She stated two residents on the unit wore Wanderguard bracelets, but was not aware R13 had one. NA-A stated if a resident with a Wanderguard attempted to go downstairs in the elevator the elevator would not work however, a

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resident could exit the unit via the stairs while wearing a Wanderguard bracelet.

NA-B stated on 5/17/16, at 12:43 p.m. the Wanderguard bracelet would activate the elevator and the exit doors of the facility . She stated she was aware R13 wore a Wanderguard bracelet, but further stated he has left the facility while wearing the bracelet. NA-B explained the second floor residents with Wanderguard bracelets were to be checked every 30 minutes, but the whereabouts of third floor residents was not also routinely monitored.

During an interview on 5/17/16, at 12:48 p.m. trained medication aide (TMA)-A stated, "When a resident with a Wanderguard attempts to leave the facility the door will alarm." TMA-A also said staff are aware of who was at risk for elopement "because they wear a Wanderguard bracelet." She stated the facility had a machine used to check the functioning of the Wanderguard bracelets but, but TMA-A was unsure whether there was documentation to that effect. A review of R13's May 2016, medication and treatment administration records did not reflect evidence of monitoring for placement or function of the Wanderguard.

The director of nursing (DON) stated during an interview on 5/17/16, at 1:50 p.m. R13 was unsafe to be out of the facility unsupervised. She explained he wore a Wanderguard but was able to get out of the door before the alarm sounded off by lifting up the arm while wearing the bracelet. The DON also stated the facility had been working with R13's day program to find interventions to keep him from eloping from the facility. She added, "The social worker developed

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a budget for him and the facility has purchased chewing tobacco in an effort to tide him over between cigarette breaks."

During a subsequent interview with the DON at 3:50 p.m. on 5/17/16, the DON stated if R13 leaves the facility and would not return, staff would sometimes follow him and other times observed him from the building. However, she stated if he left and could not be seen, staff waited for him to return. The DON verified there had been times when R13 had been out of the facility and not within sight of staff. She stated on the night shift there were two TMA's, one nursing assistant, and one nurse on duty. Staff tried to re-direct R13, but he went out another door. She stated when the over night nurse started blood glucose checks and insulin administration, they were unable to watch him. The DON stated there had been no formal investigations regarding R13's elopements from the facility, and stated she was unsure whether his psychiatrist had been updated regarding the elopements. The DON stated the medical director would have been aware of R13's elopements, but would not have written any orders or notes since he was not the resident's primary physician.

During an interview on 5/18/16, at 6:45 a.m. NA-C stated she was typically in the dining room in the morning. She stated she could "sometimes" hear the alarms. NA-C stated if an alarm sounded she would go to the door and follow R13. She stated if he wouldn't come back she would hope other staff would come and help.

A registered nurse (RN)-A stated in an interview on 5/18/16, at 6:51 a.m. R13 had become "quite talented at getting out" of the facility. She stated

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he could go out the back door and get out into the alley. RN-A stated R13 would frequently go out of the building around 4:00 a.m. and would eventually return. She stated staff tried to spot where he was going but was not always able to and stated, "He likes to go full speed across Central Avenue." She stated on the night shift she would try to get him to come back but could not abandon the building because there was not enough staff on duty.

While R13 had left the facility on multiple occasions and was assessed to be unsafe to leave the facility independently, there was no evidence the facility investigated the incidents nor was there evidence of care planned interventions to keep him from leaving the facility and wandering through high traffic areas.

A facility policy titled ...Health Care Wandering Prevention Plan Policy And Procedure dated 8/2010 was reviewed. The policy indicated the facility was to provide a safe environment for all residents and directed staff to assess the resident's needs prior to and after admission to determine his or her ability to leave the facility safely. The policy further directed staff to review the safety care plan quarterly and as needed.

The immediate jeopardy that began on 4/12/16 was removed on 5/18/16 when the facility had taken measures including: moving the resident to a more secure living unit, initiating 15 minute checks to verify the resident's whereabouts, utilizing 1:1 staffing as needed, adding additional activities and cigarette breaks for the resident, developing a system to check the resident's Wanderguard each shift, updated the primary physician and psychiatrist, and began

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F 323	Continued From page 41 investigating alternate placement options which may be more appropriate for the resident. Surveyors verified the plan had been implemented by observation of the resident, interviews with staff, and through review of the facility's documented protocols, assessment and plans. R103's admission Minimum Data Set (MDS) dated 5/11/16, indicated he was severely cognitively impaired, required extensive assist of two staff for toileting, transfers and ambulation and had a history of falls prior to admission to the facility. A Fall Risk Assessment - Admission/Annual dated 5/11/16, indicated R103 had been in the facility less than two months and had sustained multiple falls in the past six months. The assessment indicated R103 "attempts to ambulate independently but is very unsteady which has led to several falls since admission." He had an alarm on in bed and wheelchair to alert staff when he is attempting to self transfer and has had 5 falls since admission. The assessment further indicated R103 was being monitored for elevated blood pressure, has had medication adjustment and is receiving physical and occupational therapy. R103's care plan dated 5/13/16, identified a risk for falls and directed staff to remove foot rests on wheel chair, encourage use of handrails or assistive devices, reinforce need to call for assistance and refer to physical and occupational therapy. During an observation on 5/18/19, at 1:41 p.m., R103 was lying in bed on his back with one foot hanging off of his bed. He had a pressure pad alarm under him. R103 was wide awake with the	F 323		

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curtains pulled around his bed.

A review of the Health Care Progress Notes dated 4/28/16, through 5/19/16, indicated the following:

- 4/28/16, R103 admitted to the facility at approximately 12:00 p.m., At 4:15 p.m., R103 was ambulating in the dining room, tripped on his foot rest and fell, hitting his mouth on the table. A corresponding Health Care Resident Incident Report dated 4/28/16, indicated R103 had a bruise below his lower lip, alarms were placed on his wheel chair and his bed and a reminder to ambulate with staff assistance.

- 4/30/16, At 8:00 p.m., staff heard R103's alarm sounding and responded due to "NAR's, nurse and TMA all too busy." R103 was lying in bed with both feet on the floor. Staff directed R103 to stay in bed. At 8:20 p.m. R103 was found on the floor next to his bed. He had an abrasion on the left side of his head and he re-opened a scrape on his left knee. A corresponding Health Care Resident Incident Report dated 4/30/16, did not include any new interventions.

- 5/2/16, At 12:00 a.m. R103 attempted stand up by himself, took a couple of steps, and fell backwards on to his buttocks. The note indicated he had been incontinent of urine. A corresponding Health Care Resident Incident Report dated 5/2/16, indicated R103 seems to be sleeping better at night and did not include any new interventions however, a subsequent progress note indicated staff called nurse practitioner to request an order for physical and occupation therapy.

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F 323	Continued From page 43 - 5/6/16, At 12:15 p.m. R103 had a fall in the dining room. He stood up and fell to his bottom. A corresponding Health Care Resident Incident Report dated 5/6/16, did not include any interventions. An IDT review of R103's fall indicated the physician adjusted his medication. The note further indicated R103 was left in the dining room after the meal and nursing assistants were directed to stay with him until he returns to the unit. - 5/10/16, R103 was found on the floor in another residents room 10:00 p.m. His chair alarm was turned off. A corresponding Health Care Resident Incident Report dated 5/10/16, did not identify any new interventions. - 5/11/16, R103 was found on the floor by his bed at 9:00 p.m. He was found on his left side almost on his stomach with his head next to a trash can. A corresponding Health Care Resident Incident Report dated 5/11/16, indicated a bruise beginning to appear behind R103's left ear. The incident report identified the need for a half side rail to assist in mobility, however, during an observation on 5/19/16, at 7:00 a.m., no side rail was present on R103's bed. A subsequent note indicate R103 had bruising to the side of his face. -5/18/16, R103 was found on the floor by his bed at 9:35 p.m. A corresponding Health Care Resident Incident Report was requested but not received. During an observation on 5/19/16, at 6:36 a.m., R103 ambulated independently out of his room and into hallway and fell onto his buttocks and side. R103's pants were soaked with urine. R103's wheel chair was in his room and the alarm	F 323		

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was not sounding. At 7:13 a.m., NA-D and NA-E assisted R103 to the bathroom. R103 was wheeled to a grab bar in the bathroom where he stood while NA-D and NA-E pulled down his pants and lowered him to a shower chair. The shower chair was wheeled to the toilet. R103 was not wearing a transfer belt while staff assisted him. NA-D changed R103's pants and then wheeled the chair back to the grab bar. R103 was assisted to stand up from the shower chair, his feet were pressed against the wall while holding onto the bar with his body at an angle. R103 still did not have a transfer belt on and Both NA-D and NA-E were approximately 2 feet from him while hung hung on the grab bar. While NA-D and NA-E were applying a clean incontinent brief to R103, he was leaning against NA-E's left thigh for support. NA-D stated, "We are supposed to use a transfer belt" when assisting R103 to transfer.

During an interview on 5/19/16, at 6:37 a.m., TMA-B state R103 was at risk for falls. She stated he is supposed to have an alarm in his wheel chair and in bed. TMA-B checked the alarm on R13's wheel chair and stated it had not been turned on.

During an interview on 5/19/16, at 6:44 a.m., RN-B stated R103 is supposed to have an alarm on and stated he has had a lot of falls. She stated R103 is impulsive and tries to get up on his own. RN-B stated she was unaware of any fall interventions for R103 aside from the alarm. RN-B walked away stating, "I don't understand, why was he in the room by himself?"

During an interview on 5/19/16, at 6:53 a.m., NA-D stated R103 likes to stand by himself. She

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F 323	Continued From page 45 stated we keep eyes on him. NA-D stated she usually works the PM shift and staff toilet R103 before and after supper. She was unable to locate a care sheet to direct her when to toilet R103 or what fall interventions had been implemented. During an interview on 5/19/16, at 11:03 a.m. licensed practical nurse (LPN)-A stated a transfer belt should be used for all resident who require assistance. LPN-A was unable to locate a care sheet for R103 that directed staff regarding cares and safety interventions. During an interview on 5/19/16, at 11:03 a.m., the DON stated R103 required a two staff transfer and stated a transfer belt should be used for all residents unless they were independent. The DON stated when a resident in the facility falls the nurse on the floor starts an incident form. She stated the IDT reviews falls every Monday, Wednesday and Friday and looks to see what can be done differently. An undated facility document titled 2nd floor, directed staff to transfer R103 with assist but did not identify how much assistance was required. The document further directed staff to assist with toileting, but did not direct staff on level of assistance required. Further, while the document had a category for safety, there were no safety interventions listed for R103. While R103 had sustained eight falls in the facility since his recent admission, including some with minor injuries, and while the facility did attempt to put some interventions in place, there was no evidence the facility thoroughly investigated the falls in an effort to determine the	F 323		

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underlying cause of the falls. nor was there evidence that staff had been educated regarding fall interventions for R103.

A facility policy titled Health Care Fall Risk Assessment Policy And Procedure, dated 1/9/14 indicated: It is the policy of.. Health Care Center to provide protective and preventive care for the problems identified from the assessments. The policy directed staff to identify specific underlying causes for falls and develop a treatment plan and record it in the care plan.

R96's falls were not adequately investigated for root cause, in order for appropriate interventions to be developed.

R96's annual Minimum Data Set (MDS) dated 4/12/16, indicated the resident was cognitively intact but required extensive physical assist of two staff for toileting and transferring.

A Fall Risk Assessment dated 1/21/16, indicated R96 had sustained multiple falls in the past six months. The assessment indicated R96 "Is refusing to ambulate at this time, not because she is 'lazy' but because of the pain in her legs. She is using a wheelchair for primary mode of locomotion. She can propel herself, but moves at a very slow pace and staff assist to bring her to destinations prn [as needed]. She is very unsteady/shaky when she stands, and moves her feet very slowly. Staff provide assistance w [with]/bed mobility (lifting legs into bed prn) and with transfers as she is unsteady and needs staff to assist to steady self. No longer is able to transfer independently. Unknown cause for functional decline. Has been seen in the hospital and labs/testing were wnl [within normal

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F 323	Continued From page 47 limits]/negative. Requires up to three staff members depending on how she is feeling at the time. Often shaky and very stiff. Is discouraged form [sic] attempting self transfers due to the high numbers of falls (5 past quarter, one with minor injury). History of falls prior to admission, last noted June 2014." The assessment further indicated R96 displayed wandering, verbal and physical behaviors, and socially inappropriate behaviors in the previous seven days. R96's care plan printed 4/21/16, indicated a high risk for falls and instructed staff to encourage resident to ask for assistance with mobility needs/transfers when needed, ensure environment was free of clutter, evaluate effectiveness and side effects of medications with providers prn, orthostatic blood pressures weekly and reinforce need to call for assistance prn. An undated Nursing Assistant Sheet (care instructions) directed staff to provide R96 with assistance in transferring and toileting and indicated R96 had a colostomy, used a wheelchair and smoked. The instructions did not identify R96 as being at risk for falls, nor any reminders to prevent falls such as: reminders to ask for assistance, use the wheelchair brakes, or to call for assistance from staff. A review of Progress notes and the facility's Health Care Resident Incident Reports 10/1/15 through 5/18/16, indicated the following: 1) 10/23/15, R96 told staff she had rolled out of bed bed the previous night at 10:30 p.m. but was able to get up independently and "was 'fine.'" A corresponding Health Care Resident Incident Report dated 10/24/15, indicated R96 had	F 323		

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sustained a fall next to her bed on 10/22/16, at 10:30 p.m. The resident had reported falling/rolling out of bed, but later said she was transferring from her wheelchair and fell to her knees. Under the prevention section, it indicated it was an isolated incident, therefore the new intervention section was left blank. Under interdisciplinary team (IDT) meeting notes, staff were to encourage R96 to ask for staff assistance as needed.

2) 11/18/15, at 8:15 p.m. R96 fell in her room next to her closet. When staff asked R96 what had happened, she explained the wheelchair flipped over. The resident complained she had hit her head, shoulder and back, but denied pain. A corresponding Health Care Resident Incident Report dated 11/18/15, indicated R96 was going through a drawer in her closet when the wheelchair flipped over. The prevention and new intervention sections were left blank. The IDT notes section (also dated 11/18/15) indicated staff was to remind the resident to ask for assistant to reach times in closet and not to reach past core balance.

3) 11/21/15, at 6:10 p.m. R96 was found sitting on the bathroom floor. The resident reported she had deliberately sat on the floor. Staff had assisted her onto the toilet and went on break. The incident report was requested, but was not provided.

4) 11/21/15, at 9:42 p.m. R96 was found on the bathroom floor crying. R96 told staff she had fallen again while transferring from the wheelchair to the toilet. A corresponding Health Care Resident Incident Report dated 11/21/15, indicated the resident slipped and hit the left side

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of her head while attempting to independently stand. The prevention and new intervention sections were blank. the IDT notes dated 11/25/15, noted staff was to encourage R96 to follow through with physical and occupational therapy recommendations for strengthening and to use call light to summon staff as needed with toileting.

5) 12/18/15, at 8:46 p.m. R96 was found on floor in front of her bed. R 96 told staff she had forgotten to lock her wheelchair brakes. A corresponding Health Care Resident Incident Report dated 12/18/15, indicated R96 was found on the floor at 6:00 p.m. when the wheelchair rolled away from her when she forgot to lock her brakes. On the incident report, under the prevention section, nothing had been filled in and the new intervention section was also blank. Interdisciplinary Team meeting notes dated 12/21/15, instructed staff to encourage and remind R96 to lock wheelchair brakes before all transfers.

6) 1/10/16, at 1215 a.m. R96 was on floor in room lying on right side in front of bed. R96 stated she had missed a step while transferring herself from bed to wheelchair. The resident was reminded to use call light for staff assistance with transfers. A corresponding Health Care Resident Incident Report dated 1/10/16, indicated R96 was found on the floor at 12:15 a.m. On the incident report, under the prevention section, documentation indicated R96 required assist of one to transfer but forgets to put her call light on for staff assist. The new intervention section indicated the call light should be used by R96 during the day and suggested staff should offer assist with rounds .

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7) Subsequent notes from 1/11/16, at 3:37 p.m. indicated R96 was very difficult to transfer, was leaning forward and was hunched over. The doctor was updated. On 1/11/16, at 8:01 p.m. R96 was sent to a local emergency room (ER) for evaluation. The Emergency Center Visit Note dated 1/12/16, identified the resident's diagnoses as: fall, dehydration and low potassium. Documentation indicated R96 had returned from the ER at 3:24 a.m. on 1/12/16.

8) 1/12/16, documentation from 4:10 p.m. indicated R96 had been found on floor at 2:40 p.m. Resident stated she had been reaching for a pop, fell, and hit her head on a waste can. The note indicated R96 had sustained a one inch laceration to her forehead. A corresponding Health Care Resident Incident Report dated 1/12/16, indicated R96 was found on the floor at 2:30 p.m. On the incident report, under the prevention section, documentation indicated R96 had difficulty transferring and was suppose to use call light to have staff assist. However, the notes indicated R96 had not called for help. The section for new interventions was left blank.

9) 1/16/16, at 3:36 p.m. NA-C charted, "I think she would benefit a lot if she could transfer down to second floor, where there are more staff available to help with cares."

10) 3/2/16, at 12:18 a.m. R96 was lying on the floor. R96 stated she had fallen, and had hit her head against the bathroom door. A corresponding Health Care Resident Incident Report dated 3/2/16, indicated R96 had been found on the floor in the bathroom. The section for prevention on the incident report had been left blank. The new intervention section included instruction for staff

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to assist the resident to toilet and encourage resident to use call light.

Documentation in the progress notes from 3/14/16, at 2:42 p.m. indicated R96 was being moved to the second floor the following day.

During interview on 5/18/16, at 2:24 p.m. R96 said, "I transferred myself to bed and walked a few steps today." R96 also stated, "Quite a few times when I use the call light they come right away. I try to remember to use the call light but do not always. I do not know why I fall. The falls started at Anoka Regional Treatment Center."

NA-F stated on 5/18/16, at 3:00 p.m. R96 "does most of the work. [R96] grabs the the grab bar. I just stand by."

During interview on 5/19/16, at 1:07 p.m. the director of nursing (DON) verified the interventions identified for R96 post incidents included: encouraging R96 to use call light and not go to the bathroom by herself, to encourage R96 to not reach past center of balance, and to encourage R96 to lock her wheelchair brakes. The DON said, "we are developing a new incident report. We know the incident reports could be filled out more completely. I think the IDT team has a good grasp of root cause analysis, we are working with the nurses. As we start using the new form we will be identifying true root cause analysis." The DON said when encouraging a resident to use a call light is part of the interventions it is ok, but if it is the only intervention it would probably not be adequate. When asked how new interventions were communicated to the NAs, the DON stated "we make sure the nurse on the floor knows the

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F 323	Continued From page 52 interventions so they can tell the nursing assistants. We also use a communication page in Point Click Care (electronic medical record) and all staff can see it." A copy of the communication pages for R96s falls was requested, but none was provided.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		6/30/16

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F 431	Continued From page 53 quantity stored is minimal and a missing dose can be readily detected.	F 431		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were securely stored, and/or failed to ensure expired medications were removed from use for medications stored on 3 of 3 floors. Findings include: During a random observation on 5/16/16, at 11:44 a.m. the first floor medication and treatment carts were observed to be unlocked. There were no licensed staff within sight of the medication cart. Residents were observed to pass by the carts on their way to lunch. Upon further review, the medication cart was observed to contain resident medications including blood pressure medications, diuretics, and over the counter medications. During interview on 5/16/16, at 12:00 p.m. registered nurse (RN)-D acknowledged she had not locked the carts stating, "I received a phone call and forgot to lock the carts." During a random observation on 5/16/16 at 7:30 p.m., the second floor medication cart was observed to be unlocked. There were no licensed staff present in the area. Three residents were observed to be walking in the hallway. On 5/16/16 at 7:47 p.m. Licensed practical nurse		The facility will safely store all medications and ensure that expired medications have been removed from carts timely. All medications carts have been replaced by contracting pharmacy on 6/22/15. An insulin cart was established and an area for the clinic identified in the living room area. Medications are checked for expiration weekly by the night shift. Medications found to be expired are removed to the Nursing Office for destruction. Two audits have been established, including a weekly cart audit completed by Nursing and random checks performed by IDT. All nursing staff have reviewed the policy of medication storage. Continued compliance will be the responsibility of the Director of Nursing and the Assistant Director of Nursing. Results of the audits will be reported to QA quarterly for six months and then PRN as needed.	

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(LPN)-B verified the cart was unlocked and shouldn't have been. Upon further review, the medication cart was observed to contain resident medications including blood pressure medications, diuretics, and over the counter medications.

During the medication storage observation on 5/19/16 at 7:31 a.m., the second floor medication cart was observed to have the following expired medications available for use: a bottle of fish oil 500 mg (milligrams) with expiration date 3/16, a bottle of multivitamins with minerals with expiration date 3/16, a bottle of One-Daily multivitamin with an expiration date of 1/16, and a bottle of adult enteric coated aspirin 325 mg with an expiration date of 3/16. At that time, the trained medication aide (TMA)-C verified these medications were expired and stated it was the responsibility of every TMA to ensure expired medications were removed from the medication carts.

During the medication storage observation on 5/19/16 at 7:47 a.m., another second floor medication cart was observed to have expired medications available for use: a card of Zyprexa 5 mg for R96 was labeled as having expired 4/30/16, a bottle of fish oil 500 mg had an expiration date of 3/16, and a bottle of multi-vitamin with minerals had an expiration date of 1/16. LPN- A verified these medications had expired and stated the facility's consultant pharmacy comes out and audits the medication carts. LPN -A also said nurses and TMA's are responsible to ensure that there are no expired medications available in the medication carts.

During a random observation on 5/19/16, 12 vials

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F 431	Continued From page 55	F 431		

of Novolog insulin, 12 vials of Lantus, two Novolog flex pens, insulin syringes, and flex pen needles were noted to be unsecured in a screened area on 3rd floor where insulins were administered. There was no nurse or TMA in the area. The screened area was open in the front and in the rear. R103 and R92 were sitting immediately outside the screened area.

During interview on 5/19/16 at 8:12 a.m. registered nurse (RN)-B said she normally does leave the insulin out and stated, "Nobody touches the insulin, I figure the TMA can see if they come in. I have never had any trouble. People know to stay out until it is their turn." RN-B also stated there was a camera in place in the area. However, upon further questioning, RN-B verified someone could enter through the back area without being seen on the camera. RN-B also stated she preferred to do blood sugars and insulin in the nurses' office, but "the day nurses like to do away from that area." RN-B verified she had responded to a fall on second floor from 7:35 a.m. to about 7:45 a.m. during which time the insulins were left behind the screen unsecured. RN-B stated there was a TMA on the first floor during that timeframe. RN-B further verified R103 and R92 were both able to walk short distances.

During a medication storage observation on 5/19/16 at 8:42 a.m., the following expired medications were found in the third floor medication cart: one bottle of vitamin C 500 mg with an expiration date of 4/16, and one bottle of ibuprofen 200 mg with an expiration date of 2/16. TMA-D verified these medications were expired and stated, "we cleaned the cart out Friday and found expired meds. I don't know how you found

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 ______	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYWOOD EAST HEALTH CARE	3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 56 any in the cart. If we have expired medications we take them downstairs to the nursing office". During an interview with the director of nursing (DON) on 5/19/16 at 1:07 p.m., the DON stated she expected staff to ensure medication carts and medications were secured and/or locked when not in the nurse or TMA's view. Finally, the DON said it was her expectation that expired medications would be removed from the medication carts and brought down to the nursing office for destruction. The facility's Policy and Procedure for Storage of Medication revised 11/2012, instructed staff: ..."4. Insulin, IM (intramuscular) medications, nasal spray, eye drops and inhalers are all to be dated when opened and removed when expired. 5. All discontinued or expired medications will either be returned to pharmacy as allowed or brought to the nursing office for destruction. 6. Medications are stored in locked medication carts or in locked cupboards. The carts will be locked whenever the med passer is not in attendance. The keys to the cart will be kept by the med passer and/or nurse on that floor in their pockets and given to the oncoming staff at the end of shift...."	F 431		
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by:	F 458		

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	24E185	A. BUILDING ______ B. WING ______	05/19/2016

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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F 458	Continued From page 57 Based on observation and interview, the facility failed to provide at least 80 square feet of space per resident in 11 multiple resident rooms, potentially affecting 32 residents in the facility. Findings include: Eleven multiple rooms with three beds in each room, did not have the required amount of space per person. The square footage (SF) per resident was as follows: Room 101 had 232.72 SF total or 77.57 SF per resident Room 102 had 234.82 SF total or 78.27 SF per resident Room 107 had 228.72 SF total or 76.24 SF per resident Room 108 had 236.10 SF total or 78.70 SF per resident Room 109 had 231.91 SF total or 77.30 SF per resident Room 202 had 237.25 SF total or 79.08 SF per resident Room 301 had 236.72 SF total or 78.90 SF per resident Room 302 had 238.31 SF total or 79.44 SF per resident Room 307 had 236.66 SF total or 78.89 SF per resident Room 308 had 237.37 SF total or 79.12 SF per resident Room 309 had 237.08 SF total or 79.03 SF per resident The above rooms did not have the required square footage, however, those residents did not offere complaints during the survey regarding room size.	F 458	Waivered tag: no plan of correction required.	

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F 458	Continued From page 58 The facility's request for the health waiver of the following deficiency has been previously approved: F458 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LAST 80 SQ FT/RESIDENT	F 458		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on employee file review and interview, the facility failed to perform annual evaluation of employee performance for 5 of 5 employees (E1, E2, E3, E4, E5) reviewed for annual education and performance evaluation during extended survey.	F 497	The Facility will evaluate the job performance of all staff yearly. All departments have completed evaluations with staff hired between January and June. The remainder of staff will be evaluated in their months of hire. To ensure that evaluations continue in a timely manner, Human Resources will	6/30/16

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	24E185	A. BUILDING ______ B. WING ______	05/19/2016

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BYWOOD EAST HEALTH CARE	**3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418**

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F 497	Continued From page 59 Findings include: E1 was hired on 2/27/06, and did not have an annual evaluation in the personnel record, or in the ADON files. E2 was hired on 9/16/08, and did not have an annual evaluation in the personnel record, or in the ADON files. E3 was hired on 8/4/09, and did not have an annual evaluation in the personnel record, or in the ADON files. E4 was hired on 7/17/13, and did not have an annual evaluation in the personnel record, or in the ADON files. E5 was hired on 1/11/10, and did not have an annual evaluation in the personnel record, or in the ADON files. On 5/19/16, at 5:21 p.m. the assistant director of nurse (ADON) verified evaluations had not been conducted for the employees whose files were requested.	F 497	provide a list of staff to the administrator monthly. The department head or designee will complete the evaluations, returning them to the administrator no later than the third week of the month. Ongoing compliance is the responsibility of the Director of Human Recourses. Compliance will be presented to QA for 6 months and then as needed.	

BYWOOD EAST HEALTH CARE

Voice 612-788-9757
Fax 612-789-6564
www.bywoodeast.com

3427 CENTRAL AVENUE N.E.
MINNEAPOLIS, MINNESOTA 55418-1297

June 15, 2016

Ms. Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Dear Ms. Derfus:

Bywood East Health Care respectfully requests a waiver of Federal requirement F458 for the following rooms: 102, 107, 108, 109, 202, 208, 301, 302, 307, 308,and 309

We believe that the room sizes are in accordance with residents' special needs and will not and have not endangered the health or safety of the residents. Emergency personnel such as firemen and paramedics have not had any issues maneuvering in the rooms and we move objects as necessary in emergency situations.

Additionally we have implemented numerous practices to assure these rooms stay as clutter free, organized and safe as possible and additional storage is provided to each of the residents in these rooms.

Thank you for your consideration of this waiver.

If you have any questions please do not hesitate to contact me at 612-812-2196.

Thank you.

Sincerely,

Randal L. Hagemeyer
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FE185024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E185	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/18/2016**

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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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 18, 2016. At the time of this survey, Bywood East Health Care was found to be in substantial compliance with the requirements for participation in Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered. The building was constructed in 1968. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 98 beds and had a census of 95 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
June 8, 2016

Mr. Randal Hagemeyer, Administrator
Bywood East Health Care
3427 Central Avenue Northeast
Minneapolis, MN 55418

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE185025 and Complaint Numbers HE185037 and HE185039

Dear Mr. Hagemeyer:

The above facility survey was completed on May 19, 2016 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules and to investigate complaint number HE185037 that was found to be substantiated and complaint number HE185039 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be acknowledged electronically and submitted to this office at Minnesota Department of Health.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00176	A. BUILDING: ________ B. WING ________	05/19/2016

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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3 000	INITIAL COMMENTS	3 000		

*****ATTENTION******

BOARDING CARE HOME
LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00176	A. BUILDING: ______ B. WING ______	05/19/2016

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3 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 16-19, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Board and Care Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	3 000		

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3 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An investigation of complaint number HE185037 was completed at the time of the extended survey and was found substantiated at F280 and F323. An investigation of complaint HE185039 was also conducted and was found to be unsubstantiated.	3 000		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must	3 601		6/30/16

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3 601	Continued From page 3 be maintained by the boarding care home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 4 of 4 employees (E-2, E-3, E-4, E-5) had proper evaluation and documentation for tuberculosis (TB) testing and screening. In addition, the facility failed to ensure 5 of 5 residents (R8, R101, R76, R102, R104) had proper evaluation and documentation for tuberculosis testing and screening as recommended per State guidelines. Findings include: Employees E-2's personnel file review revealed a hire date of 4/8/16. E-2 had TB symptom screening completed on 4/8/16. A a step one Tuberculin Skin Test (TST) administered on 4/7/16, and read on 4/9/16, with 0 millimeters (mm) and no interpretation. There was no second step TST administered. E-3's personnel file review revealed a hire date of 10/21/10. E-3 had the TB symptom screening completed on 10/19/10. A step one TST had been administered on 10/19/10, and read 10/21/10, with 0 mm and no interpretation. The second step TST was administered on 11/11/10 and read 11/13/10, however, there was no interpretation. E-4's personnel file review revealed a hire date of 4/15/15. E-4 had TB symptom screening completed on 4/13/15. A step one TST had been administered on 4/13/15, and read 4/15/15, with	3 601	Corrected	

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3 601	Continued From page 4 0 mm The second step TST was administered on 5/5/15, and read 5/8/15, with 0 mm, however, there was no interpretation. E-5's personnel file review revealed a hire date of 11/13/15. E-5 had TB symptom screening completed on 11/12/15, a step one TST had been administered on 11/12/15, and read 11/14/15, with 0-4 mm, but no interpretation. Residents: R8's electronic medical record (EMR) indicated an admission date of 3/24/15. The TB symptoms screening was not completed. Quantiferon test done 10/15/15, was positive. A chest x-ray 10/15/15 indicated no evidence of active TB. R101's EMR indicated an admission date of 2/19/16. The TB symptoms screening was completed 3/2/16, (14 days after admission). A step one TST had been administered on 2/19/16, at 5:30 p.m. and was read 2/21/16, with 0 mm negative. The second step TST was administered on 3/7/16, at 2:45 p.m. and read 3/10/16, at 1:40 p.m. as negative 0-4 mm. Actual mm of induration was not recorded. R76's EMR indicated an admission date of 1/22/16. The TB symptom screening was completed 2/3/16, (11 days after admission). A step one TST had been administered on 1/23/16, at 10:00 a.m. and read 1/25/16, at 1:30 p.m.with negative 0-4 mm Actual mm of induration not recorded. R102's EMR indicated an admission date of 4/5/16, The TB symptom screening was completed 4/6/16, (one day after admission). A step one TST had been administered on 4/5/16, at 5:40 p.m.and read 4/7/16, at 3:30 p.m.	3 601		

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3 601	Continued From page 5	3 601		

negative 0-4 mm Actual mm of induration not recorded. The second step TST was administered on 4/20/16, at 10:30 a.m. and read 4/22/16, at 10:45 a.m. negative 0-4 mm Actual mm of induration not recorded.

R104's EMR indicated an admission date of 4/29/16. TB symptom screening was completed 4/29/16. A step one TST had been administered on 4/29/16, at 8:25 p.m. and read 5/2/16, at 11:00 a.m. negative 0 mm The second step TST was administered on 5/12/16, at 7:00 a.m. and read 5/14/16, at 2:00 p.m. negative 0-4 mm Actual mm of induration not recorded.

Regulation for Tuberculosis Control in Minnesota Health Care Settings dated 7/13, Screening Health Care Workers (HCW's) directed: "TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative)"
In addition the regulation further indicated: "HCW with a newly-identified positive TST or IGRA [Interferon Gamma Release Assay- blood test used to test TB]. Before the HCW has direct patient contact, the following should be documented in their record:
1. Test result,
2. Assessment for current TB symptoms,
3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and
4. Medical evaluation to rule out a diagnosis of infectious TB disease."

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BYWOOD EAST HEALTH CARE	**3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418**

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3 601	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents and staff are screened for physical signs and symptoms of active TB disease on admission. The DON or designee could educate the appropriate staff on the policies/procedures, and could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 601		
3 805	MN Rule 4655.4400 G Employees Personnel Records A current personnel record shall be maintained for each employee and placed on file in a locked cabinet in the office of the administrator, person in charge, or the business office. These records shall be available to representatives of the department and shall contain the following information: G. at least annual evaluations concerning employee's work performance; and This MN Requirement is not met as evidenced by: Based on employee file review and interview, the facility failed to perform annual evaluation of employee performance for 5 of 5 employees (E1, E2, E3, E4, E5) reviewed for annual education and performance evaluation during extended survey.	3 805	Corrected	6/30/16

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3 805	Continued From page 7 Findings include: E1 was hired on 2/27/06, and did not have an annual evaluation in the personnel record, or in the ADON files. E2 was hired on 9/16/08, and did not have an annual evaluation in the personnel record, or in the ADON files. E3 was hired on 8/4/09, and did not have an annual evaluation in the personnel record, or in the ADON files. E4 was hired on 7/17/13, and did not have an annual evaluation in the personnel record, or in the ADON files. E5 was hired on 1/11/10, and did not have an annual evaluation in the personnel record, or in the ADON files. On 5/19/16, at 5:21 p.m. the assistant director of nursing verified evaluations had not been conducted for the employees whose files were requested. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review policies and procedures related to employee evaluations, could develop a system to track, and could develop audits to ensure employee evaluations were completed in a timely manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 805		
31145	MN Rule 4655.7830 Subp. 4 Medication Containers;Out of date medications Subp. 4. Out of date medications. Medications having a specific expiration date shall not be used after the date of expiration.	31145		6/30/16

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31145	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were securely stored, and/or failed to ensure expired medications were removed from use for medications stored on 3 of 3 floors. Findings include: During the medication storage observation on 5/19/16 at 7:31 a.m., the second floor medication cart was observed to have the following expired medications available for use: a bottle of fish oil 500 mg (milligrams) with expiration date 3/16, a bottle of multivitamins with minerals with expiration date 3/16, a bottle of One-Daily multivitamin with an expiration date of 1/16, and a bottle of adult enteric coated aspirin 325 mg with an expiration date of 3/16. At that time, the trained medication aide (TMA)-C verified these medications were expired and stated it was the responsibility of every TMA to ensure expired medications were removed from the medication carts. During the medication storage observation on 5/19/16 at 7:47 a.m., another second floor medication cart was observed to have expired medications available for use: a card of Zyprexa 5 mg for R96 was labeled as having expired 4/30/16, a bottle of fish oil 500 mg had an expiration date of 3/16, and a bottle of multi-vitamin with minerals had an expiration date of 1/16. LPN- A verified these medications had expired and stated the facility's consultant pharmacy comes out and audits the medication carts. LPN -A also said nurses and TMA's are	31145	Corrected	

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responsible to ensure that there are no expired medications available in the medication carts.

During a medication storage observation on 5/19/16 at 8:42 a.m., the following expired medications were found in the third floor medication cart: one bottle of vitamin C 500 mg with an expiration date of 4/16, and one bottle of ibuprofen 200 mg with an expiration date of 2/16. TMA-D verified these medications were expired and stated, "we cleaned the cart out Friday and found expired meds. I don't know how you found any in the cart. If we have expired medications we take them downstairs to the nursing office".

During an interview with the director of nursing (DON) on 5/19/16 at 1:07 p.m., the DON stated she expected staff to ensure medication carts and medications were secured and/or locked when not in the nurse or TMA's view. Finally, the DON said it was her expectation that expired medications would be removed from the medication carts and brought down to the nursing office for destruction.

The facility's Policy and Procedure for Storage of Medication revised 11/2012, instructed staff: ..."4. Insulin, IM (intramuscular) medications, nasal spray, eye drops and inhalers are all to be dated when opened and removed when expired. 5. All discontinued or expired medications will either be returned to pharmacy as allowed or brought to the nursing office for destruction..."

SUGGESTED METHOD FOR CORRECTION: The director of nursing could monitor to assure policy and procedures are current, implemented and assessed to assure expired medications are discarded and not administered to residents.

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31145	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31145		
31980	MN Rule 626.557 Subd. 3 Reporting Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) The individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572 <http://www.revisor.leg.state.mn.us/data/revisor/statutes/2005/626/../626/5572.html>, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	31980		6/30/16

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31980	Continued From page 11 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of neglect were thoroughly investigated and reported to the designated State agency (SA) for 1 of 4 residents (R13) reviewed for elopement. In addition the facility failed to ensure background screenings were verified for 8 of 8 employees whose files were reviewed. Findings include: A review of R13's Admission Record Resident Information sheet indicated diagnosis of schizoaffective disorder, impulse disorder and borderline intellectual functioning. R13's admission Minimum Data Set (MDS) dated 3/24/16, indicated he had intact cognition and was independent with all activities of daily living.	31980	Corrected	

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31980	Continued From page 12 A Life Skill/Life Safety Pedestrian Safely [sic] evaluation dated 4/12/16, indicated the following: R13 did not understand the importance of signing in/out of the facility and indicated 20 seconds after reminder, he forget what to do. R13 was not able to recite the facility address or phone number and did not have a cell phone, nor did he have a wallet or identification card. This evaluation further indicated R13 did not understand jay walking, did not cross the street appropriately, and did not demonstrate an ability to look both ways before walking across the street. The notes included, "writer had to hold resident back...very impulsive." Further, the evaluation noted R13 was unable to demonstrate waiting for traffic to clear and had to be held back several times for safety reminders, did not hold his head up when walking, and walked between parked cars. The notes included, "is very impulsive, poor decision making skills. Walks into the street with no regard for safety." R13's care plan dated 3/22/16, identified a potential for abuse to self and/or to/from others related to impulsive behaviors and borderline intellectual functioning. The care plan further identified a history of unsafe behaviors: "such as running out into the street without looking, approaching strangers in the community and going up to strangers' cars in traffic." Care plan interventions included: assess and review quarterly, document and report any incidents, educate staff, monitor and intervene as needed. The care plan further identified use of a Wanderguard (bracelet system that activated selected doors when attempting exit) due to engaging in unsafe behaviors outside of the facility by going up to strangers in their cars on busy streets. The care plan indicated R13 had also displayed these behaviors at the previous	31980		

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facility he'd lived in.

A review of Bywood East Health Care Progress Notes dated 3/11/16 through 5/18/16 indicated the following:

1) 3/26/16, At approximately 3:00 a.m., staff noted R13 outside the back door. R13 stated he did know when he went outside but demonstrated how he exited. The noted indicated R13 held his arms and hands at shoulder level and was able to exit through the door without triggering the alarm.

2) 4/2/16, R13 was found knocking on the front door to be let in at 2:15 a.m. and again at 2:30 a.m.

3) 4/3/16, At 5:15 a.m., R13 was observed going out the back door with another resident. When the other resident returned R13 was not with him. Staff went outside to look for R13 but did not find him outside. Staff got into a car to look for R13 and found him walking south from a local pharmacy several blocks away. R13 was noted to cross the street "irregardless of any passing car." The notes further indicate that at 7:00 a.m., another staff was driving south to work and noted R13 to be walking haphazardly south on the sidewalk.

4) 4/5/16, a resident called out loudly that R13 had gone outside via the fire door. The alarm had not sounded so staff thought the resident was mistaken, "somewhat later" R13 appeared at the locked front door knocking to get in.

5) 4/6/16, R13 was heard pounding on the main lobby door at 1:00 a.m. and could not state how long he had been outside.

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6) 4/7/16, At 3:00 a.m. R13 was knocking on the glass of the front lobby door to gain access. The progress notes indicated, "Staff on his floor was not aware he had eloped."

7) 4/11/16, A note indicated R13 had a Wanderguard in place but leaves the building "up to 15 times per day."

8) 4/24/16, At 4:00 p.m. R13 was noted to be outside the facility pushing a local pharmacy's shopping cart with a couple of bags containing pop.

9) 4/28/16, At 6:00 p.m. the assistant director of nursing observed R13 at 37th avenue and central avenue (down the street from the facility) as she was driving home.

10) 5/7/16, R13 eloped from the facility at approximately 1:35 a.m. through the south emergency exit and could not be seen in the dark. He did not return for approximately 20 minutes.

11) 5/17/16, on 5/16/16 staff found R13 at 37th avenue and Central Avenue. He appeared to be headed back towards the facility. R13 refused a ride back to the facility.

During an observation on 5/17/16, at 12:34 p.m. R13 was laying in his bed and appeared to be asleep. A Wanderguard bracelet was observed on his right wrist.

During an interview on 5/17/16, at 12:43 p.m. NA-B stated the Wanderguard will activate the elevator and the exit doors of the facility. NA-B also stated she was aware R13 wore a Wanderguard bracelet but stated he has gotten

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31980	Continued From page 15 out of the facility any way. NA-B stated the second floor residents with Wanderguard's have 30 minute checks but the third floor residents are not routinely monitored. During an interview with the director of nursing (DON) on 5/17/16 at 1:50 p.m., the DON stated R13 was unsafe to be out of the facility unsupervised. She verified R13 wears a Wanderguard but confirmed he was able to get out of the door before the alarm sounded by lifting up his arm with the bracelet. The DON stated there had been times when R13 had been out of the facility and not within sight of staff. The DON stated there had been no formal investigation following R13's elopements from the facility and no reports to the SA. A facility policy titled Bywood East health Care Vulnerable Adult Abuse Prevention Policy, dated 7/15/15 was reviewed. The policy indicated: "Bywood East Health Care adheres to the Vulnerable adult act, the Elder Justice Act, and all state/federal abuse prevention statutes and does not tolerate any forms of abuse including neglect." The policy directed staff to screen upon admission for a known history of potentially dangerous behaviors as well as his/her ability to leave the facility safely. In cases where these concerns are brought forward, the case was carefully considered to ensure placement was appropriate. The policy further directed staff to develop an individual abuse prevention plan to include measures to minimize the risk for the resident. "All incidents shall be immediately reported and the information supplied to the appropriate state agency." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies	31980		

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31980	Continued From page 16 and procedures related to reporting suspected maltreatment, update any policies as needed, train staff on the policies and monitor for compliance with policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31980		
32000	MN Rule 626.557 Subd. 14 Reporting Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person ' s susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.	32000		6/30/16

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32000	Continued From page 17 (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility ' s ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse reporting policy and procedures for 1 of 4 residents (R13) reviewed for elopement and failed to implement policies for conducting background studies for employees prior to them having any direct patient contact for 6 of 8 employees (E1, E2, E5, E6, E7, E8) whose files were reviewed. Findings include: Reporting A facility policy titled Bywood East health Care Vulnerable Adult Abuse Prevention Policy, dated 7/15/15 was reviewed. The policy indicated: "Bywood East Health Care adheres to the	32000	Corrected	

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Vulnerable adult act, the Elder Justice Act, and all state/federal abuse prevention statutes and does not tolerate any forms of abuse including neglect." The policy directed staff to screen upon admission for a known history of potentially dangerous behaviors as well as his/her ability to leave the facility safely. In cases where these concerns are brought forward, the case was carefully considered to ensure placement was appropriate. The policy further directed staff to develop an individual abuse prevention plan to include measures to minimize the risk for the resident. "All incidents shall be immediately reported and the information supplied to the appropriate state agency."

A review of R13's Admission Record Resident Information sheet indicated diagnosis of schizoaffective disorder, impulse disorder and borderline intellectual functioning. R13's admission Minimum Data Set (MDS) dated 3/24/16, indicated he had intact cognition and was independent with all activities of daily living.

A Life Skill/Life Safety Pedestrian Safely [sic] evaluation dated 4/12/16, indicated the following: R13 did not understand the importance of signing in/out of the facility and indicated 20 seconds after reminder, he forget what to do. R13 was not able to recite the facility address or phone number and did not have a cell phone, nor did he have a wallet or identification card. This evaluation further indicated R13 did not understand jay walking, did not cross the street appropriately, and did not demonstrate an ability to look both ways before walking across the street. The notes included, "writer had to hold resident back...very impulsive." Further, the evaluation noted R13 was unable to demonstrate waiting for traffic to clear and had to be held back

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BYWOOD EAST HEALTH CARE	**3427 CENTRAL AVENUE NORTHEAST MINNEAPOLIS, MN 55418**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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several times for safety reminders, did not hold his head up when walking, and walked between parked cars. The notes included, "is very impulsive, poor decision making skills. Walks into the street with no regard for safety."

R13's care plan dated 3/22/16, identified a potential for abuse to self and/or to/from others related to impulsive behaviors and borderline intellectual functioning. The care plan further identified a history of unsafe behaviors: "such as running out into the street without looking, approaching strangers in the community and going up to strangers' cars in traffic." Care plan interventions included: assess and review quarterly, document and report any incidents, educate staff, monitor and intervene as needed. The care plan further identified use of a Wanderguard (bracelet system that activated selected doors when attempting exit) due to engaging in unsafe behaviors outside of the facility by going up to strangers in their cars on busy streets. The care plan indicated R13 had also displayed these behaviors at the previous facility he'd lived in.

A review of Bywood East Health Care Progress Notes dated 3/11/16 through 5/18/16 indicated the following:

1) 3/26/16, At approximately 3:00 a.m., staff noted R13 outside the back door. R13 stated he did know when he went outside but demonstrated how he exited. The noted indicated R13 held his arms and hands at shoulder level and was able to exit through the door without triggering the alarm.

2) 4/2/16, R13 was found knocking on the front door to be let in at 2:15 a.m. and again at 2:30 a.m.

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	00176	A. BUILDING: ______ B. WING ______	05/19/2016

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32000	Continued From page 20 3) 4/3/16, At 5:15 a.m., R13 was observed going out the back door with another resident. When the other resident returned R13 was not with him. Staff went outside to look for R13 but did not find him outside. Staff got into a car to look for R13 and found him walking south from a local pharmacy several blocks away. R13 was noted to cross the street "irregardless of any passing car." The notes further indicate that at 7:00 a.m., another staff was driving south to work and noted R13 to be walking haphazardly south on the sidewalk. 4) 4/5/16, a resident called out loudly that R13 had gone outside via the fire door. The alarm had not sounded so staff thought the resident was mistaken, "somewhat later" R13 appeared at the locked front door knocking to get in. 5) 4/6/16, R13 was heard pounding on the main lobby door at 1:00 a.m. and could not state how long he had been outside. 6) 4/7/16, At 3:00 a.m. R13 was knocking on the glass of the front lobby door to gain access. The progress notes indicated, "Staff on his floor was not aware he had eloped." 7) 4/11/16, A note indicated R13 had a Wanderguard in place but leaves the building "up to 15 times per day." 8) 4/24/16, At 4:00 p.m. R13 was noted to be outside the facility pushing a local pharmacy's shopping cart with a couple of bags containing pop. 9) 4/28/16, At 6:00 p.m. the assistant director of nursing observed R13 at 37th avenue and central	32000		

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avenue (down the street from the facility) as she was driving home.

10) 5/7/16, R13 eloped from the facility at approximately 1:35 a.m. through the south emergency exit and could not be seen in the dark. He did not return for approximately 20 minutes.

11) 5/17/16, on 5/16/16 staff found R13 at 37th avenue and Central Avenue. He appeared to be headed back towards the facility. R13 refused a ride back to the facility.

During an observation on 5/17/16, at 12:34 p.m. R13 was laying in his bed and appeared to be asleep. A Wanderguard bracelet was observed on his right wrist.

During an interview on 5/17/16, at 12:43 p.m. NA-B stated the Wanderguard will activate the elevator and the exit doors of the facility. NA-B also stated she was aware R13 wore a Wanderguard bracelet but stated he has gotten out of the facility any way. NA-B stated the second floor residents with Wanderguard's have 30 minute checks but the third floor residents are not routinely monitored.

During an interview with the director of nursing (DON) on 5/17/16 at 1:50 p.m., the DON stated R13 was unsafe to be out of the facility unsupervised. She verified R13 wears a Wanderguard but confirmed he was able to get out of the door before the alarm sounded by lifting up his arm with the bracelet. The DON stated there had been times when R13 had been out of the facility and not within sight of staff. The DON stated there had been no formal investigation following R13's elopements from the

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facility and no reports to the SA.

While R13 had left the facility on multiple occasions and was assessed to be unsafe to leave the facility independently, there was no evidence the facility thoroughly investigated the incidents, nor were the incidents reported to the state agency. Futher there was no evidence of an individualized abuse plan as directed in the policy.

BACKGROUND STUDIES

Employee Files were reviewed. It was determined employee background studies were not submitted and returned prior to employees working with residents.

The Vulnerable Adult Abuse Prevention Policy indicated: "All applicants for employment in the facility shall, at the minimum, have the following screening check conducted"

1. Reference checks with the current and/or past employer.
2. Appropriate licensing board or registry check.
3. Criminal background check
4. Employers, volunteers, and interns may begin work pending the outcome of the criminal background check, but must be under continuous, direct supervision if they have access to persons receiving services.

E1's hire date was 10/12/15, DHS [Department of Human Services] request to screen was dated 10/14/15. The temporary (yellow) copy was returned 10/15/15, the final (blue) copy was dated 12/26/15.
E2's hire date was 7/21/15, DHS request to screen was dated 7/22/15, received final 7/23/15.

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E5's hire date was 11/13/15, DHS request to screen was dated 11/17/16, received final 11/19/15.
E6's hire date was 5/10/16, DHS request to screen was dated 5/13/16, the facility could not locate a response as of 5/19/16.
E7's hire date 5/10/16, DHS request to screen was dated 5/13/16, the facility could not locate a response as of 5/19/16.
E8's hire date was 4/8/16, DHS request to screen was dated 4/12/16, received final on 4/14/16.

On 5/19/16, at 2:45 p.m. the ADON verified staff begin orientation Day 1 with the human resources (HR) staff, Day 2 with nursing, and are then scheduled to work with residents. The ADON also confirmed the staff reviewed had worked alone with residents prior to their background checks having been completed.

On 5/19/16, at 3:00 p.m. HR-A was interviewed and stated she was not aware background checks needed to be completed prior to employees working with patients.

SUGGESTED METHOD FOR CORRECTION:
The administrator, director of nursing and/or designee, could monitor to assure policies and procedures are current and implemented.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.